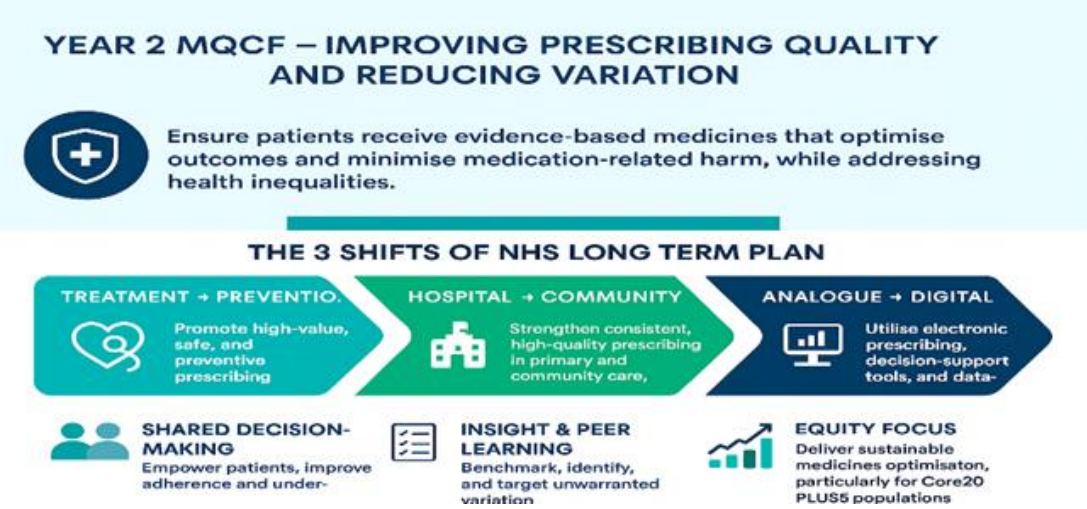
Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Medicines Quality and Commissioning Framework (MQCF) 25-27

Year 2

An Integrated Incentive Scheme for GP Practices



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Ambition Compassion Optimism Focus

Document Control Sheet

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Link to MQCF Year 1 25/26 https://www.shropshiretelfordandwrekin.nhs.uk/wp-content/uploads/Medicines-Quality-and-Commissioning-Framework-2025-2027.pdf

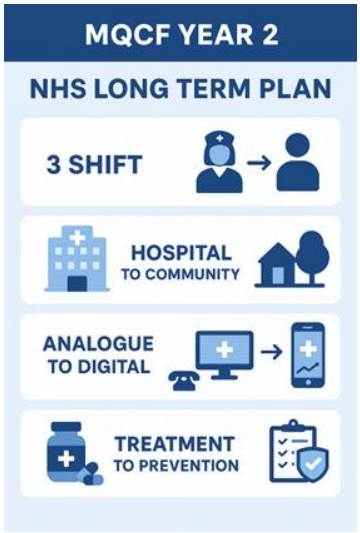
Introduction

The Pharmacy and Medicines Optimisation Team acknowledges the ongoing dedication and commitment of all GP practices to the successful delivery of Year 1 of the Medicines Quality and Commissioning Framework (MQCF) 2025–2027. The progress achieved over the past year is a testament to your hard work, collaboration, and focus on advancing medicines optimisation across the system.

As we move into **Year 2**, our focus remains towards **strengthening and supporting high-quality, safe, clinically effective, value and evidence-based prescribing practices**.

This next phase will focus on ensuring prescribing decisions deliver the best possible outcomes for patients and value for the healthcare system. The programme will support the NHS Long Term Plan by promoting high-value, preventative prescribing, improving consistency and quality across primary and community care, and making better use of digital tools such as electronic prescribing and data-driven decision support. This will help shift care towards a population-based, neighbourhood model and strengthen the infrastructure needed to support it. The approach will emphasise shared decision-making, patient empowerment and peer learning to enable sustainable and equitable medicines optimisation, with targeted action to reduce health inequalities in line with the Core20PLUS5 framework and national clinical standards.

Key Elements of the framework – in addition to practice agreement as outlined in Year 1 25/26



- Medicines Waste and Cost Efficiency
- Clinical Focus Areas
- Safe Prescribing of Medicines
- Community Pharmacy Engagement

Medicines Waste and Cost Efficiency.	Points 12.5pts
Year 2 includes several medicines optimisation initiatives designed to ensure we continue to deliver a value-based healthcare to the population of STW.	
(1). Medicines Waste Campaign	**5pts**
Building on the success of the Year 1 Medicines Waste Campaign (*Think Twice, Order Right*), Year 2 will focus on optimising prescribing quantities of long-acting (basal) insulin pens across primary care. This initiative aligns with ICB priorities relating to value-based prescribing, patient safety, sustainability, and reducing unwarranted variation.	
Aim To reduce medicines waste and improve the safe and effective use of long-acting (basal) insulin by ensuring that prescribing and dispensing quantities are aligned to individual patient need, rather than through the routine issuing of full packs. Long-acting insulin is a high-cost medicine that is frequently subject to dose titration and regimen changes. Most pre-filled long-acting insulin pens contain 3 mL (300 units), and depending on the prescribed daily dose, many patients require fewer than five pens per month. Where full packs are routinely prescribed without review of current clinical need, excess insulin may accumulate in patient homes and care settings. Routine oversupply contributes to avoidable medicines waste and unnecessary NHS expenditure. It also increases the likelihood of insulin expiring before use or being stored incorrectly, creating potential patient safety and medicines management risks. In addition, the disposal of unused insulin and packaging contributes to environmental and carbon impacts, making quantity optimisation an important component of sustainable prescribing. To support safe dispensing within community pharmacies and dispensing practices, and to minimise the need for split-pack dispensing, practices are encouraged to prescribe insulin in original pack quantities (e.g. boxes of five pens) wherever clinically appropriate. When issuing repeat prescriptions, practices should take account of pack sizes and align quantities, accordingly, balancing the need to reduce waste with safe and practical dispensing processes. It is recommended that insulin and other diabetes-related devices (e.g. test strips, lancets, needles, and sharps bins) are listed under the *Repeat Variable* section.	
Factors Affecting the Number of Pens Required (Basal Insulin Only) ➢ Basal daily dose: Quantities should be calculated using the patient's current prescribed dose of long-acting (basal) insulin only. Rapid-acting (bolus/mealtime) insulin should be excluded, as it must be assessed separately. ➢ Pen cartridge size: Most pre-filled long-acting insulin pens contain 3 mL (300 units), which should be used as the standard basis for calculating monthly requirements.	

- Dose titration: Basal insulin doses may be adjusted in response to blood glucose monitoring. Prescribing should reflect the most recent stable dose, with consideration of any anticipated adjustments.
- Practical usage factors: A small allowance may be required for wastage (e.g. priming, missed doses, or accidental loss), but routine over-ordering should be avoided.
- Individualised prescribing: Quantities should be tailored to the patient's actual monthly requirement. For many patients, this will equate to approximately **3–5 pens per month,** depending on dose.
- Patients on multiple insulin regimens: For patients prescribed both basal and bolus insulin, each type should be reviewed and prescribed independently to ensure accurate quantity optimisation.

