Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Medicines Quality and Commissioning Framework (MQCF)25-27

An Integrated Incentive Scheme for GP Practices

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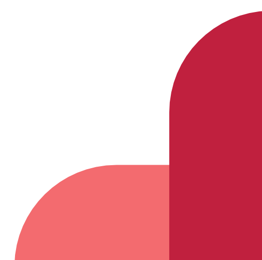


Introduction

The Pharmacy and Medicines Optimisation Team at Shropshire Telford and Wrekin is introducing the **Medicines Quality and Commissioning Framework (MQCF)** for **2025/27.**
This new framework integrates the previous **Prescribing Development Scheme (PDS)** and the **Safe Prescribing of Medicines locally commissioned service** into a single, streamlined offer for GP practices.

The MQCF aims to **enhance medicines optimisation, improve patient safety, and promote cost-effective prescribing** while aligning with national and local priorities and funding mechanisms.
The paper sets out the new framework which aims to incentivise and support practices to engage with Pharmacy, medicines optimisation strategic, quality and financial improvement plans which are aligned with some of the NHSE Priorities and Operational Guidance 25-26, **to live within our means, reducing waste and maximising productivity** and linked to primary care prescribing, without compromising patient care.

This is a **two-year scheme** that will incentivise change and prescribing improvements over a longer period than has previously been considered.

Practice and ICB Joint Working Arrangement Agreement

- The practice to have a named prescribing lead as first point of contact with the ICB Pharmacy and Medicines Optimisation Team.
- The Medicines Optimisation Team to have named allocated contacts for the practice.
- Practice to implement any agreed changes to procedures/ records and/ or provide the required returns to the ICB in a timely manner (or as stated in the MQCF document).
- The ICB to send regular updates on progress/achievement, this may be through i.e., the KPI dashboard.
- The practice to give feedback to the Medicines Optimisation Team in a timely manner. ICB to respond in a timely manner.
- ICB Medicines Optimisation Team will facilitate a prescribing meeting with the practice at **least twice a year** to discuss prescribing issues (including progress in the scheme). The practice should ensure all appropriate practice staff to attend.
- The ICB's Medicines Optimisation Team will support the practice with other medicines optimisation work, to include cost effective switches as agreed by the practice.

Key Elements of the Framework- In addition to the practice agreement, there are four key focus areas to the framework as outlined below.

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

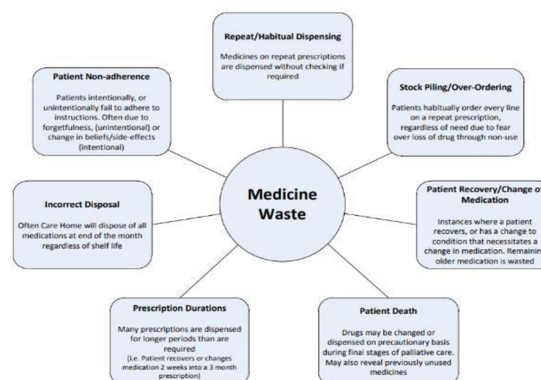
Medicines Waste and Cost Efficiency

(1) Medicines Waste Campaign

A report by the Department of Health estimates that unused medicines cost the NHS, approximately £300 million annually, with care homes alone disposing of around **£50 million** worth of supplied medicines each year.

In **Shropshire, Telford & Wrekin**, unused medicines is estimated at **£2.6 million** annually. Evidence suggests that pharmaceutical waste arises from multiple factors, including **inefficient prescribing, stockpiling, patient recovery, and non-adherence**. Waste can occur at any stage—from prescribing and dispensing to patient use—often due to **process inefficiencies or patient behaviours**.

The key causes of pharmaceutical waste are summarised in the diagram below:



To help reduce medicines waste across STW, the ICB is launching a medicines waste campaign, '**Think Twice- Only Order What You Need'**, targeting interventions to reduce unnecessary repeat prescriptions and improving prescribing practices.

