Reference: FOI.ICB-2526/061

Subject: Enhanced Services in Primary Care

I can confirm that the ICB does hold the information requested; please see responses below:

QUESTION	RESPONSE
To better understand and support the enhanced services you commission through primary care for LTC management (including Diabetes, Cardiovascular Disease, Chronic Kidney Disease, Respiratory conditions, etc.), we kindly request the following information:	
1. List of Enhances Services/Incentivisation schemes: Please provide a list of the services (specifications if possible) you commission through primary care specifically for LTC management – Please also include prescribing incentive schemes from your Medicines Optimisation team.	Please find enclosed Local Enhanced Services for the following Long Term Conditions (LTC): • Dementia LES • Insulin Initiation LES – Currently under review Also enclosed are the Prescribing Incentive Schemes – Specialist Medicines Monitoring LES and Medicines Optimisation Prescribing Quality Scheme 2025/26.
2. Delivery Level: Are these services delivered at a practice level, PCN level, or another level?	Delivered at a practice level
3. Commissioning Method: Are these services commissioned in bulk or individually? a. Contracting Details: How are primary care providers contracted to deliver these services? For example, is a	Services are commissioned individually. Payment frequency is Quarterly in arrears. Practices receive payment for each patient activity.

percentage paid upfront with the remainder upon delivery? b. Measurement Criteria: Are primary care providers measured based on activity outputs or outcomes?	
4. Review Schedule: When are these services due for review?	Local Enhanced Service for LTC: • Dementia LES - 31st May 2026 • Insulin Initiation LES – 31st May 2025 (Currently under review) Prescribing incentive schemes: • Specialist Medicines Monitoring LES - 31st March 2026
5. Support Interest: Would you be interested in any support in designing, delivering, or evaluating the impact of these enhanced services for your population?	N/A

The information provided in this response is accurate as of 20 June 2025 and has been approved for release by Jenny Bowker, Deputy Director of Performance and Delivery – Primary Care and Children's Services for NHS Bristol, North Somerset and South Gloucestershire ICB.

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	**DementiaLES2426**
Service	**Recognition and Management of People with Dementia and their Family/Carers in General Practices**
Commissioner Lead	**Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire ICB**
Provider Lead	**As per provider signatory**
Period	**1st June 2024 – 31st May 2026**
Date of Review	**January 2023**

1. Population Needs

1.1 National/local context and evidence base

Around 10,700 people across Bristol, North Somerset and South Gloucestershire are estimated to have dementia, however currently only around 67% of them have a diagnosis.

- In Bristol, around 4,200 people are estimated to have dementia, approximately 76% of them have a diagnosis.
- In North Somerset, around 3,300 people are estimated to have dementia, approximately 64% of them have a diagnosis.
- In South Gloucestershire, around 3,200 people are estimated to have dementia, approximately 62% of them have a diagnosis.

General Practitioners (GPs) have a crucial role in ensuring that early concerns about memory problems are detected and responded to.

Following national and local awareness raising campaigns, people are encouraged to express concerns about their memory at an earlier stage to ensure people get the right support as early as possible. It is envisaged that this will increase the demand on GP practice time. It is also recognised that assessing people and making a dementia diagnosis at an earlier stage could be more challenging.

The GP practice does not only have a key role in the diagnostic process, it also has an important role in following the person with dementia and their family/carers through the different stages of their condition to ensure all the support is available for the person's ongoing management of health and well-being.

Dementia is a medical disorder and should be managed like any other serious long-term illness, including prompt diagnosis, regular monitoring, conducting health checks (for the person with dementia and their family/carers), ensuring people with dementia attend screening programs, advising on preventive actions, advanced decision making

and contingency planning, and signposting people to local information, advice and support services as well as end of life care.

Dementia has been an increasing priority both locally and nationally over the past few years. There is evidence to suggest that a majority of patients and carers want a diagnosis and that diagnosis improves access to support and medication where indicated, and that support for carers enables patients to stay longer in their own homes.

This Local Enhanced Service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

It is expected that by delivering the Service, Providers will be able to deliver the following outcomes:

Domain 2 Enhancing quality of life for people with long-term conditions

- ✓ There is a culture in primary care of dementia being viewed and managed as a long term condition

Domain 3 Helping people to recover from episodes of ill-health or following injury

- ✓ There is a sustained level of diagnosis of dementia and on-going management in primary care, with appropriate signposting to post diagnostic services

Domain 4 Ensuring people have a positive experience of care

- ✓ People with dementia and their family/carers are highly satisfied that their GP practice understands their dementia and that they gain relevant information about their dementia
- ✓ Carers of people with dementia receive appropriate information and are signposted to support, to enable them to take a break
- ✓ BNSSG has an appropriately trained workforce of health professionals who are highly competent in supporting people with dementia

Domain 5 Treating and caring for people in safe environment and protecting them from avoidable harm

- ✓ An increased number of people with dementia receive a timely diagnosis of dementia in Primary Care

3. Scope

3.1 Aims and objectives of service

The Provider will work with the Commissioner to ensure that the Service meets the following aims and objectives:

- Ensure people with dementia and their family/carers receive the highest possible level of care.
- Ensure each practice has a lead GP and lead practice nurse/health practitioner for dementia.
- Increase the early recognition and diagnosis of dementia in every GP practice in BNSSG.
- Enable secondary care to support primary care to make a diagnosis of dementia.
- Provide a recall and comprehensive review system for people who are initiated and stabilised on Cholinesterase Inhibitors and/or Memantine in Primary Care with advice and support of the Dementia Wellbeing Service in Bristol and Avon and Wiltshire Mental Health Partnership in North Somerset and South Gloucestershire.
- Provide a comprehensive review process for people with dementia who are on anti-psychotic medication.
- Practices should aim for GPs to diagnose dementia in the majority of straightforward cases. Patients with atypical presentations such as young, rapid onset, frontal and Lewy Body patients might expect to be diagnosed by or with the support of the Dementia Wellbeing Service in Bristol and Avon and Wiltshire Mental Health Partnership in North Somerset and South Gloucestershire.
- Provide a holistic package of care to enable more people with dementia and their carers to live fuller lives and avoid crisis admissions.
- Enhance physical care and health promotion advice for all people and carers for people with dementia, especially regarding vascular dementia.

3.2 Service description/care pathway

To participate in the Service, Providers are required to carry out the following:

1. Having a named lead GP and a named practice nurse/health care practitioner for dementia.
2. Named lead GP and named practice nurse/ other health care practitioner participate in yearly dementia training, provided or endorsed by Clinical Leads for Dementia; this could be in person or online and will be a maximum of half a day.
3. The named lead GP for dementia to provide a structured update session on dementia for all the other GPs and practice staff at least once a year.
4. Actively participate in evaluation of the service, this may include sending out surveys to patients/families and practice staff being interviewed.