How to calculate the amount of insulin to prescribe per month- This table below can be used as a practical guide to support clinicians in calculating the appropriate number of long-acting insulin pens required per month, based on the patient's current basal insulin dose.

Basal Insulin Monthly Requirement Guide (300 units per pen)

Daily Dose (units)	Monthly Units	Pens Needed
10	300	1
20	600	2
30	900	3
40	1200	4
50	1500	5
60	1800	6
80	2400	8
100	3000	10

For the purpose of this initiative, focus is on the long-acting (basal) insulin- e.g., insulin glargine, insulin detemir, and insulin degludec. Formulary

A search which identifies the patients to be reviewed will be available on Enterprise.

Other resources-
https://diabetesonthenet.com/wp-content/uploads/Insulin-prescribing-2022.pdf

Measurable Outcomes
Practices are encouraged to review all patients routinely prescribed >5 long-acting insulin pens per month to:

- confirm dose stability and titration status
- ensure prescribed quantities reflect practicable clinical need
- reduce excess supply where appropriate

KPI: Reduction in the proportion of patients prescribed >5 long-acting insulin pens by 75% from baseline, or achievement of a prescribing rate below the ICB average threshold, whichever is achieved first, by March 2027.

(2). Working in Partnership to Support Medicines Optimisation and Cost-Effective Prescribing

2.5pts

We recognise that practices often face pressure on capacity, workforce, and time, in the delivery of some of the medicines optimisation initiatives. To support this, we will be offering additional third-party clinical support to assist with medication reviews, formulation switches, and implementation activities where needed. These initiatives will focus on:

- Ensuring patients are prescribed the most clinically effective medicine in line with current guidance.
- Reducing use of medicines with limited evidence of benefit or poor cost-value.
- Supporting safe switches to preferred formulary choice, formulations, or brands where clinically appropriate.

Practice Engagement and Participation- We encourage practices to take up this support offer, particularly where capacity is limited.
Practices have two options:

- Opt to have the third-party clinical team, support the review on their behalf, supported by approval and oversight from the practice clinical lead; or
- Choose to undertake the work in-house

Both approaches are supported, and practices may adopt a hybrid model according to need.
Some of the focus area will be on the following:

- Cost Effective medicine switches- a list of drug switches to be moved to alternatives.
- Medicines of Low Clinical Value and Over the Counter items
  - Practices to continue to review patients currently prescribed items included in NHS 'Items which should not be routinely prescribed in primary care' guidance with a view to stopping or switching to treatments with a higher clinical/ cost evidence base **https://www.england.nhs.uk/medicines-2/items-which-should-not-be-routinely-prescribed/**

- Quantity Limit Medicines Review- e.g., GLP-1 receptor agonist, Blood Glucose testing Strip.
- Deprescribing of Safety-Pen Needles and Safety Lancets in line with **STW guidance**; communications has been sent to SCHT and all Care settings.
- Stoma Care accessory Review- Support by Spirit Healthcare

- DPP-4 review in line with updated NICE 28 – February 2026 and switch to SGLT-2(generic dapagliflozin) https://www.nice.org.uk/guidance/ng28/chapter/Initial-medicines
- SGLT-2 Review- Transition to generic Dapagliflozin where clinically appropriate
- DOAC Review – Edoxaban switch to **STW Formulary First Choices**

Please note practices completing some of these workstreams in-house will be eligible for a separate incentive. Further information will follow shortly

(3). Effective Use of the Clinical Support Decision System

5pts

Script Switch supports safe, evidence-based, and cost-effective prescribing across STW Practices by delivering real-time prescribing guidance at the point of care.
Following recent feedback from GP Practices, a targeted review of Script Switch messages has been undertaken. Particular attention has been given to switches from generic to branded generic products to ensure all recommendations are:

- Clinically appropriate
- Evidence-based
- Aligned with local formulary guidance
- Consistent with national prescribing priorities

This refinement ensures that prescribing prompts support high-quality clinical decision-making without generating unnecessary alerts, thereby enhancing both patient safety and prescriber confidence.

Optimising Patient Care Through Enhanced Script Switch Functionality
Recent developments within Script Switch now allow for the implementation of:

- Quantity limit prompts
- Safety alert mechanisms

These enhancements provide additional safeguards and optimisation opportunities within prescribing workflows.

Quantity Limit Prompts
These prompts support appropriate prescribing quantities in line with best practice guidance. They help to:

- Reduce waste and overprescribing
- Promote safer initiation quantities where clinically indicated e.g., optimal duration of antimicrobial courses.
- Improve cost-effectiveness while maintaining patient-centred care

Safety Alert Mechanism
The safety alert functionality enables practices to receive targeted alerts linked to national safety updates, local prescribing guidance, and medicines optimisation priorities. This supports:

- Safer prescribing decisions at the point of issue
- Reduction in avoidable medicines-related harm
- Consistent application of safety guidance across practices
- Early identification of prescribing risks

What is Required

- Each Practice will be provided with a baseline prescribing position at the start of the scheme, based on the most recent quarterly data.
- Practices are expected to actively engage with Script Switch prompts, including quantity limit and safety alerts, where clinically appropriate.

Measurable Outcomes

Practices will be evaluated on engagement with Script Switch using the metric of **≥200 Script Switch opportunities logged per 1,000 registered practice population per month**.
Acceptance rate targets are set as follows:

- **≥25% acceptance rate for acute prescriptions**
- **≥15% acceptance rate for repeat prescriptions**

In addition, the following optimisation and safety indicators will be monitored:

- **Demonstrable reduction in prescribing volumes exceeding recommended quantity limits**, aligned with best practice guidance.

Clinical Priorities Area	30pts
Antimicrobial Stewardship The UK's second 5-year National Action Plan (2024–2029) aims to reduce human antimicrobial use by 5% by 2029 and sets key priorities: ○ Reduce the need for antimicrobials and prevent unintended exposure ○ Optimise appropriate use These initiatives support primary care clinicians in promoting antimicrobial stewardship and ensuring optimal prescribing in line with local and national guidance. **Year 2- 2026/27** **(1). World Antimicrobial Resistance (AMR) Awareness Week (WAAW):** **18–24 November 2026** **All practices** are expected to actively support WAAW to help raise awareness of antimicrobial resistance and promote responsible prescribing. Using nationally available toolkits, by **18th November**, practices should be ready to: ➢ Promote WAAW on their website ➢ Display campaign materials within the practice (Practices may wish to nominate an Antibiotic Guardian to coordinate this) Antimicrobial resistance awareness: toolkit for healthcare providers - GOV.UK World Antimicrobial Resistance Awareness Week - Antimicrobial Resistance Programme - Futures (registration required)	**1pt**
(2). Optimising antibiotic use in children(0-9years): Appropriate antibiotic prescribing for children with acute respiratory tract infection(RTI). Antibiotic prescribing in children remains an important focus of antimicrobial stewardship programmes within primary care. Higher rates of antibiotic prescribing for acute respiratory tract infections (RTIs) in young children continue to raise concerns regarding antimicrobial resistance, variation in prescribing practice, and longer-term public health impact. Building on last year's work, there has been a measurable positive shift, with sustained improvements in antibiotic prescribing for children presenting with acute RTIs. A significant	**2pt**

number of practices are now aligned with recommended guidance and are achieving the NHSE target. Continued focus in this area will help consolidate these improvements and support further progress in paediatric antimicrobial stewardship.