Project Objectives

- Reduce overall medicines waste in STW by improving prescribing practices.
- Deliver a minimum 10% reduction in repeat prescription spending.
- Improve patient awareness of appropriate repeat ordering through targeted and inclusive campaigns.
- Engage prescribers and pharmacists in system-wide improvements to reduce overprescribing.
- Support the NHS Net Zero agenda by reducing the carbon footprint of unnecessary medicines.

https://www.england.nhs.uk/wp-content/uploads/2015/06/pharmaceutical-waste-reduction.pdf

(2) Script Switch

The Script Switch Prescribing Clinical Decision Support System supports quality care and cost-effective prescribing by empowering Medicines Optimisation teams and prescribers. It displays a prescribing recommendation with quality, clinical and cost-saving opportunities, accepted with a single click, or a clinical safety alert with a call to action.

Script Switch is a prescribing decision support tool available to all GP Practices in STW.

It is recommended that the software is enabled and activated on **all prescribing clinical computers including laptops.**

Practices are required to nominate a practice lead who is responsible for overseeing the use of Script Switch ® within the practice. This would typically be a Practice/PCN pharmacist/technician, practice manager or IT manager.

- The practice lead must ensure that all clinicians with a prescribing status are set-up appropriately on the system including locums – a user guide can be provided and customer support provided by Optum is available, if required.
- The practice lead needs to provide an overview of the software or request training for new members of staff.

The practice must participate in Medicines Optimisation Team facilitated meeting to discuss usage:

- savings/missed opportunities.
- acceptance/rejection rate
- reasons for switch suggestions being rejected (is for general rejections not individual patients)
- review of never accepted messages
- suggestions for switch options/information only messages which can be incorporated into the profile.

What is Required- Each Practice will be provided with a baseline figure at beginning of the scheme for the latest quarter data.

Measurable outcome:

- Practices will be evaluated on the **200+ scripts logged (per 1,000 practice population) each month with targets set as**
  - **25% acceptance rate for acute prescriptions**
  - **15% acceptance rate for repeat prescriptions**

- Prescriber Feedback: Prescribers should use the system's feedback function for general concerns such as medicine supply issues or Script Switch functionality but should not include individual patient information.
- Engagement with System Updates: Practices are required to engage with new Optum features introduced during the period of the framework, with training and support provided as needed.

(3) Cost Effective Prescribing

Cost effective medication switches
A **switch list** will be provided to each practice of medicines that are suitable to be switched to lower-cost equivalents where appropriate. The **Medicines Optimisation Team** will offer support in implementing the necessary changes as approved.

Medicines of Low Clinical Value
Practices are 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/

Measurable Outcome

- Enterprise or other practice search functions will be used to measure the practice progress of switching initiatives.
- EPACT-2 data will be used to measure practice reduction in spend.

Review of Vitamins and Minerals In line with the NHSE guidance on conditions for which over the counter items should not be routinely prescribed in primary care
https://www.england.nhs.uk/medicines-2/conditions-for-which-over-the-counter-items-should-not-routinely-be-prescribed/

STW Guidance for the Treatment of Vitamin D Deficiency and Insufficiency

Searches will be available in the Enterprise search link on EMIS.

Measurable Outcome

- Enterprise (or other practice search function will be used to measure the practice progress of switching initiatives
- EPACT-2 data will be used to measure practice reduction in spend.

Clinical Focus Areas

1. Antimicrobial Stewardship

The aim is to support clinicians in the delivery and promotion of antimicrobial stewardship in accordance with NHS STW guidelines.
The UK 5-year National Action Plan (NAP), **Confronting antimicrobial resistance 2024 to 2029'** builds on the achievements and lessons of the first NAP and contains outcomes and commitments which include:

- Reducing the need for, and unintentional exposure to, antimicrobials
- Optimising the use of antimicrobials

The following initiatives support antimicrobial stewardship and the safe reduction of antibiotic prescribing in primary care, contributing to commitments in the NAP.

Year 1- 2025/26

(a) Appropriate durations of antibiotic course lengths

Safely reducing patient exposure to antibiotics and addressing antimicrobial resistance by supporting prescribing of the shortest effective antibiotic courses continues to be a priority for the NHS, both nationally and locally.