5. Record carers on the carers register and signpost carers for short breaks, evidenced by at least 6 monthly meetings with the Carers Support Workers,
    - In Bristol and South Gloucestershire this is provided through the Carers Support Centre. In Bristol there is also the Bristol City Council (BCC) Integrated Carers Team.
    - In North Somerset this is provided through the North Somerset Alzheimer's Society Dementia Support Worker Service.
6. :Undertake a diagnosis of uncomplicated dementia (Alzheimer's Disease or Vascular Dementia) within a Primary Care setting and provide appropriate post diagnostic support and signposting information using the supplied EMIS template

7. Carry out reviews of people with dementia and their family/carer (using the agreed template or equivalent) that delivers review of all medication including cholinesterase inhibitors, Memantine and anti-psychotic medication using the supplied EMIS template

Create Care Plans for patients with dementia that where and when appropriate contain anticipation of End of Life Care Planning needs. This would include consideration and discussion of Do Not Artificially Resuscitate orders and a discussion about Preferred Place of Care / type of care preferably avoided (such as Hospital or ITU admission) These Care Plans should be developed using the Dementia EMIS template. For patients in the palliative care phase the appropriate additional shared care template should be used. Providers will need to consider how best to manage the reviews and may wish to work together to appoint a practice nurse to carry out all the reviews across a cluster of practices.

3.2.1 Detailed Description of the Requirement

- Adopting the care pathway including management of people stable on dementia medication.
- To undertake investigations as indicated in Section 4 and investigate any abnormalities to exclude potentially treatable causes.
- To undertake a diagnosis of dementia and initiate medication in line with guidance provided in Section 4.
- To complete a plan (or ensure the practice dementia navigator or AWP equivalent has) for the patient that includes relevant information including where to go for further support and signposting.
- To note the diagnosis of dementia, if made in secondary care or by other providers and record accordingly with relevant read code.
- To review every person diagnosed with dementia at least once a year (6 monthly if on dementia related medication, 3 monthly if on anti-psychotic medication), following the review template provided in the Dementia EMIS template.
- To initiate where appropriate (with advice if needed) and continue the prescribing of Cholinesterase Inhibitors (CEIs) or Memantine. The new BNSSG prescribing guidance confirms that GPs are able to initiate and follow up all three CEI's and Memantine and drugs for BPSD. This is now an expected

part of this Primary Care Service – GPs may want to seek advice about the prescribing from the dementia clinical staff however GPs will do the prescribing. For the purposes of this enhanced service with the benefit of the annual educational events GPs are considered to have this 'specialist' knowledge.

- To notify the Dementia Wellbeing Service for Bristol or AWP for North Somerset or South Gloucestershire of any adverse drug reactions, deterioration in condition or any other clinical concerns regarding the person's health that cannot be managed in Primary Care

In order to qualify for payment the Provider must complete the work detailed above.

3.3 Population covered

This service is available to anyone who has suspected or confirmed dementia registered with the GP practice.

3.4 Any acceptance and exclusion criteria and thresholds

This service is available to anyone who has suspected or confirmed dementia and is registered on the GP register and their needs can be best met in Primary Care.

3.5 Interdependence with other services/providers

This service is closely linked with Dementia Wellbeing Service in Bristol and AWP in North Somerset and South Gloucestershire who provide services in a community setting.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The National Institute for Health and Clinical Excellence (NICE) Dementia Quality Standards provides clinicians, managers and service users with a description of what a high quality dementia care should look like. The standards describe markers of high quality, cost-effective care that, when delivered collectively should contribute to improving the effectiveness, safety, experience and care for adults with dementia and their family/carers.

https://www.nice.org.uk/guidance/ng97

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

N/A

4.3 Applicable local standards

NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group have a referral pathways tool to provide information for General Practitioners:

http://remedy.bnssgICB.nhs.uk/adults/dementia/

The following information is available for dementia:

- ✓ Pathway for diagnosis of dementia in Primary Care
- ✓ Guidelines for diagnosing Alzheimer's Disease in Primary Care
- ✓ Guidelines for prescribing and Reviewing Donepezil and Reviewing Memantine
- ✓ Guideline for Managing Behavioral and Psychiatric Disorder in People with Dementia

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

N/A

5.2 Applicable CQUIN goals (See schedule 4D)

N/A

Outcomes, monitoring and evaluation

By signing up to this enhanced service the Provider agrees to complete the EMIS template and allow BNSSG to extract data as required.

The service will be measured against the service outcomes as defined in Section 2, using the key performance indicators which will be captured via monitoring forms and an online survey as set out in the table below:

Technical Guidance Reference	Quality Requirement / Outcome	Method of Measurement	Frequency	Used by Commissioner to evidence
Domain 2: Enhancing quality of life for people with long-term conditions				
NHS Outcome Domain 2	There is a culture in primary care of dementia being viewed and managed as a long term condition	Online Survey	Annual	The shift in opinion of dementia
Domain 3: Helping people to recover from episodes of ill-health or following injury				
NHS Outcome Domain 3	There is a sustained level of diagnosis of dementia and on-going management in primary care, with appropriate signposting to post diagnostic services	Monitoring form	Quarterly	Effectiveness of service specification
Domain 4 Ensuring people have a positive experience of care				
NHS Outcome Domain 4	People with dementia and their family/carers are highly satisfied that their GP practice understands their dementia and that they gain relevant information about their dementia.	Feedback from people with dementia who have experienced the service	Annual	To understand how people feel about the management of their dementia

NHS Outcome Domain 4	Carers of people with dementia receive appropriate information and are signposted to support, to enable them to take a break	Monitoring from the 3 Local Authority carers teams and the Carers Support Centre	Quarterly	To understand the uptake of breaks
NHS Outcome Domain 4	BNSSG has an appropriately trained workforce of health professionals who are highly competent in supporting people with dementia	Training attendance records	Annual	Confirming staff up to date with relevant training
Domain 5 Treating and caring for people in safe environment and protecting them from avoidable harm				
NHS Outcome Domain 5	An increased number of people with dementia receive a timely diagnosis of dementia in Primary Care	Monitoring form	Quarterly	To ensure the service is working effectively

Appropriate coding and use of template in EMIS will allow BNSSG to extract data to calculate payment. Payments will be made on a quarterly basis but data will be extracted monthly for monitoring purposes.

Providers will be required to provide evidence of the requirements and the specific numbers of people supported under the agreement. Providers will be supplied with an EMIS template that will guide them through the review process. A random sample of review templates will be scrutinised annually. Practice registers will be monitored in order to triangulate the payment process and to ensure appropriate payment of the incentive part.
An online survey will be sent out to gain feedback on the service to inform the following year.