The **Integrated Performance Report** includes a patient safety metric to monitor antibiotic prescribing in children aged 0–9 years in primary care. This metric supports national antimicrobial stewardship objectives by monitoring the percentage of children prescribed at least one antibiotic in the previous 12 months and encouraging reductions in inappropriate antibiotic prescribing.

Measurable outcome:

Practices performing above the national target (as defined in the NHS Oversight Framework) in April 2026 are expected to reduce their rate to at or below the national target by March 2027. Practices already performing at or below the national target are expected to maintain this level of performance

NHS Oversight Framework 2025-2026 - ICB performance dashboard: Children prescribed antibiotics in primary care

(3). Optimal duration of antibiotic courses

2pt

Research shows short antibiotic courses are as effective as longer ones for uncomplicated infections (Lee et al, 2023). Each extra day increases adverse event risk by 4%, resistance by 3%, and C. difficile risk (Curran J 2022; Schechner V 2021).

Reflecting this evidence, the STW Primary Care Antimicrobial Guidelines and NICE routinely recommends the shortest effective course for many common infections.

- **Doxycycline**

Five-day doxycycline courses are recommended for acute sinusitis, COPD exacerbation, acute cough, and community-acquired pneumonia. STW remains an outlier for 5-day course lengths of doxycycline, currently prescribing around 24.96% vs 35.99% regionally and 40.23%nationally (March 2026 data).

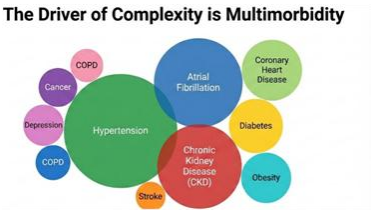
The aim is to safely increase 5-day prescribing for uncomplicated respiratory tract infections in line with guidance.

Measurable outcome:
Practices below 40% for doxycycline 5-day course length in April 2026 must work towards achieving a rate at or above this target by March 2027. Practices at or above the target of 40% will be required to maintain this good practice.

Measurement of 5-day course length is determined by a prescription for 6 x 100mg capsules (200mg on the first day then 100mg once a day for a total of 5 days).

Optimising antimicrobial duration dashboard – Doxycycline 100mg capsules

Cardiovascular Disease (CVD)



While individual cardiovascular, renal and metabolic pathways may still need to be managed separately this year, our shared vision is to begin shifting towards a more integrated, multimorbidity-focused approach.

In STW, 62% of people live with two to four associated cardiovascular, renal and metabolic conditions, creating a significant impact on individuals and the wider health economy. This drives our shift toward an integrated CVRM approach that recognises the influence of metabolic factors such as obesity and diabetes and manage these risks through a single, connected pathway.

By bringing cardiovascular, renal, metabolic and weight-related risk into a single holistic review, we can improve blood pressure, cholesterol and kidney management, increase uptake of treatments that benefit multiple conditions, and intervene earlier in CKD and heart failure.

This approach is underpinned by the CVRM, Prevent–Detect–Protect–Perfect framework: preventing risk by addressing metabolic and lifestyle drivers; detecting conditions early through systematic screening; protecting people with evidence-based interventions that reduce events and slow disease progression; and perfecting care through continuous optimisation, personalisation and reduction of unwarranted variation. Together, this creates a connected model that recognises cardiovascular, renal and metabolic risks as interdependent and best managed as a single continuum.

This transition will prepare the system for a future in which prevention, reviews and optimisation are delivered holistically rather than in silos, enabling more coordinated care, better use of clinical capacity and improved outcomes across the full CVRM spectrum.

(1). Optimisation of anti-hypertensive therapy in line with NICE guidance.

Hypertension is the most significant modifiable risk factor for CVD, contributing to approximately 50% of heart attacks and strokes. Despite this, an estimated 16 million adults in the UK have high blood pressure, and up to half are not receiving optimal treatment.[1]
BHF UK Cardiovascular Disease Factsheet

2.5pt

Evidence shows that even a modest reduction in blood pressure can have a major impact: a **10 mmHg decrease** is associated with a **17% lower risk of coronary heart disease**, **27% lower risk of stroke**, **28% lower risk of heart failure**, and a **13% reduction in all-cause mortality** (Ettehad, 2016).

This indicator continues the 25/26 focus on optimising anti-hypertensive therapy in line with NICE guidance. Practices already achieving the national ambition of 80% are exempt from further work on this indicator but are expected to maintain, and where possible improve, their current level of performance.

At the end of December 2025, across STW, approximately **64.29%** of patients with hypertension were **treated to the recommended blood pressure threshold**, compared to the **national ambition of 80%**. This means around **33,345 individuals** with hypertension were **not managed to target levels**. STW ranked **lowest** for this measure, with considerable **variation** observed between GP practices.[2,3]

- Regional & ICS Insights | CVDPREVENT
- CVDPREVENT Sept 2025

Local data highlights key health inequalities in blood pressure management, particularly among:

- People in the most deprived quintiles (Index of Multiple Deprivation)
- Individuals of Black or Mixed ethnicity
- Males
- Adults aged 18–59

Aims

- To increase the proportion of patients with diagnosed hypertension who achieve their treatment targets, while narrowing the health inequalities gap.
- To ensure patient reviews are conducted holistically with lifestyle management advice, and the decision on hypertension treatment is based on an informed shared decision.
- To ensure the patient is offered an annual review and supported with adherence to treatment.
- To support the prevention priorities outlined in England's 10-Year Health Plan: *Fit for the Future* (GOV.UK).

Measurable outcomes:

- Practices will be required to work towards the national ambition of 80% of patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.
- Practices currently at or above the national ambition of 80% are expected to maintain this level of performance. Those with achievement rates of 70% and under are required to demonstrate a minimum of 10% improvement on top of their current rate. Practices performing above 70% and below 80% are expected to achieve the national ambition of 80% by March 2027.

Support and Resources

Community Pharmacy BP Services
Supporting guidance flowchart
Overview | Hypertension in adults: diagnosis and management | Guidance
NICE NICE NG136 Visual summary
UCLPartners search and risk stratification tool (supplied by MM Team via Enterprise)
Eclipse VISTA Pathway Hypertension Perfect
DES Contract specification
*network-contract-DES-contract-contract specification 2026-27.

(2). Optimisation of Heart Failure treatments

10pt

Heart failure (HF) remains substantially under-detected and under-diagnosed across STW, reflecting the national picture. Around 80% of patients receive their diagnosis only after an acute hospital admission, despite evidence showing that up to 40% had previously presented to primary care with symptoms that could have prompted earlier investigation.