Building on the success of 24/25, which has seen a significant increase in 5-day prescribing of amoxicillin across Shropshire, Telford and Wrekin (STW) primary care, the aim is to safely increase % of doxycycline 5-day prescribing for uncomplicated respiratory tract infections (RTIs) in line with local and national guidance.
STW remains an outlier for 5-day course lengths of doxycycline, currently prescribing 13% vs 27% regionally and nationally (ePACT2 Nov24).

Measurable outcome

- Practices will be required to work towards the aim of achieving 27% prescriptions for doxycycline 100mg capsules being issued for a 5-day course length.

Supporting resources/interventions

Eolas Medical antimicrobial prescribing guidelines
PrescQIPP Antimicrobial Stewardship VPG - November 2023 on Vimeo
Shorter Is Better With Antibiotics: Lessons & Resources

(b) Appropriate antibiotic prescribing for children with acute respiratory tract infection (RTI)

Since 2019, primary care antibiotic prescribing for children aged 0–9 years has seen a significant increase nationally, rising by 29%.
In the Midlands region, this increase was even higher at 33% and locally at STW particularly concerning at 50%, significantly surpassing both the national and regional averages.

Before the COVID-19 pandemic, antibiotic prescribing in general practice had been steadily declining across all age groups, reflecting ongoing efforts to promote antimicrobial stewardship and reduce unnecessary antibiotic use. However, the post-pandemic period has seen a reversal of this trend, particularly among younger children, raising concerns about antibiotic resistance, appropriate prescribing practices, and the impact on long-term public health.

This upward trend highlights the urgent need for targeted interventions to optimise antibiotic prescribing in primary care, ensuring that antibiotics are used appropriately and only when clinically necessary.

Respiratory tract infection (RTI) symptoms and cough are the most common reasons for healthcare consultations in children.

The primary aim is to safely reduce unnecessary antibiotic exposure in children presenting with uncomplicated acute RTI symptoms, where antibiotics are not immediately required.

Where clinically appropriate, this can be achieved through:

- Reassurance and safety-netting advice for parents and caregivers.
- Non-antibiotic management strategies to support symptom relief.
- Delayed (back-up) prescribing strategies, ensuring antibiotics are only used when symptoms worsen or fail to improve as expected.

The ambition is to achieve a 5% reduction in primary care antibiotic prescribing for children aged 0–9 years across Shropshire, Telford, and Wrekin (STW) by March 2026. This goal aligns with national antimicrobial stewardship efforts and aims to promote responsible prescribing while ensuring patient safety.

Measurable Outcome

- Practices below the national target of 27% are required to maintain the good practice.
- Practices above the national target of 27% will be informed by the Medicines Optimisation Team and we recommend that practice conduct an audit of immunocompetent children (3 months–9 years) presenting with uncomplicated RTI symptoms to assess current prescribing practices to identify areas for improvement.

An initial retrospective audit from the previous winter is advised, to enable team discussion and development of an action plan in good time, before the following winter.

The sample size for the audits is dependent on the Practice list size as below:

List size	Number of consultations to review
Less than 5000	10
5,000 – 9,999	15
10,000 – 19,999	20
20,000+	25

Requirement of audit summary and action plan to be submitted by 1st November 2025 to the Medicicines Optimsation Team.

Antimicrobial Stewardship Year 2 2026-27

To be communicated by April 2026

2. Cardiovascular Disease (CVD)

Cardiovascular disease (CVD) affects approximately seven million people in the UK and is responsible for one in four premature deaths. It also represents the largest contributor to health inequalities in life expectancy. Individuals in the most deprived 10% of the population are almost twice as likely to die from CVD compared to those in the least deprived 10%.
High blood pressure and high cholesterol are major risk factors for CVD, making management a priority for the NHS. Effective treatment significantly reduces the risk of serious cardiovascular events, such as heart attacks and strokes. However, despite this, many individuals with high blood pressure or high cholesterol do not receive optimal treatment, leaving them at continued high risk of serious cardiovascular events, such as heart attacks and strokes.
The NHS Long Term Plan aims to have 80% of the expected number of people with hypertension diagnosed and 80% of those diagnosed are treated to target by 2029.

