NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Primary Care Prescribing Priorities 2026/2027

Introduction of the Prescribing Quality Scheme

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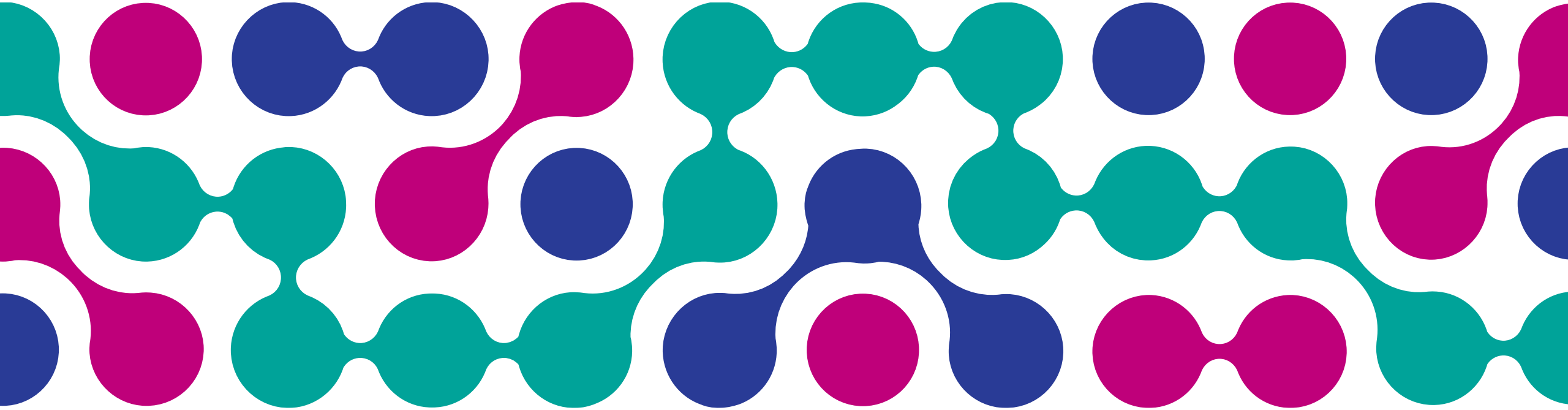
Integrated Care Board

Prescribing Quality Scheme



Prescribing Quality Scheme

	Financial stewardship	Target	Payment
1	**GLP1 Optimisation** **Practices are expected to review and optimize GLP1 prescribing in T2DM. This indicator has two parts:**		
	1a: Improvement on the proportion of Semaglutide use out of all GLP1 prescribing. NHS BSW ICB in conjunction with the BSW diabetes steering group, recommend the use of **Semaglutide as the 1st line GLP1 for ALL patients living with T2DM (ahead of Tirzepatide (GLP1/GIP).** Practices are expected to prescribe Semaglutide at new initiation of GLP1 for appropriate patients.	Meet or exceed the national median for the proportion of semaglutide prescribing versus all GLP-1 items, or by demonstrating improvement on their previous quarter, with a payment of 2.5p per registered patient made at year end for **each** quarter where target achieved	**Up to 10p Annual payment per (raw) registered patient (p)**
	1b: Gain-share agreement for Tirzepatide to Semaglutide switch • Practices are expected to review patients currently using Tirzepatide for the management of T2DM. • Where appropriate, follow the available guidance to switch well controlled T2DM patients to Semaglutide.	Patients on Tirzepatide reviewed and where appropriate switched to Semaglutide.	**£90 Gain-share per patient switched**
2	**Optimise Rx Engagement** • Optimise Rx to be switched on and active in the clinical system. • Increase the message acceptance count by 10% from current baseline or maintain above national level.	Increase the message acceptance count by 10% from current baseline or maintain above or equal to national median.	**5p Annual payment per (raw) registered patient (p)**
3	**Prescribing cost effectively** • Practices are expected to remain within their allocated prescribing budget or evidence reduced prescribing spend by adhering to good practice prescribing, robust medicines optimisation, and routine review of prescribing patterns. • Prescribing should align with the BSW formulary, Prescribe Well Spend Less guidance and local/national best practice recommendations. • Active engagement with high value medicines optimisation opportunities is required to deliver cost savings while maintaining clinical effectiveness and patient safety. • Current priority areas include switching to preferred biosimilar insulins (Trurapi®), denosumab biosimilar switches in line with BSW formulary choices, and appropriate oral nutritional supplement (ONS) switches.	Prescribing spend will remain withing allocated budget based on 50% forecast outturn and 50% Prescribing Needs Index (Fair Share) of the allocated ICB budget (will be set in Q2/June 2026) OR Evidence of reduced spend compared to 25/26	**15p Annual payment per (raw) registered patient (p)**