Local burden-of-disease data shows that 6,516 people in STW are currently living with heart failure, with modelling suggesting a further 2,700 individuals remain undiagnosed. These patients are at increased risk of avoidable hospitalisation, accelerated disease progression and poorer outcomes

Evidence from NICE NG106 and European Society of Cardiology (ESC) guidance demonstrates that patients with heart failure with reduced ejection fraction (HFrEF) experience significant improvements in survival, quality of life, and reduced hospital admissions when treated with guideline-directed medical therapy (GDMT).

This includes the early and comprehensive use of:

- ACE inhibitor (ACEi), angiotensin receptor blocker (ARB), or angiotensin receptor–neprilysin inhibitor (ARNI)
- Evidence-based beta-blocker
- Mineralocorticoid receptor antagonist (MRA)- Spironolactone, Eplerenone
- Sodium-glucose co-transporter-2 (SGLT2) inhibitor

Despite strong evidence, local and national audits consistently demonstrate unwarranted variation in prescribing, with under-utilisation of SGLT2 inhibitors and ARNIs, delayed initiation, and sub-optimal dose titration. These gaps represent a significant opportunity to improve outcomes while supporting system sustainability.

Improving early detection, strengthening coding accuracy and increasing optimisation of guideline-directed therapy represent major opportunities to reduce acute admissions, improve quality of life and deliver more proactive, equitable HF care across the system.

Primary care clinicians are skilled in using established heart failure treatments such as ACE inhibitors/ARBs, beta-blockers and MRAs. As evidence has progressed, it is essential that practices also optimise newer therapies, including ARNIs and SGLT2 inhibitors, when clinically appropriate. For patients with HFrEF, the greatest prognostic benefit comes from delivering all four components of guideline-directed medical therapy, unless contraindicated.

Data from ECLIPSE shows that only 17% of patients with HFrEF are on the four pillars.

This workstream will also support with the delivery of the GP contract QOF on HF009.

Aim

To improve the optimisation of heart failure treatment in primary care, ensuring eligible patients receive evidence-based therapy at appropriate doses, thereby improving clinical outcomes and reducing avoidable hospital activity.

Objectives

- Increase uptake of NICE-recommended therapies in HFrEF
- Improve dose optimisation and structured follow-up
- Reduce variation in HF management across practices
- Improve patient experience and quality of life

- Reduce non-elective HF admissions and bed days

Delivery may be supported by PCN pharmacists, nurses, and multidisciplinary team working.

Note: The accuracy of the pre-built Medicines Optimisation Team search on Enterprise is dependent on effective coding within each practice; while it incorporates the agreed exclusion criteria, all remaining patients still require clinical review to confirm appropriateness.

Scope and Eligibility- Focus will be on adult patients on the QOF Heart Failure Register (HF001) with confirmed HFrEF (LVEF <40%)

Practice Requirements-

- **Register Validation and Case Finding**
  - Review the HF register to ensure accurate coding
  - Confirm left ventricular ejection fraction (HFrEF vs HFpEF)
  - Exclude patients receiving end-of-life care or with documented contraindications

- **Heart Failure Clinical Review.** For eligible HFrEF patients:
  - Undertake a medication review of HF patients
  - Assess current therapy against NICE guidance
  - Initiate missing therapies where clinically appropriate
  - Optimise existing therapy toward target or maximally tolerated dose
  - Safety checks include reviewing side effects, potential drug interactions, blood pressure, pulse, blood test results and renal function.
  - Document contraindications or intolerance clearly.

- **Mineralocorticoid Receptor Antagonist (MRA) Optimisation**
  - Identify eligible HFrEF patients not currently prescribed an MRA **(e.g. spironolactone or eplerenone**)
  - Initiate MRA therapy in line with NICE guidance, unless contraindicated
    - Assess baseline renal function and serum potassium prior to initiation
    - Provide patient counselling regarding potential adverse effects
    - Arrange monitoring of renal function and potassium at 1 week, 4 weeks, and periodically thereafter
    - Clearly document contraindications or intolerance where MRA therapy is not appropriate
    - Note the risk of hyperkalaemia when MRA are combined with ACEi/ARB/ARNI

- **SGLT2 Inhibitor (Generic Dapagliflozin) Optimisation**
  - Initiate SGLT2 inhibitors in eligible patients (generic **dapagliflozin**)- consider contraindications and cautions in line with pathway protocol.
  - Provide patient counselling including sick-day rules
  - Arrange renal function monitoring in line with guidance

- **ARNI Review**
  - Identify patients who may be suitable for sacubitril/valsartan in line with local guidance.
  - Initiation of sacubitril/valsartan should be undertaken by the specialist cardiology team.
  - Following specialist initiation, prescribing may be continued in primary care in line with formulary status (Amber) and shared care arrangements where appropriate.

Pathway Protocol on Heart Failure- will be provided.

Measurable Outcomes

Metric (KPI)	Target	Rationale	Core20PLUS5 Benefit
Heart Failure Medication Review Completion **HF Med review code- Practices to use 473226007 SNOMED code for HF Review**	≥90%	Ensures proactive HF management, safety monitoring (renal function, potassium, blood pressure, pulse rate and rhythm), and identification of optimisation opportunities.	Supports earlier identification of deterioration in vulnerable groups and improves access to proactive care in underserved communities.
Cardiovascular Risk Factor Control (BP and Lipids). Percentage of HFrEF patients with documented blood pressure and lipid review.	≥75% with documented review	Hypertension contributes to HF progression and CVD risk, while lipid optimisation reduces residual atherosclerotic risk even in established HF. Targets should be individualised, with avoidance of overtreatment causing hypotension. In HFrEF, BP targets should be applied in a clinically appropriate manner, prioritising GDMT tolerance over strict thresholds.	Better risk factor control reduces excess cardiovascular morbidity in deprived populations where multimorbidity and uncontrolled risk factors are more common.
SGLT2 Inhibitor Uptake Percentage of eligible HFrEF patients prescribed an SGLT2 inhibitor (**generic Dapagliflozin**)	≥75% improvement from baseline	SGLT2 inhibitors provide mortality and admission reduction benefits independent of diabetes status. Uptake remains variable nationally.	Reduces cardiovascular admissions disproportionately affecting deprived communities and supports improved outcomes in people with multimorbidity (e.g., diabetes + HF).
Four pillar therapy Percentage of eligible HFrEF patients prescribed	≥75% improvement from baseline	Full guideline-directed medical therapy (GDMT) significantly reduces mortality and	Patients in deprived communities have higher HF prevalence and admission rates. Improving

ACEi/ARB/ARNI + beta-blocker + MRA + SGLT2 inhibitor		hospital admissions in HFrEF. Ensures evidence-based standardisation of care and reduces unwarranted variation.	GDMT uptake reduces premature mortality and emergency admissions within Core20 populations.

Resources:
HF treatment protocol.
Structured Medication Reviews Best Practice Guidance

Diabetes

Type 2 diabetes is a significant long-term condition within the STW population and is closely associated with overweight and obesity, which are major risk factors for its development and progression. Diabetes substantially increases the risk of cardiovascular disease, chronic kidney disease (CKD) and microvascular complications such as retinopathy and neuropathy. Around 40% of people with diabetes develop CKD, placing them at markedly higher risk of cardiovascular morbidity and mortality, with cardiovascular disease remaining the leading cause of death in this group.