Addressing this treatment gap is crucial to improving cardiovascular outcomes and reducing health inequalities.

Quality improvement in CVD prevention, why it matters-

UCLPartners Health Innovation

Time for Action

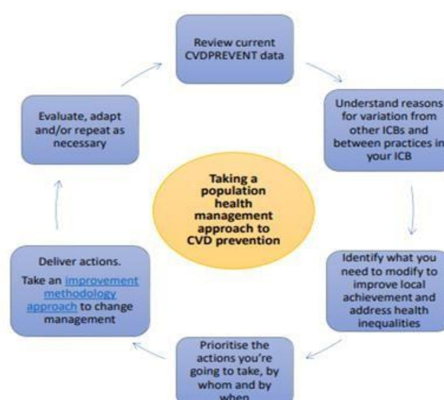
Across NHS Shropshire, Telford and Wrekin Integrated Care Board at the end of September 2024

14,610 people with hypertension did not have a recent blood pressure reading

33,825 people with hypertension were not treated to the appropriate blood pressure threshold

12,045 people at a high risk of CVD* did not have a current prescription for lipid lowering therapy

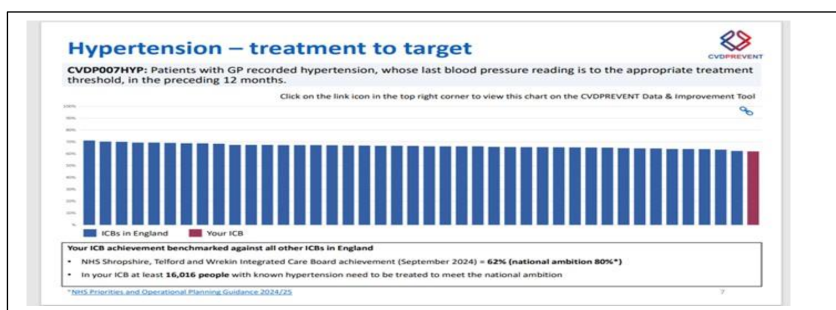
Using the UCLPartners Size of the Prize resources, it's estimated that treating an additional 16,016 hypertensive patients to threshold in NHS Shropshire, Telford and Wrekin Integrated Care Board would prevent **96 heart attacks** and **143 strokes**, saving **77 lives** and **£2.7M.**



https://www.england.nhs.uk/ourwork/clinical-policy/cvd/

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

Across Shropshire, Telford and Wrekin (STW) at the end of September 2024, **only 62% of people with hypertension were treated to the appropriate blood pressure threshold**, which compares with the England average of 67%. The **national ambition is that 80%** of people with hypertension are treated to the appropriate threshold.



Data from CVDPREVENT and UCLPartners Size of the Prize shows:

- Treatment optimisation in STW has reduced since March 2024 (67%) and was lower in September 2024 than in the same period the previous year.
- STW are the lowest performing system for this indicator, however there is significant practice variation (46-84% patients treated to threshold).
- In STW, people aged 18-59, those in the lowest two deprivation quintiles and males are least likely to have their treatment optimised. Variation also exists across ethnic groups, with people of either Black or Mixed ethnicity being the least likely to have treatment optimised, whilst those of White ethnicity, the most likely. See here for more information.

It is estimated that in STW, reaching 80% ambition equates to treating an additional 16,016 hypertensive patients to threshold which would prevent **96 heart attacks** and **143 strokes**, saving **77 lives** and **£2.6M** for the NHS.

Aims

- To increase the number of patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months. *

*For patients with no BP reading in the previous 12 months, they are counted as not at appropriate treatment threshold.

- To ensure patient review is 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 reduce the gap in the percentage treated to target between the core 20 population versus the least deprived populations.

This could be undertaken as part of Structured Medicine Review (SMR)- an evidence-based, comprehensive, and holistic review of a patient's medications, taking into consideration all aspects of their health.

Measurable outcome:

- 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 2026.

*Risk stratification/prioritisation should also consider patients where there are known healthcare inequalities in blood pressure management and for those who are further from target.**

- Final achievement will be measured using the CVDPREVENT dashboard.