5.3 Read Codes

Data will be extracted via EMIS search and report. By signing up to this enhanced service you agree for the data be extracted as required. Read codes should be used for reporting, suggested read codes for the identification of people with dementia are the following:

"Alzheimer's disease unspecified"	Eu00z
"Multi-infarct dem'"	Eu011
"Alzheim' disease“	F110
"Lewy body dementia”	F116

SCHEDULE 3 – PAYMENT

A. Local Prices

Dementia

Dementia Diagnosis

EMIS Web search criteria for calculating LES payment:-

All patients (including deducted and deceased) who have been coded with any of the codes from the QOF (V48 Release 1.5) Dementia Register (DEM001) where the earliest coding is within the search period AND the consultation type was not 'Scanned document' AND the patient has any of the below codes added in the nine months prior to the end of the search period AND the consultation type where the codes were added (except for a GPCOG or Assessment for dementia code) was not 'scanned document'.

Clinical Code Description	SNOMED Description ID
Assessment for dementia	2247561000000112
TYM (Test Your Memory) test total score	3637929018
Mini-Cog test score	3289307011
Mini-Addenbrooke's cognitive examination score	2015691000006116
Addenbrooke's cognitive examination-III score	2015461000006110
Addenbrooke's cognitive examination revised - score	1554191000000113
General practitioner assessment of cognition patient score	1667281000000112
GPCOG (general practitioner assessment of cognition) score	1667301000000113
6CIT (Six Item Cognitive Impairment Test) total score	2718871000000119

Dementia Review

EMIS Web search criteria for calculating LES payment:-

All patients (including deducted and deceased) who have been coded with any of

Clinical Code Description	SNOMED Description ID
Review of dementia advance care plan	1906941000006119
Review of dementia advance care plan	2742991000000115
Dementia care plan reviewed	2439631000000113
Review of dementia care plan	1996991000000118

where the code was added within the search period.

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date).

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG ICB to extract the relevant data	Quarterly	EMIS Search and report	Monthly extract used by ICB to inform quarterly payment	**All service specs**

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	InsulinStartLES2425
Service	Type 2 Diabetes Insulin Start LES
Commissioner Lead	Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	1st June 2024 – 31st May 2025
Date of Review	April 2024

1. Population Needs

1.1 National/local context and evidence base

Type 2 diabetes is a chronic metabolic condition characterised by insulin resistance (that is, the body's inability to effectively use insulin) and insufficient pancreatic insulin production, resulting in high blood glucose levels (hyperglycaemia). Type 2 diabetes is commonly associated with obesity, physical inactivity, raised blood pressure, disturbed blood lipid levels and a tendency to develop thrombosis, and therefore is recognised to have an increased cardiovascular risk. It is associated with long-term microvascular and macrovascular complications, together with reduced quality of life and life expectancy.

This Local Enhanced Service should help to improve the quality of life for patients with Type 2 Diabetes Mellitus, improve the patient's understanding of their condition and reduce referrals to secondary care which will make the service more local and accessible to patients.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

Diabetes Insulin initiation occupies an important place in the management of type 2 diabetes. The National Diabetes Audit has shown BNSSG as outliers for 'diabetes treated to target'. Skilled clinicians are required in general practice for recognising insulin as the clear next step and initiating it with confidence as part of normal work.

This Local Enhanced Service specification outlines the process for undertaking treatment initiations in primary care, reducing the need for patient referral to secondary care. It will necessitate additional training for some practice clinicians and as such, will help improve the general management of patients with type 2 diabetes.

This service is an example of integrated primary and community care, with simplified access points for patients to specialised services.

3. Scope

3.1 Aims and objectives of service

To provide an insulin initiation service for patients with type 2 diabetes which is convenient to the patient and provides safe, high quality, evidence based effective care.

The service detailed in this service specification must have a designated lead within the practice/locality. In usual circumstances routine insulin initiation and other non insulin injectable diabetes treatment initiation must be provided by the practice and its employed clinical staff and not by community or specialist nurses.

Objectives:

- To improve the quality of care provided in the community to patients with type 2 diabetes by making the service more accessible and responsive. This is facilitated by the shift from secondary to primary care and removing the need for patients to travel to acute trusts to undergo Insulin Initiation
- This enhanced service will fund practices to identify and initiate patients suitable for Insulin initiation, (HbA1c> 57)
- Provide patients with education around lifestyle and self titration of insulin doses, which in turn will promote the self care agenda as vital in the management of long term conditions such as diabetes
- The frequency of appointments is agreed on an individual basis with the patient.
- To reduce HbA1c to agreed individualised targets
- To reduce the long term complications of diabetes
- To reduce non-elective hospital admissions in patients with diabetes.
- To work towards NHS BNSSG ICB's objectives of delivering care closer to home
- Improve outcomes for patients by optimising glycaemic control
- Facilitate intensification of therapy in primary care, when this requires parenteral therapy
- Improve adherence to the latest NICE guidance
- Deliver safe, effective, and sustainable treatment
- Evaluation the quality of care for patients with diabetes through regular audit process

3.2 Service description/care pathway

The insulins prescribed as part of this LES should be in line with the BNSSG Joint Formulary. Prescribers are also expected to follow the BNSSG guidelines for the prescribing of ancilliary devices for blood glucose monitoring and injecting (needles).

The patient outcomes requiring monitoring as part of this LES are:

- Identification of patients who need intensification of their drug therapy for diabetes
- Have a designated diabetes lead within the practice.
- Intensify drug therapy in line with BNSSG formulary
- Optimise glycaemic control

- Frequency of episodes of hypoglycaemia including emergency admission
- Ensure a patient centred approach to the initiation of insulin therapy which empowers the person with type 2 diabetes to be actively involved in their treatment
- Ensure that cost-effective consumables are supplied to patients
- Patients initiated on insulin therapy are coded on the EmisWeb prescribing system with

Clinical Code Description	SNOMED Description ID
Conversion to insulin	264706016
Insulin treatment initiated	646031000000112

- Provide safe, high quality, evidence based effective care

When starting insulin therapy in adults with type 2 diabetes, primary care should offer to refer patients to a structured education programme (Diabetes and You Type 2), and provide 1 on 1 support to patients, employing active insulin dose titration that encompasses:

- Injection technique, including rotating injection sites and avoiding repeated injections at the same point within sites
- Continuing telephone and/or face to face support
- Self-monitoring
- Dose titration to target levels
- Dietary and lifestyle advice
- Insulin storage
- DVLA guidance (At a glance guide to the current medical standards of fitness to drive)
- Risks/causes and management of hypoglycaemia
- Management of acute changes in glucose control
- Advice regarding management during illness
- Support from an appropriately trained and experienced healthcare professional.

By agreeing to participate in this LES the practice will also be required to provide the following information:

- Share information with BNSSG ICB about significant events, including root cause analyses, involving the medications included in this LES.

Information should be reported within 48 hours of the clinician being made aware of the incident and should be shared using the BNSSG ICB online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/

- Agree to extraction of data to monitor the number of insulin initiations in patients with type 2 diabetes via EMIS Search and Report

BNSSG ICB will obtain information on the number of patients being initiated onto insulin therapy under this LES using Emis Search and Report. By signing up to this enhanced service you agree for the data be extracted as required.