Achieving the Three Treatment Targets (TTT): glycaemic control (HbA1c), blood pressure and cholesterol/lipids, is central to reducing these risks. Local data, however, show substantial variation in target attainment both between practices and across population groups. People from deprived communities, ethnic minority backgrounds and those living with multiple long-term conditions are less likely to meet these targets, contributing to widening health inequalities

Pathway	Patients needing Review	Monitored	Rank	Rating	
HbA1c	3422 View Patients	90.0% 30,856	50 / 75	Satisfactory	View
Cholesterol	5713 View Patients	83.3% 28,565	64 / 75	Requires Improvement	View
BP	4144 View Patients	87.9% 30,134	68 / 75	Requires Improvement	View

Data from ECLIPSE https://www.nhspathways.org/nhspathways/members/SONAR/lander.aspx- January 2026

The ECLIPSE tool provides practices with a systematic way to identify gaps in Three Treatment Target (TTT) monitoring, track progress, and prioritise Core20PLUS5 populations for structured review and support. This enables proactive identification of those at greatest risk of poor outcomes.

While optimisation of the TTT remains essential, emerging evidence and national guidelines (NICE NG28, NG203, NG136 and UK Kidney Association guidance) make clear that achieving targets alone is not sufficient for people with diabetes and CKD. Early initiation of evidence-based cardioprotective therapies, particularly SGLT2 inhibitors and GLP-1 receptor agonists, is now strongly recommended regardless of HbA1c level, given their proven ability to slow CKD progression, reduce heart failure admissions, and lower the risk of myocardial infarction and cardiovascular death.

Despite this strong evidence base, uptake and optimisation of these therapies remain variable across primary care in STW. Local ICB prescribing dashboards and CVD Prevent data show unwarranted variation in their use, leading to avoidable disease progression, increased unplanned care activity and poorer outcomes for patients.

Aligning TTT monitoring with optimisation of cardioprotective therapy offers a significant opportunity to strengthen diabetes, heart failure, CVD and CKD management, reduce inequity, and deliver clinically and financially meaningful improvements.

(1). Three Treatment Targets (3TTT) in Adults with Type 2 Diabetes

2.5pt

Aim: To improve achievement of the Three Treatment Targets (HbA1c, blood pressure, and cholesterol) in adults with Type 2 Diabetes through systematic identification, prioritisation, and review of patients, including those within Core20PLUS5 groups—using ECLIPSE to support structured optimisation of care.

Note: The accuracy of the pre-built Medicines Optimisation Team search on Enterprise is dependent on effective coding within each practice; while it incorporates the agreed exclusion criteria, all remaining patients still require clinical review to confirm appropriateness.

Blood glucose management | Type 2 diabetes in adults: management | Guidance | NICE
NG136 Hypertension in adults: Visual summary 23/07/2025

Measurable Outcomes

Metric (KPIs)	Target for Practices	Rationale / Objective	Core20PLUS5 Link
HbA1c (glycaemic control) Target: **≤48–53 mmol/mol** (individualised)	Practices should aim for **≥70%** of patients achieving an HbA1c within their personalised target range, or ≥10% improvement from baseline	Tight glycaemic control reduces microvascular complications and long-term diabetes-related morbidity.	Supports improved diabetes outcomes in deprived and minority groups who face barriers to optimal self-management and review access.
Blood Pressure <140/90 mmHg (note: <130/80 mmHg for albuminuria/CKD/high CV risk) HBPM/ABPM target: below 135/85 mmHg	≥70% of patients achieving BP target, or ≥10% improvement from baseline	Reduces risk of stroke, cardiovascular events and progression of CKD	Addresses higher cardiovascular risk and poorer hypertension control in Core20PLUS5 populations.
Lipids- % of patients achieving a reduction of non-HDL cholesterol (non-HDL-C) of >40%	≥70% of patients achieving lipid target, or ≥10% improvement from baseline	Lowers risk of premature cardiovascular disease in T2DM.	Ensures equitable access to lipid optimisation (statins, ezetimibe) for underserved groups.

(2). Early Initiation of Cardioprotective Agents for People with Type 2 Diabetes and Chronic Kidney Disease

10pts

The updated **NICE guidance NG28** now supports earlier and broader use of SGLT2 inhibitors across the Type 2 Diabetes (T2DM) population following metformin initiation.

While recognising this shift, it is important to ensure that implementation at a local level is safe, prioritised, and deliverable for practices.

A pragmatic phased approach will therefore be adopted. In Year 1, practices were offered the Cardiovascular Risk Reduction Type 2 Diabetes Service, with 60% of GP practices benefiting following an expression of interest process.

Building on this, it is recommended that practices identify and optimise therapy in patients with Type 2 Diabetes and chronic kidney disease (CKD), where there is strong evidence of benefit from early cardioprotective therapies. This approach enables targeted optimisation while aligning with national guidance and managing workload across primary care.

Aim: To support consistent and equitable use of SGLT2 inhibitors **(generic dapagliflozin**) in adults with T2DM and CKD stage ≥3a.
This indicator also supports Core20PLUS5 by addressing health inequalities, particularly in STW, where rurality, deprivation, and variable access contribute to later diagnosis and poorer outcomes. Continuing this workstream helps identify gaps, support timely initiation, and maintain consistent care across the population

Requirement for Practices – Search and Identification
Practices are expected to use the pre-built search developed by the Pharmacy and Medicines Optimisation Team or create an equivalent local clinical system search to:

1. Identify all adults with T2DM and CKD stage ≥3a (eGFR <60 and ACR >3 mg/mmol).
2. Exclude patients who clearly meet predefined exclusion criteria.
3. Generate a prioritised cohort of patients requiring clinical review for suitability for SGLT2inhibitor initiation.

Choice of SGLT-2 inhibitor should be generic Dapagliflozin in line with STW formulary

Note: The accuracy of the pre-built Medicines Optimisation Team search on Enterprise is dependent on effective coding within each practice; while it incorporates the agreed exclusion criteria, all remaining patients still require clinical review to confirm appropriateness.

Measurable Outcomes

MQCF Metric	Target	Rationale	Benefit to Core20PLUS
SGLT2 Inhibitor Uptake in T2DM + CKD **Note- To be prescribed as generic Dapagliflozin** Percentage of eligible patients (eGFR ≥15 ml/min/1.73m² unless contraindicated) prescribed dapagliflozin)	**≥80%** of eligible patients **or** ≥50% improvement from baseline	SGLT2 inhibitors slow CKD progression and reduce HF hospitalisation and CV mortality, independent of glycaemic control. Early initiation reduces renal decline and system cost pressures.	Higher CKD and T2DM burden in deprived and ethnically diverse groups. Increased uptake reduces progression to dialysis and premature CVD mortality.