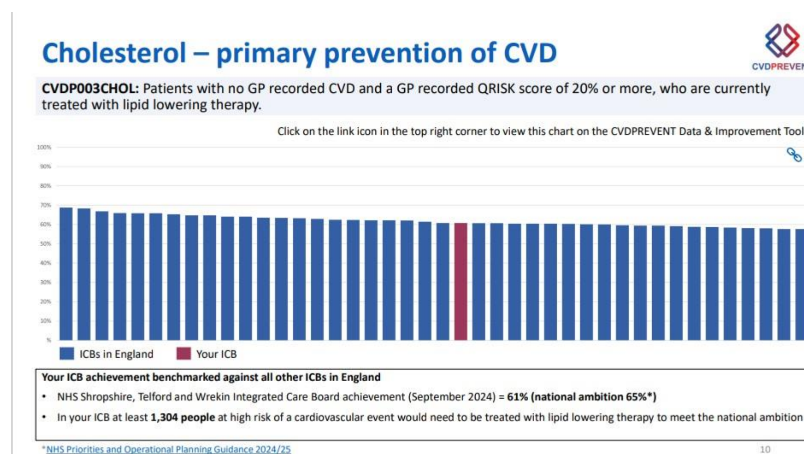
The Medicines Optimisation team can support with reviewing trends in prescribing, and importing searches onto the clinical system to aid patient identification.

Support and resources

HINWM-delivered education session
Community Pharmacy BP service
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-2025-26.pdf

(b) Lipid modification therapy-Primary Prevention in line with NICE guidance and the national Lipid Management Pathway

Across STW at the end of September 2024, 61% of people with **no recorded CVD and a recorded QRISK of 20% or more** were treated with lipid lowering therapy. This is slightly below the England average of 62% and below the **national ambition of 65%.**



Data from CVDPREVENT shows:

- Lipid lowering therapy for primary prevention in STW has gradually increased since September 2023, when 57% of people were treated with lipid lowering therapy for primary prevention
- Nationally, there is system variation, the highest performing ICB has 69% of patients treated for primary prevention, the lowest has 58%.
- In STW, people aged 18-39 are least likely to be treated for primary prevention, whilst those aged 40-59 are most likely to be treated, and people in the most deprived quintiles are more likely to be treated than those in the least deprived. See here for more information.
- There is little variation between males and females being treated, whilst there is variation across ethnic groups, with those of Mixed or Asian ethnicity being the most treated.
- In STW, at least 1,300 people at high risk of a cardiovascular event would need to be treated with lipid lowering therapy to meet the national ambition.

Aims

To increase the number patients with **no GP recorded CVD and a GP recorded QRISK score of 20% or more**, who are treated with lipid lowering therapy.

- To ensure patient review is conducted holistically with lifestyle management advice, and the decision on lipid management is based on an informed shared decision (see lipid management pathway)
- To ensure the patient is offered an annual review and supported with adherence to treatment (see lipid management pathway and statin intolerance pathway, if applicable).

This could be undertaken as part of Structured Medicine Review (SMR)- an evidence-based, comprehensive, and holistic review of a patient's medications, taking into consideration all aspects of their health.

Measurable outcome

- Practices will be required to work towards the national ambition of 65% of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy. *
- Practices currently at or above the national ambition of 65% are expected to maintain this level of performance. Those with achievement rates of 55% and under are required to demonstrate **a minimum** of 10% improvement on top of their current rate. Practices performing above 55% and below 65% are expected to achieve the national ambition of 65% by March 2026.

***Risk stratification/prioritisation should also consider patients where there are known healthcare inequalities in lipid treatment.**

Final achievement will be measured using the CVDPREVENT dashboard.
The Medicines Optimisation team can support with reviewing trends in prescribing, and importing searches onto the clinical system to aid patient identification.

Support and resources

HINWM-delivered education session lipid-management-pathway-v7.pdf statin-intolerance-pathway-v2.pdf
Overview | Cardiovascular disease: risk assessment and reduction, including lipid modification | Guidance | NICE
UCLPartners search and risk stratification tool (supplied by MM Team via Enterprise)

References

NHS England » Cardiovascular disease (CVD) 2024/25 priorities and operational planning guidance CVDPREVENT

3. Diabetes

Diabetes is a major public health challenge in the UK, affecting approximately 3.5 million diagnosed individuals, with many more remaining undiagnosed. Undiagnosed cases significantly increase the risk of complications, long-term health issues, and healthcare costs.

