Item: 12

NHS
North East and
North Cumbria

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official	✓	Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

BOARD 29 JULY 2026	
Report Title:	**NENC ICB Medicines Strategy 2025-2030 Year 1 Progress and Delivery Mechanisms**

Purpose of report

This report provides an update on the implementation of the North East and North Cumbria (NENC) Medicines Strategy following its first year of delivery.

It outlines the strategic priorities approved by the Board in 2025 and details the system-wide contracting mechanisms now in place across primary care, secondary care and community pharmacy to deliver the strategy. The report also describes refinements to indicators in response to national data changes and provides assurance on progress to date.

Key points

- The Medicines Strategy has made strong progress in Year 1, establishing a consistent, system-wide approach to prescribing improvement, supported by aligned contractual mechanisms across primary and secondary care.
- Improvements in prescribing are contributing to improved outcomes across key clinical conditions, directly supporting delivery of the ICB Clinical Conditions Strategic Plan, particularly in cardiovascular disease, respiratory care, diabetes and mental health.
- A robust delivery infrastructure is now in place, including system-wide baselines, comprehensive dashboards, and strengthened governance arrangements, enabling improved visibility of variation and targeted intervention.
- Early evidence demonstrates a positive direction of travel across the majority of indicators, with improvements in antimicrobial prescribing, opioid reduction, cardiovascular preventative prescribing and respiratory management.
- Two priority areas requiring focused intervention have been identified: increasing polypharmacy in patients aged 75+ and rising use of multiple antidepressants, with targeted clinical support and system-wide engagement underway.
- Delivery is supported through a structured Prescribing Outcomes Scheme, embedding Medicines Strategy priorities into GP contracts, alongside strengthened requirements within Trust contracts to ensure whole-system accountability.
- The Board can be assured that the system is fully mobilised, with strong provider engagement and early measurable impact, providing a solid foundation for continued delivery of the five-year strategy.

Risks and issues

- Fragmented systems and data - Limited interoperability across primary care, secondary care and pharmacy systems continues to constrain information sharing and continuity of care. In particular, the absence of community pharmacy access to shared care records (e.g. GNCR) and the inability to routinely read and write into GP records restricts fully integrated working.
- Workforce capacity and sustainability - An ageing pharmacy workforce, combined with recruitment and retention challenges across geographically diverse areas especially in North Cumbria, presents a risk to delivery. There is limited succession planning in key technical services roles, alongside increasing training requirements and reduced training budgets, impacting system capacity.
- Finance and resource pressures - GP and community pharmacy collective action may reduce engagement and risk diverting resource from other priority areas. The shift towards preventative prescribing requires a period of double running before benefits are realised, alongside increasing costs associated with new technologies and treatments. There is also limited flexibility to prioritise locally within national and constitutional requirements, including NICE guidance.
- Regulation and policy alignment - Misalignment between national policy and local system priorities may limit delivery, alongside regulatory frameworks which can restrict the adoption of innovative medicines supply and service delivery models.
- Health inequalities - Persistent variation in access to medicines, services and technologies continues to drive inequalities in patient outcomes across the population.
- Cultural and behavioural factors - A continued emphasis on traditional, medicine-led models of care, reinforced by prescriber and public expectations, can limit progress in areas such as prevention, deprescribing and use of non-pharmacological interventions.
- Evidence base and national guidance - Concerns regarding the applicability of aspects of the evidence base, including NICE recommendations, to real-world populations and long-term outcomes, alongside the statutory requirement to implement such guidance, present ongoing challenges.
- Supply chain resilience - Ongoing global supply disruptions and medicines shortages increase operational workload across the system, reducing capacity for proactive medicines optimisation and higher-value interventions.

Assurances and supporting documentation

The medicines strategy, alongside the contractual delivery mechanisms have all been designed with clinical engagement to support and deliver the clinical conditions strategy and be a part of our broader system strategy and plans.

Recommendation/action required

The Board is asked to:

- Note the progress already made within Year 1
- Support the delivery through aligned contractual mechanisms
- Approve the updating of the NENC ICB Medicines Strategy 2025-2030 with the refinement of indicators.