ACEi/ARB Optimisation in Albuminuric CKD Percentage of patients with T2DM and albuminuria (ACR ≥3 mg/mmol) prescribed ACEi/ARB unless contraindicated	**≥90%** of eligible patients	RAAS blockade reduces proteinuria, slows CKD progression, and lowers cardiovascular events. Remains foundational therapy.	Albuminuria and uncontrolled hypertension are more prevalent in deprived groups. Optimisation reduces inequality in renal and cardiovascular outcomes.	
Early Combination Therapy Percentage of eligible T2DM + CKD patients on both ACEi/ARB and SGLT2 inhibitor (generic dapagliflozin)	**≥75%** of eligible patients	Combined therapy provides additive renal and cardiovascular protection and supports proactive disease modification.	Reduces avoidable admissions and progression to ESRD, which disproportionately affects deprived communities.	
Annual Renal Review Completion Percentage of T2DM + CKD patients with documented eGFR and ACR in last 12 months	**≥95%**	Enables early identification of decline and timely optimisation of cardioprotective therapy. Supports safe prescribing.	Improves access to preventative monitoring and reduces late presentation of advanced CKD in underserved groups.	

Training

As part of the delivery of key clinical focus areas within the framework, a series of training sessions will be delivered throughout the year. These sessions are designed to support practices in the implementation of the workstreams.

Practices will need to ensure attendance at these sessions- Further details will be circulated in advance of the sessions.

2.5pt

Safe Prescribing of Medicines	50pts
The allocated payment for this section supports practices in actively engaging with and adopting Integrated Care Protocols (ICPS), and in ensuring the effective monitoring, review, and safe management of medicines.	
In NHS Shropshire, Telford, and Wrekin, the **Local Health Economy formulary** is structured around a Red/Amber/Green/Black classification system, which plays a pivotal role in defining prescribing responsibilities. **Amber medicines** are divided into the following subcategories. AR - Amber Specialist Recommendation: Initiation and maintenance of prescribing in Primary Care following recommendation from a specialist. AI – Amber Specialist Initiation: Initiation and maintenance of prescribing by Specialists and transfer to Primary Care prescribing when appropriate. This may be supported by a RICaD document, which is a prescribing support document to outline the reasoning for initiation, continuation and discontinuation of a medicine. SC - Amber Shared Care: Initiation and maintenance of prescribing by Specialists and transfer to Primary Care prescribing, in accordance with an Integrated Care Protocol (formerly known as ESCA), annotated within the formulary entry. As the name implies, an Integrated Care Protocol (ICP) defines the responsibilities to be fulfilled by each sector and promotes collaborative arrangements to safeguard treatment delivery. ICPs depend on consistent and timely communication between specialist services and Primary Care. A dedicated mechanism for GPs to access advice and guidance from specialist services must be established to ensure the continued safe prescribing and management of treatment. Ongoing efforts are focused on developing a Specialist Medicines Governance Framework, which will provide Primary Care with clear guidance on the wraparound care available to support the prescribing of specialist medicines within the primary care setting. To achieve these outcomes, it is imperative that GPs actively support shared care agreements. This support, backed by robust systems and clear specialist clinical responsibilities, is crucial in ensuring patient safety and optimising treatment outcomes. *Decisions about who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on the patient's best interests, rather than on convenience or the cost of the medicine and associated monitoring or follow-up.* (Shared care - professional standards - GMC) However, shared care prescribing should only occur when primary care prescribers have sufficient information and feel competent to take responsibility for prescribing with adequate and accessible specialist support. A decline to prescribe process is in place if there is a clinical reason why primary care prescribers feel that they cannot continue with the ongoing prescribing**. (20220726 NHS STW Decline to prescribe V4_1.docx)** **The key benefits of effective shared care:** 1. Improved patient experience – Patients can receive care closer to home while still accessing specialist advice and guidance when needed, leading to seamless and coordinated care. 2. Enhanced communication – Regular and effective communication between specialists and primary care allows for better information sharing and informed decision making. 3. Effective resource utilisation – Clearly defined roles and responsibilities, making better use of healthcare resources.	

4. Early intervention and preventative care – Accessible routes to specialist services for primary care providers can seek timely advice and guidance enabling proactive management of chronic conditions.
5. Facilitates the flow of patients and enables capacity to be freed in specialist services both for inpatient beds and outpatient clinic appointments.
6. Improved clinical outcomes – Better coordination of care and access to specialist expertise means that patients with chronic conditions can receive person centred treatment plans and potentially achieve better health outcomes.
7. Professional development – Improved collaboration and shared learning opportunities between primary care and specialist teams can enhance clinical knowledge and practice.

To achieve these outcomes, it is imperative that GPs actively support shared care agreements. This support, backed by robust systems and clarity about specialist clinical responsibilities, is crucial in ensuring patient safety and optimising treatment outcomes.

Medication	**Indication/ Category**
Amiodarone	Cardiac rhythm disorders in adults
Antipsychotics: Risperidone, Olanzapine, Quetiapine, Aripiprazole, Amisulpride	Schizophrenia, bipolar disorder
Apomorphine	Parkinson's Disease
Atomoxetine	ADHD
Azathioprine	DMARDs for all licensed indications
Ciclosporin	DMARDs
Cinacalcet	Complex Primary Hyperparathyroidism only
Dapsone	DMARDs
Denosumab	Osteoporosis
Donepezil	Dementia
Dronedarone	Non-Permanent Atrial Fibrillation (AF)
Fluoxetine- Paeds	CAMHS- Depression
Galatamine	Dementia
Hydroxychloroquine	DMARDs
Leflunomide	DMARDs
Lisdexamfetamine	ADHD
Liothyronine	Hypothyroidism
Lithium	MH
Memantine	Dementia
Mercaptopurine	DMARDs
Methotrexate	DMARDs
Methylphenidate	ADHD
Mycophenolate mofetil	DMARDs
Penicillamine	DMARDs
Riluzole	Motor Neurone Disease

Risperidone	CAMHS-Conduct disorder
Rivastigmine	Dementia
Sodium Valproate for women of childbearing age	For all licensed indications
Somatropin	Growth Hormone deficiency
Sulfasalazine	DMARDs

Key Components of Safe Prescribing and Drug Monitoring

This element focusses on improving and reinforcing safe and effective processes to ensure robust drug monitoring.

1.Development and Maintenance of a Register
Providers should be able to produce an up-to-date register of all patients on the specified medicines included in shared care agreements, using appropriate Read codes.

2.Call and Recall System
Providers must have a systematic call and recall system in place and be able to demonstrate its effectiveness. Where patents fail to adhere to required monitoring or any clinical communication, practices must have clearly documented processes in place to assess and action if prescribing remains appropriate. E.g. patients fail to attend for blood monitoring; prescription quantities reduced until monitoring is completed.

3.Safety Systems and Processes
Practices should have systems to identify and manage patients at risk of HARMS or serious adverse events, particularly those on high-risk medicines or requiring regular monitoring. This includes addressing MHRA/CAS drug safety alerts for both new and existing medications.
The ICB Medicines Optimisation team can also provide guidance to support with best practices to enhance risk stratification and identify high-risk patients effectively.