Data extracted will be used to assess delivery of the following measures:

Diabetes Clinical and Social Outcome Measures
LTC 3 - Potential Years of Life Lost (PYLL) in people with diabetes
LTC14 Smoking in people with diabetes
LTC15 Obesity in people with diabetes
LTC16 Episodes of ill health requiring emergency admission in people with diabetes
LTC17 Days disrupted by care in people with diabetes
LTC19 Acute symptoms related to diabetes control
LTC23 Acute Kidney Injury (AKI) in people with diabetes
LTC53 Lower limb amputation in people with diabetes
LTC54 End-Stage Renal Failure (ESRF) in people with diabetes
LTC55 Blindness in people with diabetes
LTC57 Age at onset of first stroke in people with diabetes
LC58 Age at onset of first MI in people with diabetes

Initial Training: To ensure staff have the appropriate skills to deliver this Enhanced Service and are familiar with current treatments, the following pre-requisites for training apply to this LES:

- Practice Nurses/Clinical Pharmacists - completion of the 2 day locally run insulin initiation programme facilitated by the Community Diabetes specialist team, or evidence of further training in diabetes if from outside of area. Prior to taking on insulin initiation training it is expected that a certain level of diabetes care competence has been achieved, this would normally include an accredited module in diabetes course received from an accredited training provider. Examples include:
  - 'Care of the adult with diabetes' module available from the University of the West of England (UWE). https://courses.uwe.ac.uk/UZTR3Q203/care-of-the-adult-with-diabetes
  - Diploma level education available from:
    - Education for Health

https://www.educationforhealth.org/education/z-courses/

- Primary Care Training Centre: https://www.primarycaretraining.co.uk/training/

- GPs - At least one GP from each locality (who will clinically support the initiating clinician) is encouraged to attend the local 2 day insulin programme, or have evidence of attending an equivalent course in the last 2 years.

Assessment of Competency: All practitioners undertaking initiation of insulin shall have up to 10 supervised initiations assessed by the Community Diabetes Nurse Specialist and will be advised when they are deemed competent to initiate without supervision (the number of supervised initiations will depend on the competence of the practitioner). The Practice will not be eligible for payment until competency has been assessed and confirmed, at which point a certificate will be issued.

Ongoing Diabetes CPD- PNs/clinical pharmacists and GPs who initiate insulin are expected to maintain their skills by attending diabetes CPD annually either virtual, national or local meeting/conference

Ongoing advice and guidance – for support with clinical decisions and complex patients practice teams are encouraged to telephone/email the Sirona Diabetes Advice and Guidance service

The service, which is for healthcare professionals only, is available between 8am-5pm, Monday-Friday and run by a team of Community Diabetes Specialists.

For queries requiring same day response, call 0300 124 5908.

For routine advice and guidance, e-mail sirona.diabetesadvice@nhs.net. Please include details of the situation, background, assessment and proposed recommendation requiring advice and guidance review.

3.3 Population covered

This service is for all patients registered with a GP in BNSSG.

3.4 Any acceptance and exclusion criteria and thresholds

The following exclusions will apply:

- Patients under the age of 16
- Patients with Type 1 Diabetes

- Patients with CKD 4 or worse (consultation with diabetes specialist and or renal team required)
- Patients with Gestational diabetes
- Patients with complex complications (unless agreed with secondary care there is appropriate communication mechanisms in place between primary and secondary care)
- Patients who have previously been initiated on insulin

3.5 Interdependence with other services/providers

Community based diabetes specialist services who deliver training and support for clincians to be able to sign up to this LES. If practices do not sign up there will be an expectation for this service to be delivered by the locality in order to meet the needs of the population.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The following guidance from NICE:

- Type 2 diabetes in adults: management. NICE Guideline 28 (June 22) http://www.nice.org.uk/guidance/ng28
- NICE Diabetes quality standards: Overview | Type 2 diabetes in adults | Quality standards | NICE

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- https://www.rcn.org.uk/clinical-topics/diabetes/professional-resources Starting injectable treatment in adults with Type 2 diabetes (3rd edition). This resource requires an RCN login to access.

4.3 Applicable local standards

- The Bristol, North Somerset, & South Gloucestershire (BNSSG) Joint Formulary https://www.bnssgformulary.nhs.uk/

- BNSSG Type 1 diabetic blood glucose monitoring guidance https://remedy.bnssgccg.nhs.uk/formulary-adult/local-guidelines/6-endocrine-system-guidelines/
- BNSSG Type 2 diabetic blood glucose monitoring https://remedy.bnssgccg.nhs.uk/formulary-adult/local-guidelines/6-endocrine-system-guidelines/

  The Community Diabetic Nurse Specialist is to be consulted if there are any doubts about the appropriateness of commencing a patient on insulin

Reporting Requirements

BNSSG ICB will obtain information on the number of patients being monitored under this LES using Emis Search and Report. By signing up to this enhanced service you agree for the data be extracted as required.

By agreeing to participate in this LES the practice will also be required to provide the information detailed in schedule 6A

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

N/A

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Principal:

Branch:

SCHEDULE 3 – PAYMENT

A. Local Prices

Insulin Initiation

EMIS Web search criteria for calculating LES payment:-
All patients (including deducted and deceased) who have been coded with any of

Clinical Code Description	SNOMED Description ID
Conversion to insulin	264706016
Insulin treatment initiated	646031000000112

where the code was added within the search period AND NOT before AND the patient was 16 years or older at the time of coding AND they have type 2 diabetes mellitus coded.

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date)

Payment frequency is Quarterly in arrears.

What will be Paid For?

Practices will receive one payment for each patient initiated onto insulin therapy.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Provide assurance that a robust re-call system is in place to ensure recall of patients for the necessary monitoring	April each contract year	Declaration with contract sign up	April	**Insulin LES**
Assurance that there is a process to identify and manage patients not engaging with the necessary monitoring including cessation of prescriptions supply.	April each contract year	Declaration with contract sign up	April	**Insulin LES**
During quarter three submit a review of practice monitoring activity as per the provided template	Quarter 3	Template 2425 Insulin initiation LES audit FINAL versic EMIS Web Search Insulin Initiation LES Audit.xml	By 1 December, due each contract year	**Insulin LES**
The practices current standard operating procedure for the above activities as part of the review of practice monitoring activity	April each contract year	Declaration with contract sign up	April	**Insulin LES**
Share information with BNSSG ICB about significant events, including root cause analyses, involving the medications included in this LES. Information should be reported within 48 hours of the clinician being made aware of the incident and should be shared using the BNSSG ICB online clinical	Ongoing	Datix	April	**Insulin LES**

reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/				
Number of patients monitored each quarter as part of this LES if Emis Search and Report becomes unavailable.	If required	TBC as required	April	**Insulin LES**