Acronyms and abbreviations explained

- POS – Prescribing Outcomes Scheme for GPs
- NENC – North East and North Cumbria
- ICB – Integrated Care Board
- ICP – Integrated Care Partnership
- GP – General Practitioner
- PCN – Primary Care Network
- NHS – National Health Service
- NHSE – NHS England
- NTAG – Northern Treatment Advisory Group
- CVD – cardiovascular disease
- SABA - short-acting beta-2 agonist inhalers.
- COPD – Chronic Obstructive Pulmonary Disease
- NSAIDs – Non-Steroidal Anti-Inflammatory Drugs

- DOAC – Direct Acting Oral Anticoagulant
- GLP-1 – Glucagon-Like Peptide-1 (agonists)
- IV – Intravenous
- DDD – Defined Daily Dose
- ADQ – Average Daily Quantity
- ePACT2 – Electronic Prescribing Analysis and Cost Tool (version 2)
- KPI – Key Performance Indicator
- BI – Business Intelligence
- Digital / Tools / Systems
- GNCR – Great North Care Record
- OptimiseRx – Clinical decision support prescribing tool
- AnalyseRx – Prescribing analytics and optimisation tool

Sponsor/approving executive director	Dr Neil O'Brien, Chief Medical Officer
Date approved by executive director	19 May 2026
Report author	Kate Huddart, Deputy Director of Medicines and Pharmacy, NENC ICB

Link to ICP strategy priorities	
Longer and Healthier Lives	✓
Fairer Outcomes for All	✓
Better Health and Care Services	✓
Giving Children and Young People the Best Start in Life	✓

Relevant legal/statutory issues

Note any relevant Acts, regulations, national guidelines etc

Any potential/actual conflicts of interest associated with the paper?	**Yes**		**No**	✓	**N/A**	
Equality analysis completed	**Yes**		**No**	✓	**N/A**	
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken?	**Yes**		**No**		**N/A**	✓

Key considerations	
Financial implications and considerations	Many of the interventions within the medicines strategy are underpinned by national guidance from bodies such as NICE, who have already deemed the intervention to be cost effective.
Contracting and Procurement	The strategy details the system-wide contracting mechanisms now in place across primary care, secondary care and community pharmacy to deliver the strategy
Commissioning Team	Not applicable
Digital implications	Not applicable
Clinical involvement	Please see the wide spread clinical involvement under stakeholder engagement below.
Health inequalities	The strategy will reduce unwarranted variation, drive quality improvement in our use of medicines and narrow the health inequality gap.

Patient and public involvement	Patient feedback received as part of the engagement on the draft medicines strategy.
Partner and/or other stakeholder engagement	Stakeholder engagement has been a key enabler of delivery, with contractual mechanisms for both the GP Prescribing Outcomes Scheme and the secondary care Medicines Optimisation Service Specification co-designed collaboratively with GP and Trust clinical and operational colleagues. This approach has ensured that schemes are clinically credible, operationally deliverable and aligned to system priorities. Engagement with primary care has been particularly strong, with all GP practices across North East and North Cumbria (334 practices) signed up to the Prescribing Outcomes Scheme, with only one exception, demonstrating a high level of system-wide commitment to delivery of the Medicines Strategy.
Other resources	Resourcing the delivery of the strategy has been the repurposing and consolidation of historic Local Delivery Team (LDT) incentive schemes into a single, standardised North East and North Cumbria (NENC)-wide GP Prescribing Outcomes Scheme. This approach has enabled the system to maximise the impact of existing investment by reducing variation, duplication and administrative complexity, while ensuring alignment with Medicines Strategy priorities. By bringing together previously disparate schemes into a unified model, resources have been deployed more efficiently and transparently, supporting a consistent, system-wide approach to driving prescribing improvement and delivering greater value from existing funding.

Medicines Strategy – Year 1 Progress and Delivery Mechanisms

Summary

This paper provides an update on the implementation of the North East and North Cumbria (NENC) Medicines Strategy following its first year of delivery. It outlines the strategic priorities approved by the Board in 2025 and details the system-wide contracting mechanisms now in place across primary care, secondary care and community pharmacy to deliver the strategy.
The paper also describes refinements to indicators in response to national data changes and provides assurance on progress to date.

Overall, the paper confirms that significant progress has been made in establishing delivery mechanisms and infrastructure, with early evidence of improvement against baseline measures, providing a strong foundation for the remaining years of the strategy.

1. Background and Strategic Context

The NENC Medicines Strategy (2025–2030) was approved as a five-year programme to optimise the use of medicines to improve population health, reduce inequalities, and ensure value for money. The strategy aims to shift the system from a reactive model of care to a proactive, prevention-focused and population health approach, addressing unwarranted variation and improving outcomes.