4.Prescribing Responsibilities
The patient's GP is responsible for prescribing medications and making any necessary dose adjustments based on monitoring, unless dosing is managed by another provider (e.g., warfarin dosing by a Secondary Care Anticoagulation Clinic or a specialist as outlined in the Integrated Care Pathway [ICP]). In such cases, the specialist provider assumes clinical responsibility for dosing decisions.
Practices should have standard operating procedures in place for all aspects of high-risk drug prescribing, including Variable-Known-Activity (VKA) anticoagulant prescribing. For example, Practices prescribing test strips for patient INR testing must obtain documentation from Secondary care re Anticoagulation Services to confirm that the patient's INR testing equipment undergoes regular quality control checks.

5.Monitoring Requirements
Prescribers must ensure that patients are monitored regularly in accordance with the ICP, RiCaD (Risk Communication and Decision), or product recommendations when ICP or RiCaD are not required, before issuing repeat prescriptions.
Some patients may opt for self-monitoring (e.g., INR or blood pressure monitoring) using a point- of-care device. The practice or specialist provider should assess patient suitability for self- monitoring, and any decision should be fully documented in the clinical record. INR self-monitoring must follow the Secondary Care Anticoagulation Clinic agreement, with patients receiving the necessary training.

6.Individual annual review Service providers will be required to conduct a formal review of the patient's health in relation to their medicine(s) at least annually, including review of continued need for treatment where this aspect of treatment is being managed by primary care. This review should be conducted and clearly communicated to the GP Practice and documented in the patient's clinical record.
Where patients are managed under a shared care arrangement with a provider under an ICP, Primary Care service providers should confirm the patient has attended for review by their specialist as appropriate; and take any necessary action if the patient did not attend or has been discharged due to persistent failure to attend, to ensure ongoing safe prescribing.

7. Record- keeping. Providers should maintain adequate records of the performance and results of the service provided, incorporating all known information relating to any significant events e.g., hospital admissions, death of which the practice has been notified.

7a. Where patients are managed entirely by their specialist including prescribing responsibility, practices should still ensure there is an appropriate record of the medicine(s) within their clinical record (medication profile) for drug interaction purposes and the ability to recognise any adverse effects or drug interactions relating to that medicine.

8.Incident Reporting and Learning from Errors
Primary care providers must maintain a robust incident management policy that ensures timely recognition, reporting and management of all clinical and non-clinical- incidents. This policy should clearly outline processes for incident recognition, data collection, formal risk assessment, action planning, and mechanisms for shared learning to support continuous improvement across services. (Primary Care Patient Safety Strategy)

Providers are required to report incidents resulting in significant patient harm, including those related to medication, equipment, clinical processes, or serious communication failures, to the ICB Quality Team in accordance with the local incident management policy. Incidents should be reported **as soon as reasonably practicable**, in line with the Patient Safety Incident Response Framework (PSIRF) principles, to enable timely review and, where appropriate, submission to the national reporting system.
Where a formal investigation is required, this should be undertaken using an appropriate **patient safety incident investigation approach**, with a focus on understanding contributory factors and identifying opportunities for learning and system improvement. Investigation findings should be shared within agreed organisational and national timeframes

Additionally, providers must inform the ICB Medicines Optimisation Team of all medication-related incidents. This includes, but is not limited to, **prescribing errors, dispensing errors, adverse drug interactions, delayed or missed monitoring, and inappropriate initiation, continuation or discontinuation of treatment.**
Additionally, providers must inform the ICB Medicines Optimisation Team of all medication-related incidents. This includes but is not limited to adverse interactions, delayed or missed monitoring, or inappropriate continuation of treatment.

To support system-wide learning and strengthen patient safety culture primary care providers are encouraged to use the Datix incident reporting system for all medication errors and near misses. Consistent use of this platform enables trend analysis, shared learning, and the development of targeted interventions to reduce future risk.

Ensuring Medication Safety with ECLIPSE Live

To support GP practices in maintaining robust safety systems and processes, the ICB continues to invest in ECLIPSE Live (Electronic Care Leading to Improved Safety & Empowerment). This clinical risk assessment tool enhances medication safety, reduces the risk of medicine-related emergency admissions, and supports GP CQC inspections by helping practices improve medicine-related systems and processes. It ensures safer prescribing, facilitates active monitoring of alerts, and demonstrates adherence to best practices in patient safety.

Medication-related incidents contribute to thousands of preventable deaths each year. Eclipse Live serves as a proactive intervention tool, enabling GP practices to monitor patients against predefined safety criteria, allowing for timely clinical action.
In NHS STW, Eclipse Live has already led to life-saving interventions, significantly reducing preventable medication-related hospital admissions.

What is required:

(1). Review Safe Prescribing of Sodium Valproate
A recent audit across STW GP practices indicates that approximately 70% of patients prescribed sodium valproate are compliant with MHRA Pregnancy Prevention Programme (PPP) requirements. Key gaps have been identified in clinical coding, completion of Annual Risk Acknowledgement Forms (ARAF), and documentation of contraception status where applicable.

To support GP practices in addressing these gaps, a clinical system search will be made available to support case finding and identify patients requiring review as part of this process.
This includes completing structured patient reviews, undertaking risk stratification (with a particular focus on females of childbearing potential), implementing recall systems, and utilising standardised documentation templates. Multidisciplinary team involvement and consistent coding practices are expected to ensure safe prescribing, effective monitoring, and compliance with regulatory requirements.

Measurable outcome:
Achieve and maintain **≥90% compliance with PPP requirements across GP practices**. This includes evidence of a PPP referral within the last two months or accurate PPP coding in the last 12 months (e.g. completed ARAF or documented non-compliance), up-to-date risk acknowledgement documentation, and recorded contraception status where applicable.

This will be reviewed on a quarterly basis, and practices that do not meet this requirement will incur 5% deducted from their Safe Prescribing of Medicines quarterly payment.

Further guidance on prescribing and coding requirements can be found here:
Sodium Valproate primary care pathway - Updated Feb 2026.pdf

This will be implemented from Q2

(2). Practices must regularly review CQC High-Risk Medicines and Eclipse RADAR alerts, taking appropriate action based on risk levels

- CQC High-Risk Medicines
  - Ensure 90% compliance with appropriate monitoring, aligned with CQC searches within ECLIPSE

- RED Alerts (High-Risk Patients)
  - Review all patients with a RED alert.
  - Review alerts weekly for prompt action and improved patient safety.
  - RED alerts must be addressed by Friday of the week they are raised.
- AMBER Alerts (Moderate-Risk Patients)
  - Review all patients with an AMBER alert.
  - Review alerts weekly for prompt action and improved patient safety.
  - AMBER alerts must be addressed by Friday of the week they are raised

List of Medicines Requiring Monitoring

Medication	Indication/ Category
ACE inhibitors/ARB's	For all licensed indications
Antidiabetics including GLP-1's	Diabetes
Antiplatelets	For all licensed indications
5-Aminosalicylates – Balsalazide, Mesalazine and Olsalazine	DMARDs
Apixaban	Anticoagulation
Brivaracetam	Epilepsy
Carbamazepine	For all licensed indications
Carbimazole	Hyperthyroidism
Oral Corticosteroids	For all licensed indications
Citalopram	Anti-depressant
Combined Hormonal Contraception	Contraception
Dabigatran	Anticoagulation
Dapagliflozin	Heart failure
Digoxin	Rate control- arrhythmia
Diuretics	Oedema- various
Edoxaban	Anticoagulation
Enoxaparin	Sub-therapeutic INR, DVT bridging, VTE in cancer
Empagliflozin	Heart Failure
Eplerenone	Heart Failure
Melatonin	Insomnia/Sleep disturbances
Mirabegron	Incontinence
Nitrofurantoin	Infection
NSAIDs	For all licensed indications
Phenytoin	Epilepsy
Proton pump inhibitors	Acid-suppression
Propylthiouracil	Hyperthyroidism