SCHEDULE 2 – THE SERVICES

A. Service Specification

Service Specification No.	SSM LES 2426
Service	Specialist Medicines Monitoring LES
Commissioner Lead	Primary Care Contracts Team NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)
Provider Lead	As per provider signatory
Period	6th January 2025 – 31st March 2026
Date of Review	March 2026

1. Population Needs

1.1 National/local context and evidence base

This Local Enhanced Service specification outlines a specialised medicines monitoring service for certain medicines as listed below. All treatments used have the potential for harm as well as benefit. Appropriate and vigilant monitoring during therapy is required to minimise the risk of adverse effects and maintain patient safety.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	✓

Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

All of the drugs covered by this service are appropriate for shared care between a specialist and a GP practice. The BNSSG Joint Formulary contains Shared Care Protocols (SCPs) which offer guidance in this respect. Experience demonstrates that patients are more likely to engage with a regular monitoring service for their long-term condition that is provided in an organised manner in a convenient location such as closer to home in primary care. Appropriate and vigilant monitoring during therapy is required to minimise the risk of adverse effects.

3. Scope

3.1 Aims and objectives of service

To ensure adults and children treated with certain drugs with specific monitoring requirements are monitored by a service that is safe, effective, sustainable and closer to home.

Objectives:

1. To provide patients with the information they need to safely manage their treatment.
2. To monitor the safety and effectiveness of treatment by performing defined investigations monitoring at defined regular intervals.
3. To ensure that patients are managed appropriately, in collaboration with specialists where necessary, according to the results of the defined investigations.
4. To provide these patients with optimised treatment.
5. To provide a therapy monitoring service close to the patient.
6. To evaluate the quality of care delivered through an annual review process and to effect change when required to improve the service provided.

3.2 Service description/care pathway

All of the drugs covered by this service are included in the BNSSG Joint Formulary and are appropriate for shared care between a specialist and a GP practice. The BNSSG Joint Formulary contains Shared Care Protocols (SCPs) which offer guidance in this respect. Regular monitoring and/or

administration is required as part of the BNSSG Shared Care Protocol (SCP). Mesalazine prescribing guidance is available for Mesalazine.

GP practices are required to ensure that the correct monitoring and investigations are done, at the correct frequency according to the SCP and/or specialist advice, and the results of the investigations are reviewed and appropriate action is taken as required, including amendment of the current prescription. Monitoring is predominantly undertaken using blood tests, however other monitoring is also required for some of the included medications as set out in the Shared Care Protocols (SCPs).

The latest versions of the Shared Care Protocols (SCPs) are available from:
https://remedy.bnssg.icb.nhs.uk/formulary-adult/scps/scps/
https://remedy.bnssg.icb.nhs.uk/formulary-paediatric/paediatric-shared-care-protocols/scps/

The medications subject to this LES will be subject to change. As new drugs are deemed suitable for shared care according to the BNSSG Formulary and a shared care protocol (SCP) is put in place amendments may be made to the list below.

The medicines currently requiring monitoring as part of this LES are:

1. Azathioprine
2. Denosumab (Prolia) 60mg/ml
3. Leflunomide
4. Mercaptopurine
5. Methotrexate
6. Penicillamine
7. Sulfasalazine
8. Mycophenolate
9. Cinacalcet
10. Testosterone injections (male hypogonadism)
11. Dapsone
12. Methylphenidate
13. Lisdexamfetamine
14. Dexamfetamine
15. Atomoxetine
16. Guanfacine
17. Lithium
18. Mesalazine

By agreeing to participate in this LES the practice will also be required to provide the following information:

- Assurance that a robust re-call system is in place to ensure recall of patients for the necessary monitoring.
- Assurance that there is a process to identify and manage patients not engaging with the necessary monitoring including cessation of prescriptions.
- By the 1st of December each year submit a review of practice monitoring activity as per the provided template in schedule 6A
- The practices current standard operating procedure for the above activities as part of the review of practice monitoring activity.
- Share information with BNSSG ICB about significant events, including root cause analyses, involving the medications included in this LES. Information should be reported within 48 hours of the clinician being made aware of the incident and should be shared using the BNSSG ICB online clinical reporting tool Datix https://bnssg-datix.scwcsu.nhs.uk/
- Number of patients monitored each quarter as part of this LES if EMIS Search and Report becomes unavailable.

How Will Activity Data be Obtained?

BNSSG ICB will obtain information on the number of patients being treated with the relevant medication and being monitored under this LES using EMIS Search and Report. By signing up to this enhanced service you agree for the data be exatracted as required.
Introduction of the Eclipse Live prescribing safety tool will alert prescribers to patients who have triggered one of the 14 PINCER indicators which would include the inadequate monitoring of methotrexate. This tool should further enhance practices ability to improve prescribing safety.

3.3 Population covered

This service is for all patients registered with a participating practice, for whom it is clinically appropriate and beneficial.

3.4 Any acceptance and exclusion criteria and thresholds

Any patients having all of the necessary monitoring for these medications provided by another care provider are excluded from this LES.

3.5 Interdependence with other services/providers

N/A

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

The following guidance from NICE:

- Psoriasis: assessment and management (CG153)
- Spondyloarthritis in over 16s: diagnosis and management (NG65)
- Denosumab for the prevention of osteoporotic fractures in postmenopausal women (TA204)
- Rheumatoid arthritis in adults: management (NG100)
- Crohn's disease: management (NG129)
- Ulcerative colitis: management (NG130)
- Attention deficit hyperactivity disorder: diagnosis and management (NG87)
- Bipolar disorder: assessment and management (CG185)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- British Association of Dermatologists' guidelines for the safe and effective prescribing of azathioprine 2011. Meggitt SJ, Anstey AV, Mohd Mustapa MF, Reynolds NJ, Wakelin S. Br J Dermatol 2011; 165; 711-734.

- British Association of Dermatologists' guidelines for the safe and effective prescribing of methotrexate for skin disease 2016. Warren R.B., Weatherhead S.C., Smith C.H., Exton L.S., Mohd Mustapa M.F., Kirby B., Yesudian P.D. Br J Dermatol 2016; 175: 23-44.

- BSR and BHPR guideline for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs. BSR and BHPR guideline for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs. Jo Ledingham, Nicola Gullick, Katherine Irving, Rachel Gorodkin, Melissa Aris, Jean Burke, Patrick Gordon, Dimitrios Christidis, Sarah Galloway, Eranga Hayes, Andrew Jeffries, Scott Mercer, Janice Mooney, Sander van Leuven, James Galloway, on behalf of the BSR and BHPR Standards, Guidelines and Audit Working Group. Rheumatology, Volume 56, Issue 6, 1 June 2017, Pages 865–868,

- British Society of Gastroenterology consensus guidelines on the management of inflammatory bowel disease in adults. Lamb CA, Kennedy NA, Raine T, et al. 2019;68:s1-s106.