The strategy was developed in response to a number of significant system challenges, including high levels of variation in prescribing practice and clinical outcomes, increasing polypharmacy and overprescribing, and medicines expenditure approaching £1 billion annually across the system. In addition, there was a recognised need to improve patient involvement in decisions about medicines, ensuring that prescribing better reflects individual needs, preferences and outcomes.

The strategy is underpinned by a clear set of principles that guide delivery across the system. These include ensuring that prescribing is appropriate and evidence-based, strengthening the emphasis on prevention and early intervention, and making greater use of data and population health intelligence to inform decision-making. A central focus is also placed on reducing health inequalities, ensuring more consistent and equitable access to effective treatments.

To support delivery of these principles, the strategy sets out a number of strategic priorities focused on areas where improvement will have the greatest impact. These include reducing inappropriate polypharmacy and overprescribing; strengthening antimicrobial stewardship; addressing dependence on analgesia; improving outcomes in cardiovascular disease and diabetes through optimisation of treatment; enhancing respiratory prescribing and care; and reducing inappropriate long-term use of antidepressants alongside improving access to non-medicines interventions.

Delivery of the strategy requires system-wide change, supported by aligned contractual mechanisms across all sectors.

2. Delivery Mechanisms

2.1 Primary Care – GP Prescribing Outcomes Scheme (2026/27)

A key delivery mechanism within primary care is the introduction of a single NENC-wide GP Prescribing Outcomes Scheme (POS) for 2026/27. Historically, prescribing incentive schemes across the region have varied significantly, with eight different models in operation. While this local flexibility allowed adaptation to place-based priorities, it also introduced unnecessary complexity and administrative burden, alongside inconsistent approaches to prescribing. Importantly, system review found no clear evidence that this variation translated into improved prescribing outcomes or better value. As a result, it was concluded that no single model demonstrated superiority. In response, a decision was taken to transition to a single, standardised ICB-wide prescribing outcomes scheme, aligned to the Medicines Strategy, to provide greater consistency, clarity and system-wide impact.

The GP Prescribing Outcomes Scheme is commissioned under GP contracts, representing a formal contractual mechanism to support and drive improvements in prescribing practice. The scheme operates over the period April 2026 to March 2027 and is available to all GP practices across North East and North Cumbria. It is delivered within a defined financial envelope of approximately £6.6 million, including additional investment to support system priorities.

The Prescribing Outcomes Scheme has been designed as a structured, layered model to ensure both engagement and delivery. It comprises a mandatory gateway element, alongside components focused on continuing good practice, delivery of the Medicines Strategy, and high-impact medicines optimisation priorities. This design ensures that practices meet baseline expectations around governance, engagement and system working, while also delivering measurable improvements in clinical outcomes and prescribing value.

The scheme translates Medicines Strategy priorities directly into practice-level delivery, ensuring alignment between strategic intent and day-to-day clinical activity. This includes a focus on respiratory optimisation, particularly reducing inappropriate SABA prescribing and improving adherence to guideline-based care, alongside reducing overprescribing through addressing anticholinergic burden and medicines oversupply. It also supports improved diabetes management through increased uptake of evidence-based therapies and biosimilars, and strengthens prescribing practice in mental health by reducing inappropriate long-term use of antidepressants.

The ICB is also supporting delivery of the Medicines Strategy through targeted public engagement and behaviour change campaigns, including the Blue to New toolkit. This campaign has been developed to support patients with asthma to move away from reliance on short-acting “blue” inhalers towards more effective combination inhalers, in line with national clinical guidance. It provides consistent, evidence-based messaging and resources for use across GP practices, community pharmacy, and wider NHS and local authority communication channels, helping to improve patient understanding, promote safer self-management and encourage appropriate use of medicines.

Alongside these priorities, a significant proportion of the scheme is dedicated to high-impact medicines optimisation opportunities that deliver both clinical and financial benefit. These include reducing over-the-counter prescribing to promote self-care and appropriate use of NHS resources, improving formulary adherence in key areas such as inhaler prescribing, and optimising prescribing for oral nutritional supplements and other specialist treatments. The scheme also enables patient-level optimisation through digital tools such as Optimise Rx and AnalyseRx, allowing practices to systematically identify and act on prescribing opportunities within their populations.