	Prescribing Safety and Quality	Target	Payment
4	**Eclipse Radar 500 (Red Alerts)** **Eclipse Live (i): For all Practices** • Payment will be made for reviewing 80% of BSW ICB Eclipse RED alerts. To achieve 80%, practices will need to review alerts every week. Please ensure you either click 'Review' or 'Address' to mark an alert as reviewed. See screenshots in Appendix 1.	80% or more RED alerts need to be actioned on Eclipse across the Financial Year (alerts updated weekly)	**10p Annual payment per (raw) registered patient (p)**
5	**Antimicrobial Stewardship, Prescribing Quality and Safety** **Antimicrobial stewardship:** **Optimising 5-day course lengths.** Reach at or above target or at least a 20% improvement from baseline (% of total course durations that are 5-days): • Amoxicillin 500mg capsules – 5 days duration (target 80%) • Doxycycline 100mg capsules – 5 days duration (target 55%) • Clarithromycin 500mg capsules – 5 days duration (target 50%) **Anticoagulant prescribing safety:** **DOAC monitoring – patients prescribed a DOAC have at least an annual calculated creatinine clearance recorded.** Reach at least 80% or above, and for practices already ≥80% at baseline, show an improvement in percentage (optimal target 100%) **by 31st of March 2027.** **Dependence forming medicines:** **Complete one Quality Improvement (QI) Project.** Choose either reducing high dose opioid prescribing (chronic non-cancer pain) ***or*** reducing anxiolytics and hypnotics prescribing. *Proposed QI project plan to be agreed by peers at a PCN meeting.* **Submit QI template (appendix 2) by 31st of March 2027** **Baseline is Q4 2025/2026**		**30p Annual payment per (raw) registered patient (p)**

DRAFT

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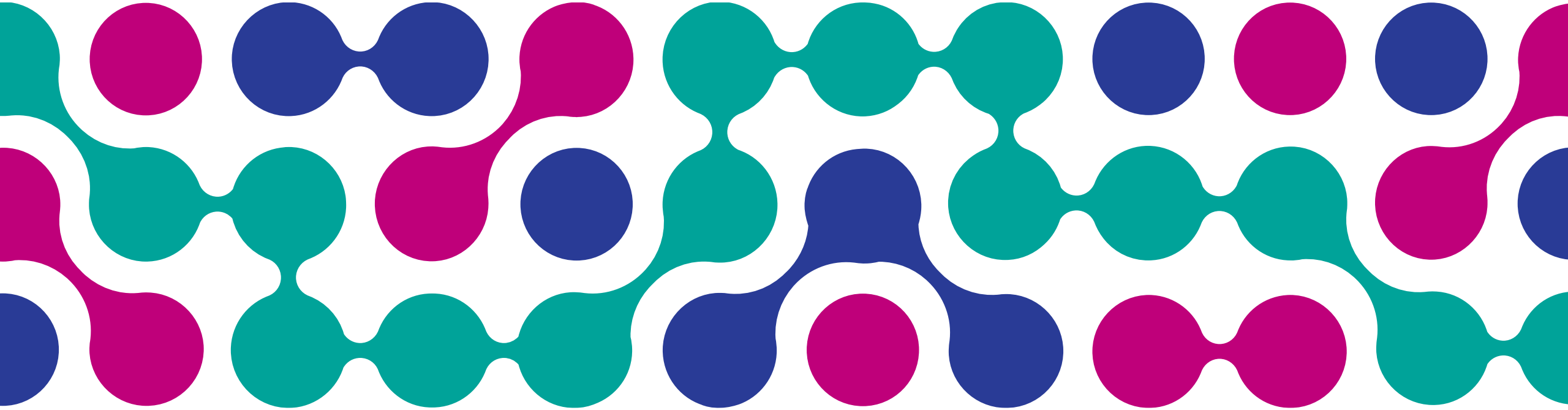
High value, cost-effective prescribing