4.3 Applicable local standards

BNSSG Shared Care Protocols (SCPs) and prescribing guidance (Mesalazine)
https://remedy.bnssg.icb.nhs.uk/formulary-adult/scps/scps/

https://remedy.bnssg.icb.nhs.uk/formulary-paediatric/paediatric-shared-care-protocols/scps/

BNSSG Mesalazine IBD Prescribing Guidance

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts [A-D])

By the 1st of December each year submit a review of practice monitoring activity as per the provided audit template

5.2 Applicable CQUIN goals (See Schedule 4 Part [E])

N/A

6. Location of Provider Premises

The Provider's Premises are located at:

Principal:

Branch:

SCHEDULE 3 – PAYMENT

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Local Requirements Reported Locally				
EMIS search and report will be run by BNSSG ICB to extract the relevant data	Quarterly	EMIS Search and report	Quarterly extract used by ICB to inform payment	**All service specs**
During <u>quarter three</u> submit a review of practice monitoring activity as per the provided template	Quarter 3	Template	By 1 December, due each contract year	**SMM LES**

- Practices entering into this contract agree to participate fully in the post payment verification/validation process determined by the Commissioner and LMC. Practices should ensure that they keep accurate records to ensure a full and proper audit trail is available.
- As part of contract management with all providers the ICB may carry out random verification visits during the course of the year to validate data submitted for payment under this scheme. Practices will be notified in advance if they have been selected.
- Payment appeal process – should the practice wish to challenge – written request must be presented for the attention of commissioners (but no later than 12 weeks after the original extraction date)

Specialist Meds Monitoring

EMIS Web search criteria for calculating LES payment:-

<u>Atomoxetine</u>

- All patients (including deducted and deceased) who have been issued with an NHS prescription of atomoxetine by the surgery during the search period AND are 18 years and over.

<u>Azathioprine</u>

- All patients (including deducted and deceased) who have been issued with an NHS prescription of azathioprine by the surgery during the search period.

Cinacalcet

- All patients (including deducted and deceased) who have been issued with an NHS prescription of cinacalcet by the surgery during the search period AND are 18 years or older AND have any of the following coded diagnoses

Clinical Code Description	SNOMED Description ID
Hyperparathyroidism	111289013
Ectopic hyperparathyroidism	49080014
Primary hyperparathyroidism	60663012
Familial hyperparathyroidism	356183018
Normocalcemic primary hyperparathyroidism	4024743018
Parathyroid hyperplasia	16008014

Dapsone

- All adult patients (including deducted and deceased) who have been issued with an NHS prescription of dapsone by the surgery during the search period.

Denosumab

- All patients (including deducted and deceased) who have been issued with an NHS prescription of denosumab 60mg/ml by the surgery during the search period.

Dexamfetamine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of dexamfetamine by the surgery during the search period AND are 18 years and over

Guanfacine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of guanfacine by the surgery during the search period AND are 18 years and over

Leflunomide

- All patients (including deducted and deceased) who have been issued with an NHS prescription of leflunomide by the surgery during the search period.

Lisdexamfetamine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of lisdexamfetamine by the surgery during the search period AND are 18 years and over

Lithium

- All patients (including deducted and deceased) who have been issued with an NHS prescription of lithium by the surgery during the search period AND are 18 years and over.

Mercaptopurine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of mercaptopurine by the surgery during the search period.

Methotrexate

- All patients (including deducted and deceased) who have been issued with an NHS prescription of methotrexate by the surgery during the search period.

Methylphenidate

- All patients (including deducted and deceased) who have been issued with an NHS prescription of methylphenidate by the surgery during the search period AND are 18 years and over AND have any of the following coded diagnoses

Clinical Code Description	**SNOMED Description ID**
Attention deficit hyperactivity disorder (or child codes)	2158158016

Mesalazine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of mezalazine by the surgery during the search period AND DON'T have a prescription issue of mesalazine > 12 months and < 24 months previously AND are 18 years and over.

Mycophenolate

- All patients (including deducted and deceased) who have been issued with an NHS prescription of mycophenolate by the surgery during the search period AND are 18 years or older.

Penicillamine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of penicillamine by the surgery during the search period AND have any of the following coded diagnoses

Clinical Code Description	**SNOMED Description ID**
Cystinuria (or child codes)	140962014

- OR

Clinical Code Description	**SNOMED Description ID**
Rheumatoid arthritis (or child codes)	116082011
Inflammatory polyarthropathy (or child codes)	2548331017
Rheumatoid arthritis and other inflammatory polyarthropathy (or child codes)	168751000006115

Sulfasalazine

- All patients (including deducted and deceased) who have been issued with an NHS prescription of sulfasalazine by the surgery during the search period AND the first issue date in the associated EMIS Web sulfasalazine medication course is ≤ 1 year before the start of the search period.

Testosterone injection (male hypogonadism)

- All patients (including deducted and deceased) who have been issued with an NHS prescription of testosterone injection (Sustanon or Nebido as per SCP) by the surgery during the search period AND have any of the following coded diagnoses

Clinical Code Description	**SNOMED Description ID**
Hypogonadism (or child codes)	80201014

- AND DON'T have a prescription issue of testosterone > 9 months previously.

Medicines Optimisation Prescribing Quality Scheme 2025/26

The BNSSG ICB Medicines Optimisation Prescribing Quality Scheme (PQS) is offered to all GP practices with the aims of improving the quality, safety and ensuring best value for primary care prescribing.

The scheme is a 12-month scheme where it is requested that practices focus the first few months of the year on ensuring cost effective prescribing in key areas as directed by the ICB Medicines Optimisation Team to enable savings to be continued throughout the year. Quality projects will be available in the first quarter and practices should plan implementation of these projects as soon as possible to maximise outcomes. The payment to practices and the value of the scheme will be up to a £1 per patient as per previous years.

The Prescribing Quality Scheme for 2025/26 has been developed whilst considering the response needed to support primary care with ongoing system pressures to ensure quality and safety with all medicines prescribed. Where possible the PQS has been aligned to the ICS Joint Forward Plan and supports national and local priorities.

The BNSSG Medicines Optimisation Team recognises the significant variation in prescribing between practices due to many influencing factors. These factors can include age and gender of patient, as reflected in the ASTRO-PU, but other factors such as deprivation and disease prevalence also influence prescribing patterns. We wish to work closely with GP practices to understand and reduce any unwarranted prescribing variation, which will achieve both financial stability and best practice prescribing. BNSSG ICB Medicines Optimisation Team are also committed to working towards reducing health inequalities. Projects will consider health inequalities and aim to identify actions that can be taken to support reducing the impact of health inequalities.

The BNSSG Joint Formulary is the evidence-based list of commissioned medicines, and it is expected all prescribers across all sectors within BNSSG support and adhere to this.