Delivery is supported by a robust and streamlined monitoring framework, with performance assessed solely through routinely available prescribing datasets, removing the need for manual submissions and reducing administrative burden. Regular reporting via system dashboards provides transparency and enables ongoing assurance and oversight.

2.2 Development of Community Pharmacy Medicines Outcomes Scheme

To complement delivery across primary and secondary care, a Community Pharmacy Medicines Outcomes Scheme is planned for introduction in the final six months of 2026/27. This scheme will extend Medicines Strategy priorities into community pharmacy settings, supporting more consistent patient messaging around appropriate medicines use, while aligning activity within community pharmacy with wider system objectives. This represents a further step towards a fully integrated, whole-system approach to medicines optimisation.

2.3 Secondary Care – Integration into Trust Contracts

A major area of progress has been the introduction of a dedicated Medicines Optimisation Service Specification within Trust contracts, establishing a clear and formal contractual requirement for providers to deliver the Medicines Strategy. This includes expectations that providers deliver across all strategic domains, supported by the development of detailed delivery plans with defined KPIs, alongside the establishment of baseline data and improvement trajectories to enable measurable progress over time.

Contracts have been further strengthened through enhanced governance and system integration requirements, including mandatory adherence to formulary and NTAG decisions, robust audit and reporting arrangements, and active participation in system-wide patient safety and improvement initiatives. There is a clear focus on improving interface working across primary and secondary care, supporting safer transfer of care, strengthened shared care arrangements, and improved continuity for patients. In addition, the specification embeds expectations around value and efficiency, including the use of best value medicines and biosimilars, optimisation of high-cost drugs and procurement, and a clear contribution to system financial sustainability. Collectively, this represents a transition to a fully aligned, contractual, system-wide model, ensuring that secondary care is directly accountable for delivery of the Medicines Strategy.

3. Indicator Amendments and Data Considerations

A number of refinements have been made to indicators and underlying data to improve alignment with available national datasets, national definitions and system reporting. This includes updates where indicators have changed definition (for example, opioid measures now aligned to newly reduced ≥90mg morphine equivalence rather than historically ≥120mg), and clarification of

baselines to bring all indicators inline for consistent reporting outputs. Appendix Two outlines the refinements made to indicators. These amendments strengthen the overall robustness and consistency of the framework, while recognising that further development is required in specific areas to ensure complete system-wide visibility and assurance.

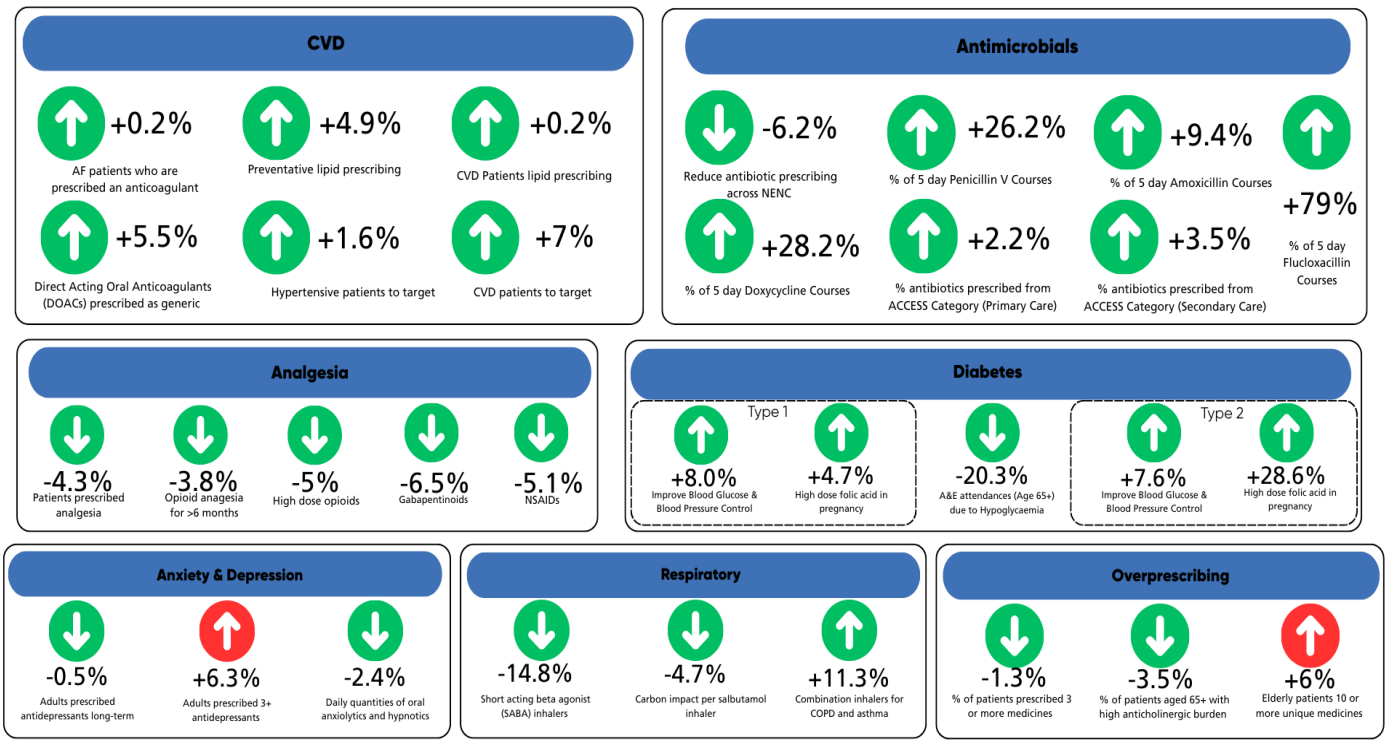
In several areas, national data availability remains a constraint, particularly for secondary care metrics such as IV antibiotic prescribing and GLP1 use, with alternative data sources currently being explored. It should be noted that there are variations in data frequency and lag across indicators, with most primary care measures supported by routine monthly prescribing datasets (typically with a two-month lag), while some national audit-based measures are reported quarterly or less frequently.