In Shropshire, Telford, and Wrekin (STW), an estimated 30,000 people are living with diabetes, placing the region among the higher prevalence areas in England. This underscores the urgent need for prevention, early diagnosis, and comprehensive management strategies to improve patient outcomes and reduce health inequalities. Despite ongoing efforts, reports indicate that the proportion of people receiving the full suite of recommended diabetes care processes in STW is lower than the national average. These essential care processes are crucial in preventing severe complications such as cardiovascular disease (CVD), kidney failure, and lower-limb amputations.

Aim of the Scheme

Review of Diabetes Optimal Treatment targets in Type 2

- Optimising Treatment targets in Type 2 diabetes ensuring patients receive personalised treatment plans that support better glycaemic control and cardiovascular health- Strategic Approach to Diabetes Management.
- Management of type 2 diabetes patients to all 3 treatment targets (BP, cholesterol & HbA1c) in 80% of patients.

This scheme systematically identifies and optimises treatment for diabetes patients, ensuring they meet the recommended targets. The aim is to reduce complications, improve patient outcomes, and enhance cost-effective prescribing across primary care.

This initiative will be implemented over two years, prioritising:

Year 1

(a) The Cardiovascular Risk Reduction Type 2 Diabetes Service

The Cardiovascular Risk Reduction Type 2 Diabetes Service (the service) is a non-promotional medical service which is funded by AstraZeneca and delivered by a team of pharmacists employed by Interface Clinical Services (Interface), working on behalf of AstraZeneca. It is provided to healthcare organisations (HCOs) within a Local Health Economy (LHE) to provide equity of care where a need has been identified to review patients with Type 2 diabetes with, or at risk of, cardiovascular disease (CVD) to assess and review the management of their condition.

The service supports the adoption of best practice clinical guidelines enabling the practice to implement a systematic approach to the cardiovascular and renal protection of patients with type 2

diabetes and to ensure patients are being optimally managed in alignment with clinical guideline recommendations**.** **(More information to follow).**

(b) Ongoing from 2024/25- **Blood Glucose and Ketone Strips Formulary Implementation**

Diabetes Year 2-- 2026-27

To be communicated by April 2026

Safe Prescribing 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) provides a list of responsibilities to be adhered to by each sector and encouragers collaborative arrangements to safety net the treatment.

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 Medicine 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. This framework will be tailored to specific medications and treatment pathways, with the goal of collaborating with each specialist provider to deliver an individualised approach to each specialised medicine.

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:

- 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.
- Enhanced communication – Regular and effective communication between specialists and primary care allows for better information sharing and informed decision making.
- Effective resource utilisation – Clearly defined roles and responsibilities, making better use of healthcare resources.
- 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.
- Facilitates the flow of patients and enables capacity to be freed in specialist services both for inpatient beds and outpatient clinic appointments.
- 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.
- 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.

List of medicines with an Integrated Care Protocol

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 child-bearing 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 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 have a robust incident management policy that ensures the recognition and management of all incidents. This policy should include data collection mechanisms, formal risk assessment, action planning, and shared learning to support continuous improvement.

Providers must report any incident causing significant patient harm, including medication, equipment, or serious communication failures, to the ICB Quality Team in line with their internal serious incident policy. Serious incidents must be reported within two working days as per the National Serious Incident (SI) Framework, allowing the ICB to submit them to the national reporting system. A Root Cause Analysis (RCA) must be completed, with the investigation report shared within the required national timeframes.

Additionally, providers must inform the ICB Medicines Optimisation Team of any drug-related incidents, including adverse interactions, delayed or missed monitoring, or inappropriate continuation of treatment.

Primary care providers are encouraged to use the Ulysses incident reporting system for all medication errors and near misses to support system-wide learning.