Medicines directly or indirectly account for approximately 25% of carbon emissions within the NHS. Most of these emissions result from the manufacture, procurement, transport and use of medicines. Effective medicines optimisation can have beneficial environmental impacts for the NHS such as:

- Reducing waste and prescribing, for example by reducing inappropriate polypharmacy through structured medication reviews and therefore demand and manufacturing of unnecessary medicines.
- Supporting patients to be treated in the right setting to reduce avoidable appointments.
- Where appropriate, through shared cared decision with patients, switching medicines to suitable alternatives with lower carbon footprint.

As part of the PQS practices may be requested to respond to unplanned or ad hoc medicines optimisation work such as safety alerts or in year identified saving opportunities. The Medicines Optimisation Team has factored this in when planning projects as part of this year's

PQS and will review any additional requests and work with practices to ensure workload is manageable.

1. Financial Details

This agreement is to cover the period from 1st April 2025 to 31st March 2026.

The Provider is the GP Practice and the Commissioner is Bristol, North Somerset and South Gloucestershire ICB. If providers would like to work at PCN level to achieve the scheme this can also be considered, particularly if a PCN level budget is calculated.

Funding for the Prescribing Quality Scheme equates to £1 per actual patient on the practice list (payment will be split between different parts of the scheme).

Where payment is based on registered patient numbers at the GP practice, the patient numbers used will be those registered on ePACT2 in September 2025 (mid-point in the year).

While demographic growth has been added as part of the budget setting methodology for 2025/26, any significant changes in practice population in-year will be taken into consideration. The budget setting methodology will use weighted population to allow for better comparison, however actual population will also be reviewed to ensure fairness. Practice size will be reviewed in September 2025, comparing this to March 2025 list size to take into account significant changes in patient list size.

Calculations of payments due for achievements for the 2025/6 scheme will be made during June/July 2026 when full year ePACT2 prescribing monitoring data is available.

Practices, supported by the ICB Medicines Optimisation Pharmacists (MOPs) will need to continue to work to maximise potential savings by prescribing efficiently. MOPs working in each practice will continue to work closely with practice prescribing leads and PCN/practice members to identify and target areas of cost saving and items growth reduction.

If practices/PCNs are signed up to the repeat prescribing hub scheme and are also participating in the PQS then they will receive the financial payment for whichever scheme (i.e financial aspect of the PQS or the hub savings) gives the larger of the two payments, minus hub set up costs (for both parties), but not payments for both. Practices signed up to the repeat prescribing hub will continue to receive payment for completed quality and safety projects from the PQS.

2. Prescribing Quality Scheme Details

For 2025/26, the scheme will consist of two parts. Each part should be undertaken by practices in order to achieve the full scheme outcomes.

The different sections of the scheme have a quality, safety or cost saving focus, or a combination of all of these:

Part One: Achieving Financial Balance
Part Two: Quality and Safety Projects

Prioritisation

Cost saving work will be identified for implementation throughout the year by the BNSSG Medicines Optimisation Team and will need to be prioritised by the ICB Medicines Optimisation Pharmacist (MOP).

ICB MOPs will support each practice with safe, evidence based and cost-effective prescribing. This will include activities such as reviewing BNSSG Formulary red drugs, high-cost drugs, unlicensed 'specials' along with brand switching. These tasks are in addition to supporting the practice to undertake the quality projects of the Prescribing Quality Scheme.

Principal Pharmacists will ensure that they are in contact with practices and prescribing leads, along with GP/PCN and ICB employed pharmacists throughout the year to support them to achieve all aspects of the Prescribing Quality Scheme.

In order to deliver a successful scheme it will be important to:

- Design, share and implement a clear communication pathway across the practice and PCN to ensure that all health care professionals work closely together for shared agreed outcomes. A MOP and Practice Communications Plan template should be completed and submitted to the ICB if this has not been done.
- Ensure the ICB medicines optimisation pharmacist is embedded within the practice, having regular meetings with the prescribing lead and a clear communication pathway with the wider practice team to ensure project outcomes are sustained.

Part One – Achieving Financial Balance

The ICB primary care prescribing budget for 2025/26 has been uplifted from 2024/25 primary care spend to cover demographic growth and anticipated prescribing growth. A savings target has been applied to give an overall primary care prescribing budget for the year. It is vital that there is financial stability within the ICB and control of prescribing costs is always a key focus.

The Medicine Optimisation team in the ICB will continue to identify potential cost saving activities throughout the year and communicate these to the MOPs directly supported by the EMIS Cost Saving Dashboard or through project documentation. This will ensure that the most cost-effective choices are being prescribed and that best value from the medicines

is being achieved. The Cost Saving Dashboard found on EMIS will be regularly updated for 2025/26 to identify the most significant savings opportunities through switches that the MOPs will be reviewing and actioning following agreement with the practice. A document has also been produced to explain these switches and they will also be supported by messages on Scriptswitch. This work should be prioritised for implementation with the aim of aiding practices to prescribe within their allocated budget.

Cost saving activities will include, but are not limited to, the list below.

- Working through and actioning switches highlighted on the Cost Saving Dashboard.
- Engagement and acceptance of Scriptswitch (SS) messages relating to most cost-effective prescribing choices – The Medicines Optimisation Team will feedback to practices their SS performance.
- Switching to biosimilar insulins where appropriate
- Continued review of medicines which are part of the NHSE 'drugs of low priority for NHS funding' guidance (NHS England » Items which should not be routinely prescribed in primary care)
- Supporting the self-care agenda and following the BNSSG self care guidance for prescribers. and NHS England conditions for which OTC items should not be routinely prescribed in primary care guidance (NHS England » Policy guidance: conditions for which over the counter items should not be routinely prescribed in primary care)
- Ensuring the appropriate cost-effective prescribing of appliances as guided by the Medicines Optimisation Team including formulary adherence and cost effective switches.
- Initiating and where appropriate switching to apixaban or rivaroxaban as the direct-acting oral anticoagulants (DOACs) with the lowest acquisition cost, for the treatment of people with non-valvular atrial fibrillation (AF).
- Reviewing methylphenidate prescribing to ensure it is consistent with local guidance and provides the best value for our population.
- Cost-effective inhaler prescribing
- Review of dipeptidyl peptidase 4 (DPP-4) inhibitors in treatment of diabetes and switch to most cost-effective product (sitagliptin)
- Review of carbocisteine prescribing
- Encouraging branded prescribing of enoxaparin to ensure consistency of device for patients and promoting Inhixa® as the most cost-effective brand.
- Specific tasks directed by the ICB Medicines Optimisation Team including review of areas where practices benchmark high across BNSSG or nationally. These will be tailored to individual practices or PCNs.
- Implementation of BNSSG ICB medicines prescribing guidelines and policies. This includes the adherence to the BNSSG Joint Formulary and prescribing as per the Traffic Light System. Adherence to the formulary will be monitored, with an aim to achieving a minimum of 90% adherence of all prescribing.