4. Progress to Date (Year 1)

The medicines strategy monitoring dashboard can be found in full within Appendix 1. Performance against the majority of Medicines Strategy indicators shows a clear positive incremental improvement across the reporting period from the baseline. (please refer to figure 1 below) This includes reductions in overall antibiotic prescribing, improvements in short-course antimicrobial use for several agents, and progress in reducing opioid prescribing volumes and high-dose opioid use, alongside improvements across cardiovascular and respiratory indicators. While many indicators remain short of their ambitious 5-year end-state targets, the consistent direction of travel provides assurance that the strategy is beginning to deliver system-wide impact through the established delivery models.

These improvements align with and contribute directly to the delivery of the Clinical Conditions Strategic Plan, with measurable impact emerging across priority disease pathways including cardiovascular disease, respiratory conditions and diabetes.

Figure 1 - MO Strategy Year 1 achievement Summary



Two indicators show a deterioration from baseline and therefore represent priority areas for targeted intervention:

- the increasing proportion of patients aged 75 and over prescribed 10 or more unique medicines,
- the rise in the number of adults prescribed multiple antidepressants.

These trends highlight ongoing challenges in managing complex polypharmacy and long-term prescribing. Targeted support is therefore being prioritised through the GP prescribing outcomes scheme delivery model, including a programme of focused clinical engagement.
In particular, two system-wide webinars are being delivered in May and June, led by Dr Mark Horowitz, a nationally recognised clinical leader in this field, focusing on safer and more appropriate antidepressant prescribing and deprescribing approaches.

This is being complemented by continued patient-level review using digital tools, strengthened clinical leadership within practices, and alignment with PCN-level Medicines Optimisation plans. Addressing these areas will be critical to sustaining progress and ensuring delivery of the strategy's overarching aims of improving patient outcomes, reducing harm, and supporting more sustainable prescribing.

5. Conclusion

Significant progress has been made in the first year of the Medicines Strategy, with a clear focus on establishing the core infrastructure required for effective system-wide delivery. This has included the development of robust baselines across all priority areas, the introduction of comprehensive dashboards and reporting systems to improve visibility of prescribing variation, and the alignment of contractual arrangements across primary and secondary care. High levels of engagement from providers have supported this mobilisation, enabling a coordinated approach to delivery across the system.

Early evidence demonstrates that these foundations are beginning to translate into impact. There is improved system-wide visibility of variation, increasing alignment in prescribing practices, and early indications of behaviour change in key priority areas. While progress against individual indicators varies, the overall direction of travel is positive, reflecting the benefits of a consistent, structured and population health driven approach to medicines optimisation.