Incidents can be reported via the following link:

Ulysses Incident Reporting

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 medicines-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:

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.
  - **Best Practice:** 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.
  - **Best Practice:** Review alerts **weekly** for prompt action and improved patient safety.
  - AMBER alerts must be addressed **by Friday** of the week they are raised

Managing Eclipse Alerts in Clinical Practice-

RADAR User Guide-

User Guide - Radar.pdf

1. Reviewing and Documenting Actions- Please see page 8 on HOW TO RECORD THE OUTCOME OF THE REVIEW AGAINST THE PATIENT.

HOW TO RECORD THE OUTCOME OF THE REVIEW AGAINST THE PATIENT

Click the review button

This brings up the review form:

Review box
This needs completing once an action has been decided.

Within the Action dropdown choose from one of the following:

- No Action Needed
- Appointment Requested
- Blood Test Requested
- Medication Altered
- Patient Called
- Information Passed On
- Addressed

Notes: You may record here why you have chosen a particular option, e.g. 'No action because the patient doesn't tolerate the alternative medication'.

Exclude: If it is not relevant, appropriate or after clinical review that repeat alerts keep appearing then there is the option to exclude from future runs of the search for up to 12 months. The initial run of alerts will always contain patients that you may wish to exclude as the search criteria algorithm looks purely at data extracted and not any free text information or exemption codes.

2. Exporting the RADAR Report
Once patient alerts have been reviewed and actions documented:

- Click **"EXPORT RADAR".**
- Open the Excel document.
- **Save and attach** the file to an email.
- Send it to the **local Medicines Optimisation Team's generic email account**.

3. Excluding Patients from Future Alerts
If a patient qualifies for exclusion from future alerts:

- Select the **"Exclude"** box.
- Specify the **duration** of exclusion.
- Ensure exclusions are **clinically appropriate.**

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

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 support 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 12 months, these services have diverted activity from other settings, widened patient access, and supported a reduction in healthcare inequalities.

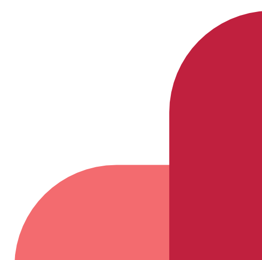
The future vision of community pharmacy, seeing care delivered closer to home and an increased focus on prevention, will likely see positive outcomes that exceed the sizeable positive impact we can already see from community pharmacy. To realise this future vision of community-based care, ongoing work 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.
- 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 will be required to work towards increasing formal referrals to Community Pharmacy Blood Pressure Check Service.



Training

As part of the delivery of key clinical focus areas within our projects, a series of clinical training sessions will be delivered throughout the year via MS Teams. These sessions are designed to support practices in implementing the agreed priorities and ensuring consistency across the system.
Please note that attendance at these sessions is required. Further details and invitations will be circulated in advance of each session.

Antimicrobial Lunch & Learn – Potential Training Dates with Conor Jamieson

- **Tuesday, 8 July 2025 | 1:00–2:00 PM**
- **Thursday, 25 September 2025 | 1:00–2:00 PM**

Please note: You only need to attend one of the sessions.

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.

Practice Payment – Payment for 25/26 will be based on Practice weighted list size as of January 2025(most current data available at the time of publishing).	
Medicines Waste and Cost Efficiency	**20%**
Clinical Focus Areas + Training sessions	**25%**
Safe Prescribing of Medicines	**50%**
Community Pharmacy Engagement	**5%**

Use of Medicines Quality and Commissioning framework Payment by Practices

Payments under the ICB Medicines Quality and Commissioning Framework should be utilised by Practices to improve patient care within their practice. This may include purchasing equipment, improving patient facilities or one-off staff training for new services. Practices may be required to evidence how this money is spent.

Appendix 1

Medicines Quality and Commissioning Framework Practice Agreement form

Practice Name and address:

I confirm that our Practice wishes to take part in the MQCF for 25-26

Signature:

Print Name:

Job Title:

Date:

Please indicate preference for meetings with the Medicines Optimisation Team

In Practice ☐ **Via Microsoft Teams** ☐

Please return signed form to stw.motqueries@nhs.net by 30th of May 2025.