Relugolix-estradiol-norethisterone acetate (Ryeqo®)	Treating moderate to severe symptoms of uterine fibroids
Rivaroxaban	Anticoagulation
Sacubutril/Valsartan	Heart failure once stabilised
Sirolimus	Immunosuppressant
Sodium Zirconium Cyclosilicate (Lokelma)	Chronic hyperkalaemia in adults
Spironolactone	Heart Failure
Statins	Lipid management
Tacrolimus	DMARDs
Theophylline	Respiratory
Tinzaparin	Sub-therapeutic INR, DVT bridging, VTE in cancer
Warfarin	Anticoagulation

Community Pharmacy Engagement	5pts
In addition to providing pharmaceutical supply services for Shropshire Telford and Wrekin, community pharmacies are a source of expert health advise and clinical service delivery from within our communities. Over recent years the clinical service offering from community pharmacies has expanded vastly to include support for self-care, minor ailments advice, common condition treatments, contraception supply, prevention and reducing harms associated with medicines use. The network of 80 community pharmacies across the area supports all three pillars of channel shift from: Analogue to Digital, Treatment to Prevention, and Hospital to Community. With easy access from within communities who need them the most, community pharmacies represent a vital pillar of primary care that supports patients and the wider healthcare system. Through a range of Essential, Enhanced, and Advanced NHS services, our community pharmacies deliver significant outcomes and impacts to patients and the system. A key workstream in the Delivery Plan for Recovering Access to Primary Care was the implementation and expansion of the Pharmacy First service, Blood Pressure Check service and Oral Contraception service. Over the past years, these services have diverted activity from other settings, widened patient access, and supported a reduction in healthcare inequalities. As outlined in the 10-year Health Plan for England, a Neighbourhood Health Service that is designed around individuals and communities will be required to realise a shift from hospital to community-based care. As a key provider of health service in the community, the community pharmacy sector will be an integral partner in the formation and delivery of the new Neighbourhood Health Service. Based around the principles of **Wrap around care**, **Promoting health and well-being**, and **Increasing community resilience**, community pharmacy will continue a transformation and integration journey to meet the needs of the new Neighbourhood Health Service and the residents they serve. The future vision of community pharmacy, seeing care delivered closer to home and an increased focus on prevention, will likely see positive outcomes that exceed the sizeable positive impact we can already see from community pharmacy. To realise this future vision of community-based care, ongoing work is needed to ensure community pharmacy is fully integrated into primary care structures going forward. Aims: • Increase primary care access for STW residents by promoting and increasing referrals to the Community Pharmacy Blood Pressure Check Service, supporting local cardiovascular health priorities. • Increase primary care access for STW residents by promoting and increasing referrals to the Pharmacy First service, supporting community-based access for minor ailments and common conditions. • Strengthen collaboration between General Practice and Community Pharmacy teams to enhance an integrated primary care model, improving patient care pathways and outcomes.	

Measurable outcomes:
 	
• **Practices to refer appropriate patients to the Community Pharmacy <u>Blood Pressure Check Service</u>** to achieve an average weekly referral rate of **1.00 per 1,000 registered patients by Q4 2026/27**, in line with the phased thresholds below:
  • **Q1 (Apr–Jun 2026):** ≥0.40 referrals per 1,000 patients per week
  • **Q2 (Jul–Sep 2026):** ≥0.60 referrals per 1,000 patients per week
  • **Q3 (Oct–Dec 2026):** ≥0.80 referrals per 1,000 patients per week
  • **Q4 (Jan–Mar 2027):** ≥1.00 referrals per 1,000 patients per week
 	
Practices already achieving a referral rate of **≥1.00 per 1,000 patients per week in 2025/26** must maintain at least this level throughout 2026/27.
Performance will be assessed using the **average weekly referral rate per 1,000 registered patients**, based on referrals recorded via EMIS local services.
	2.5pt

• Practices to refer appropriate patients to the <u>Pharmacy First</u> to achieve an average weekly referral rate of **1.00 per 1,000 registered patients by Q4 2026/27**, in line with the phased thresholds below:
  • **Q1 (Apr–Jun 2026):** ≥0.40 referrals per 1,000 patients per week
  • **Q2 (Jul–Sep 2026):** ≥0.60 referrals per 1,000 patients per week
  • **Q3 (Oct–Dec 2026):** ≥0.80 referrals per 1,000 patients per week
  • **Q4 (Jan–Mar 2027):** ≥1.00 referrals per 1,000 patients per week
 	
Practices already achieving a referral rate of **≥1.00 per 1,000 patients per week in 2025/26** must maintain at least this level throughout 2026/27.
Performance will be assessed using the **average weekly referral rate per 1,000 registered patients**, based on referrals recorded via EMIS local services.
	2.5pt

Monitoring and Governance

The scheme will be monitored by the ICB Medicines Optimisation Team using EPACT2, PrescQIPP data, Enterprise/Clinical system searches, Eclipse dashboard achievement. Practices will also be monitored against an ICB Medicines Optimisation dashboard with key priority indicators set. There will be oversight from the Medicines Optimisation Senior Team who will review year end outcome and practices achievements plus any mitigating submissions. There will be a formal appeals process for practices who wish to appeal against their allocation award.

Payment – Based on the Practice weighted list Q4 25/26 the most current data available at the point of publishing is £3.57 per weighted patient.

Payment will be calculated on a points-based methodology, whereby points are awarded in proportion to achievement against the weighted population size. In specified areas, a tiered points system will apply, with points awarded based on the practice's level of achievement at the end of the reporting period against the agreed targets. Total payment will be determined by the aggregate points achieved.

Medicines waste and cost Efficiencies	**12.5points**
Clinical Priorities	**30points**
Training	**2.5points**
Safe Prescribing of Medicines	**50points**
Community Pharmacy Engagement	**5points**

Use of Medicines Quality and Commissioning FSramework Payment by Practices

Payments under the ICB Medicines Quality and Commissioning Framework should be used by practices to improve patient care. This may include purchasing equipment, improving patient facilities, or providing one-off staff training to support new services. Practices may be required to evidence how the funds are spent.

Practices Sign-Up Process

Practices wishing to participate in the MQCF Year 2 programme are asked to complete the Microsoft sign-up form, below.

Link - Medicines Quality and Commissioning Framework (MQCF) 2026/27 Year 2 Agreement Form – Fill in form

Please note that the deadline for sign-up is **30th June 2026.**

If there are any queries, please contact stw.motqueries@nhs.net.


Ambition
Compassion
Optimism
Focus