The introduction of consistent contractual mechanisms across both primary and secondary care, alongside strengthened governance and accountability arrangements, has been a key enabler of delivery. These are supported by a developing data infrastructure which allows for routine monitoring, assurance and targeted intervention. Whilst further refinements are required in some areas, particularly relating to data completeness and indicator definitions, the core framework is now established and operating effectively.

The Board can therefore be assured that the system is fully mobilised for delivery, with Medicines Strategy priorities embedded across all sectors and early progress evident, representing a strong first year of the five-year strategy. Early impact is now emerging, with improvements in prescribing translating into better patient outcomes and the Medicines Strategy acting as a key enabler of the Clinical Conditions Strategic Plan across major disease areas.

7. Recommendations

The Board is asked to: -

- Note the progress already made within Year One.
- Support the delivery through aligned contractual mechanisms
- Approve the updating of the Medicines Strategy with the refinement of indicators.

Sponsor/approving chief officer: Dr Neil O'Brien, Chief Medical Officer
Report author: Kate Huddart, Deputy Director of Medicines and Pharmacy, NENC ICB
May 2026

Appendix 1 - Medicines Strategy Dashboard Year One delivery

NENC ICB 2026/27 Medicines Strategy Summary Table

Latest available ePACT2 data: Jan-26

Date of Update 29/04/2026

Strategy Area	Aim	Indicators	Chart Indicator title	Data Frequency	Baseline measuring period	Baseline Value	Latest Data Time Period	Latest Data Figure	Change from Baseline	% Change from Baseline
Overprescribing	Reduce inappropriate polypharmacy and overprescribing to reduce medicine related harms and medicines waste	Reduction in % of patients prescribed 3 or more medicines that can have an unintended hypotensive effect	% of patients prescribed 3 or more medicines that can have an unintended hypotensive effect	Monthly	Jun-24	**6.6**	Jan-26	**6.5**	-0.1	-1.3%
		Reduction in % of patients aged 65 and over with an anticholinergic burden score of 6 or more	% of patients aged 65 and over with an anticholinergic burden score of 6 or more	Monthly	Jun-24	**0.9**	Jan-26	**0.8**	-0.03	-3.5%
		Reduction in % of patients aged 75 and over on 10 or more unique medicines to below current England average	% of patients aged 75 and over on 10 or more unique medicines	Monthly	Jun-24	**10.7**	Jan-26	**11.3**	0.6	6.0%
Antimicrobial medicines	Improve the quality of antimicrobial prescribing to support antimicrobial stewardship	Reduce antibiotic prescribing across NENC Integrated System	Abx DDD per 1000 Patients (12 MR)	Monthly	Dec-24	**5,614.6**	Jan-26	**5266.5**	-348.1	-6.2%
		Reduce course length of antimicrobial prescribing from 7 to 5 days for 4 key antibiotics used for specific common infections	% 5 Day Amoxicillin	Monthly	Oct-24	**73.6**	Jan-26	**80.5**	7.0	9.4%
			% 5 Day Doxycycline	Monthly	Oct-24	**41.4**	Jan-26	**53.1**	11.7	28.2%
			% 5 Day Flucloxacillin	Monthly	Oct-24	**20.3**	Jan-26	**36.2**	16.0	79.0%
			% 5 Day Phenoxymethylpenicillin	Monthly	Oct-24	**32.5**	Jan-26	**41.1**	8.5	26.2%
		% of antibiotics prescribed from the ACCESS category	% of antibiotics prescribed from the AWARE ACCESS category (Primary Care)	Monthly	Oct-24	**66.3**	Jan-26	**67.8**	1.4	2.2%
			% of antibiotics prescribed from the AWARE ACCESS category (Secondary Care)	Quarterly	Q4 24/25	**57.0**	Q3 25/26	**59.0**	2.0	3.5%