Payment for Part One

Practices will be paid **up to 50pence per registered patient**.

For 2025/26 all GP practices will be set a 'fair share' prescribing budget.

The methodology for setting this budget considers as many factors as possible which create prescribing variation between practices. The methodology creates a percentage of the whole budget each practice will be allocated (taking into account their list size, demographics, disease prevalence and prescribing of High-Cost Drugs).

Further information regarding the full budget setting methodology can be obtained from the Medicines Optimisation Team.

For those practices not achieving the fair share budget set, a review of their achievement in the cost saving work that has been directed by the ICB will also be undertaken. This will include a review of the savings potential that the practice could engage in and how this impacts their overall financial position. A part payment (25p) of this element of the scheme will be paid based on the achievement of work (80%) related to the Cost Saving Dashboard, completion of key cost saving projects and adherence to the formulary (most practices are already achieving this), which will be reviewed at the end of the year. The Medicines Optimisation Team will develop some key Performance Indicators to measure this achievement against which will be transparent for all practices who can work towards achieving these, which will contribute to their achievement of financial balance. This part payment will remunerate the practices for their engagement in this work, ensuring they have been making cost effective choices and switches for these medications. Continual review with Medicine Optimisation Pharmacists as to how well a practice is doing in relation to cost saving opportunities will occur throughout the financial year to support their feedback to their practices.

Please note for practices/PCNs that have signed up to the repeat prescribing hub scheme they will receive payment for whichever scheme (i.e financial aspect of the PQS or the hub savings) gives the larger of the two payments, minus hub set up costs (for both parties) but will not receive payment for both.

Payment Schedule:

	Pence per registered patient
Achieve 25/26 allocated budget	50p
Up to 0.5% over the allocated budget	40p
>0.5% - 1% over the allocated budget	30p
>1% over the allocated budget but achievement of cost saving KPIs	25p

Part Two – Quality & Safety Projects

Practices will be requested to complete projects that align with local priorities. Where practices benchmark favourably for a project and have identified another specific area the practice/PCN would like to focus on, this should be discussed with the Principal Pharmacist to agree if the project is suitable and the intended outputs. Standard criteria and documentation for listed projects will be produced by the Medicines Optimisation Team, but practices will be required to design and develop their own project criteria and documentation if they choose to review a local priority.

ICB MOPs will continue to coordinate the quality projects and support practices to complete them. However, the MOPs will be tasked with prioritising cost saving work throughout the year. It is requested that the practice prescribing lead and MOP meet early in the year once the projects are available to agree how each project will be undertaken and continue to meet regularly throughout the year to review progress of projects. A project lead clinician should be identified to be responsible for completion of each project area with the MOP acting as support specifically around the searches and initial data collection.

Each of the projects below will have a written project pack (including relevant EMIS web searches) and a template for submission detailing outcomes of the project and will act as evidence of completion of the review.

Payment for Part Two

Practices will be paid **50 pence per registered patient in total** for undertaking all projects as described.

If a practice feels that a particular project below offers limited value to their practice demographics it may be possible for the practice to undertake a different project specific to them. This would have to be agreed by the ICB Medicines Optimisation Team.

Projects Summaries	
Review area & remuneration	**Quality improvement project**
Medicines Safety	This project aims to continue to promote medicines safety and reduce the potential harm associated with medicines. Safety work will include: • Continued use and embedding of the Medicines Safety Dashboard (MSD). This will include the addition of updated indicators. This dashboard runs alongside Eclipse Radar to identify patients at risk of harm from their medicines. • Continued use and embedding of Eclipse Radar, a risk stratification tool to review patients highlighted as potentially

	at risk from their medicines. Expecting all practices to have a robust process in place for reviewing these high-risk patients
Antimicrobial Stewardship	This project promotes a continued awareness of antimicrobial stewardship with a focus on prescribing in children as this is a national priority. Locally, there is practice variation and a significant increase in prescribing since pre-pandemic rates. The project will identify practice in known areas of stewardship for example otitis media as well as having a focus on lower respiratory tract infections. Alternative practice specific projects will be developed where a focus on prescribing in children is not required.
Respiratory	**Asthma** A project to promote and embed the updated Asthma guidelines for adults and children over 16 years. Review patients at risk of exacerbation to improve asthma care and outcomes by following the national and local guidance. A teaching session will be provided as part of this project.
Project choice	Practices will be required to complete **one project** either: **Cardiovascular** • An extension of the hypertension CVD project (as a system BNSSG GP practices still benchmarks low nationally for this CVD prevent indicator). It is intended to learn from outcomes of the hypertension project in 24/25 and take this learning forward to work with individual practices to support and understand how improvements can be made in the future. **or** **Chronic Kidney Disease (CKD) reviews** • If a practice is benchmarking well for hypertension targets an alternative option to do a CKD project/review to aid understanding of value and what further project work is required in future years. This project aims to optimise medicines in patients with CKD to improve medicines safety, reduce the risk of acute kidney injury and ensure prescribing is aligned to national and best practice guidance
Standard projects will be produced for these topics by the Medicines Optimisation Team, however, if there are specific areas which a PCN or practice would like to focus on these should be discussed your Principal Pharmacist and the project will need to developed and written by the practice/PCN.	

Prescribing Quality Scheme payments

Payments for the scheme will be made to practices that have achieved objectives and met the targets set for each of the parts of the scheme.

All payments under the scheme will go into the general practice funds and not to individuals. The awards will be awarded to practices proportional to practice list size based on the practice population figure held by the NHS business Services Authority for September 2026.

Awards must be used to reimburse the practices for expenditure on goods or services that were purchased with the aim of improving quality of patient care and experience at the practice. In general terms, capital costs or one-off costs can be claimed, whereas revenue costs (for example consumables and other recurring expenditure) should not be. This is because reimbursement of expenditure via this scheme cannot be relied on in future years.

Examples of items this could be spent on includes: new equipment (couches, chairs, medical equipment, IT hardware and software), training costs, refurbishment (waiting room, consulting room etc). If it is planned to spend over £5000 on a single item, it should be ensured that there is evidence available of three or more quotes so the preferred supplier can be justified.

Once money is received by the practice, they will be required to confirm receipt of the payment by email to the ICB Medicines Optimisation team and that it will be spent on items as detailed above. Full details of all the items purchased will not be required.

Medicines Optimisation Prescribing Quality Scheme – Practice Agreement

Practice Name: ……..

Notification of the Prescribing Quality Scheme payment due to practices will be given in July 2026 following publication of March 2026 ePACT2 data.

We agree to participate in the Medicines Optimisation Prescribing Quality Scheme for 2025/26.

Signature on behalf of the GP Practice Name……Date…… Signature…… Position:……
Signature on behalf of Bristol, North Somerset, South Gloucestershire Integrated Care Board Date:…….. Name & Position:…….. Signature……

Please return this completed form to: bnssg.medicines-optimisation@nhs.net