		Reduce the number of patients receiving IV antibiotics past the point at which they meet the switch criteria and to reduce the proportion of IV doses	Trust reported data no longer available. Exploring alternative secondary care data metrics.						N/A	N/A
Analgesia medicines	**Reduce dependence on analgesia for chronic non-cancer pain**	Reduce the number of people prescribed an opioid or compound analgesic, weighted for adult list size	Number of unique patients (18+) prescribed either an opioid (excluding opioid containing compound analgesics and injections) or opioid containing compound analgesic, weighted for registered 18+ list size (per 1,000 patients)	Quarterly	Q1 24/25	**80.6**	Q2 25/26	**77.1**	-3.5	-4.3%
		Reduce the number of people receiving opioid pain medicines for 6 months or more, per 1000 patients	Number of people receiving opioid pain medicines for 6 months or more, per 1000 patients	Monthly	Oct-24	**30.0**	Jan-26	**28.9**	-1.1	-3.8%
		Reduce the prescribing of opioids with likely daily dose of **≥90mg** morphine equivalence, per 1000 patients	Opioids with likely daily dose of ≥90mg morphine equivalence per 1000 patients	Monthly	Sep-25	**1.2**	Jan-26	**1.2**	-0.1	-5.0%
		Reduce the volume (defined daily doses) of gabapentinoids prescribed, per 1000 patients	Total DDD of pregabalin + gabapentin per 1000 patients	Monthly	Oct-24	**552.2**	Jan-26	**516.2**	-36.0	-6.5%
		Reduce the volume (average daily quantity) of NSAIDs prescribed, per 1000 patients	NSAIDS Prescribing (ADQ per 1000 Patients)	Quarterly	3 Months to Oct-24	**1,718.1**	Q3 25/26	**1630.5**	-87.6	-5.1%
CVD	**Reduce deaths and hospital admissions from cardiovascular disease through appropriate and evidenced-based management and optimisation of medications**	Atrial Fibrillation: Increase the number of patients with diagnosed atrial fibrillation who are prescribed an anticoagulant	Increase the number of patients with diagnosed atrial fibrillation who are prescribed an anticoagulant	Quarterly	Q1 24/25	**92.3**	Q2 25/26	**92.4**	0.1	0.2%
		Atrial Fibrillation: Increase the number of patients who are treated with a first line choice DOAC as per NHSE recommendations (apixaban or rivaroxaban)	Proportion of Direct Acting Oral Anticoagulants (DOACs) prescribed as generic rivaroxaban or generic apixaban tablets	Monthly	Oct-24	**83.6**	Jan-26	**88.1**	4.6	5.5%
		Blood Pressure: Increase the number of patients with diagnosed hypertension who are treated to target with antihypertensive medication	Increase the number of patients with diagnosed hypertension who are treated to target with antihypertensive medication	Quarterly	Q1 24/25	**71.1**	Q2 25/26	**72.3**	1.1	1.6%

		Cholesterol - Primary Prevention: Increase the number of patients at risk of CVD who are prescribed lipid lowering medication	Increase the number of patients at risk of CVD who are prescribed lipid lowering medication	Quarterly	Q1 24/25	**57.5**	Q2 25/26	**60.4**	2.8	4.9%
		Cholesterol - Secondary Prevention: Increase the number of patients with diagnosed CVD who are prescribed lipid lowering medication	Increase the number of patients with diagnosed CVD who are prescribed lipid lowering medication	Quarterly	Q1 24/25	**87.4**	Q2 25/26	**87.6**	0.2	0.2%
		Cholesterol - Secondary Prevention: Increase the number of patients with diagnosed CVD who are treated to target with lipid lowering medication	Increase the number of patients with diagnosed CVD who are treated to target with lipid lowering medication	Quarterly	Q1 24/25	**49.7**	Q2 25/26	**53.2**	3.5	7.0%
Diabetes	**Reduce morbidity, mortality and hospital admissions from Diabetes through optimised treatment**	Reduce inappropriate polypharmacy in people living with frailty and diabetes, to prevent over treatment leading to hypoglycaemia.	A&E attendances (Patients Age 65+)as a result of Hypoglycaemia	Quarterly	Q3 24/25	**227.0**	Q3 25/26	**181.0**	-46.0	-20.3%
		Increase uptake of high dose folic acid in pregnancy in patients living with Type 1 diabetes		24M	2021-2023	**42.6**	2022-2024	**44.6**	2.0	4.7%
		Increase uptake of high dose folic acid in pregnancy in patients living with Type 2 diabetes		24M	2021-2023	**17.5**	2022-2024	**22.5**	5.0	28.6%
		Type 1: Improve both NICE recommended glucose and blood pressure control and achieve cardiovascular risk reduction by improved medicines optimisation	Type 1: Improve both NICE recommended glucose and blood pressure control and achieve cardiovascular risk reduction by improved medicines optimisation	Quarterly	Q2 24/25	**26.4**	Q2 25/26	**28.5**	2.1	8.0%
		Type 2: Improve both NICE recommended glucose and blood pressure control and achieve cardiovascular risk reduction by improved medicines optimisation	Type 2: Improve both NICE recommended glucose and blood pressure control and achieve cardiovascular risk reduction by improved medicines optimisation	Quarterly	Q2 24/25	**43.2**	Q2 25/26	**46.5**	3.3	7.6%
		Increase the number of people prescribed GLP1 agonists for managing overweight and obesity in line with NICE eligibility criteria	Awaiting NHSE data release for BI to provide data. Escalated in BI.						N/A	N/A

Respiratory	**Reduce deaths and hospital admissions from Respiratory through optimised treatment**	Number of short acting beta agonist (SABA) inhalers - compared with number of all inhaled corticosteroid inhalers and SABA inhalers	Number of short acting beta agonist (SABA) inhalers - salbutamol and terbutaline - compared with number of all inhaled corticosteroid inhalers and SABA inhalers	Monthly	Apr-24	**53.2**	Jan-26	**45.3**	-7.9	-14.8%
		Mean carbon impact per salbutamol inhaler	Environmental impact of inhalers - average carbon footprint per salbutamol inhaler	Monthly	Apr-24	**19.6**	Jan-26	**18.7**	-0.9	-4.7%
		Weighted prescribing volume of combination inhalers for people with COPD and asthma	Weighted prescribing volume (Items) of combination inhalers (Items per 100 Patients with COPD and Asthma)	Quarterly	Q1 24/25	**103.9**	Q2 25/26	**115.7**	11.8	11.3%
Anxiety and Depression	**Reduce inappropriate and long-term prescribing of anti-depressants and anxiolytics**	Reduction in the Number of identified adults on long term use (over one year) as a % of the number of identified patients prescribed selected antidepressants (adults)	Proportion of patients aged >18y taking antidepressants who have been taking antidepressants long-term	Quarterly	Apr 2022 - Jun 2023	**43.8**	Oct 2024-Dec 2025	**43.6**	-0.2	-0.5%
		Reduction in the Number of adults prescribed multiple antidepressants (3 or more)	Number of adults prescribed multiple antidepressants (3 or more)	Quarterly	Jul 2023 - Jun2024	**9,030**	Jan 2025 - Dec 2025	**9,600**	570.0	6.3%
		Prescribing rates anxiolytics in people aged 18+ measured as number of average daily quantities (ADQs) per item for anxiolytics and hypnotics	Number of average daily quantities (ADQs) per item for oral anxiolytics and hypnotics	Monthly	Nov-24	**10.1**	Jan-26	**9.9**	-0.2	-2.4%

Appendix 2 - Changes to Medicines Strategy Indicators and Baselines (due to monitoring alignment and national changes)

Strategy Area	Aim	Indicators	Change to indicator	Change to baseline
Antimicrobial medicines	**Improve the quality of antimicrobial prescribing to support antimicrobial stewardship**	% of antibiotics prescribed from the ACCESS category	No	Baseline now 66.3 vs previous baseline 64
Analgesia medicines	**Reduce dependence on analgesia for chronic non-cancer pain**	Reduce the prescribing of opioids with likely daily dose of **≥90mg** morphine equivalence, per 1000 patients	Indicator changed to ≥90mg vs original ≥120mg	Baseline now 1.245 was previously 1.076
Diabetes	**Reduce morbidity, mortality and hospital admissions from Diabetes through optimised treatment**	Reduce inappropriate polypharmacy in people living with frailty and diabetes, to prevent over treatment leading to hypoglycaemia.	No	Baseline switch to Quarterly RAIDR value of 227 vs previous 12 month value of 875
Respiratory	**Reduce deaths and hospital admissions from Respiratory through optimised treatment**	Number of short acting beta agonist (SABA) inhalers - compared with number of all inhaled corticosteroid inhalers and SABA inhalers	No	Baseline now 53.2 was previously 49.16
Anxiety and Depression	**Reduce inappropriate and long-term prescribing of anti-depressants and anxiolytics**	Reduction in the Number of identified adults on long term use (over one year) as a % of the number of identified patients prescribed selected antidepressants (adults)	No	Baseline now 43.8 was previously 42.4
		Reduction in the Number of adults prescribed multiple antidepressants (3 or more)	No	Baseline now 9030 was previously 8858