Dapagliflozin Gainshare Continues until Q2 2026/27

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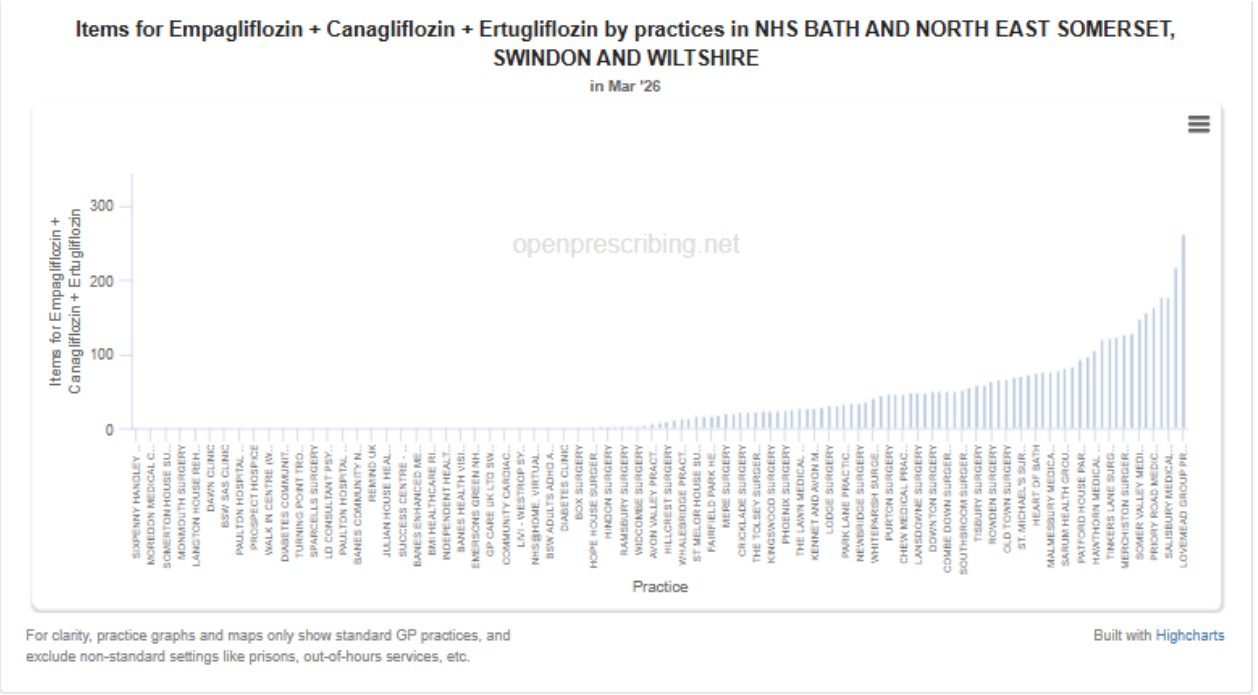
GP practices will receive 50% of the in-year savings realised by switching from other SGLT2is (empagliflozin, canagliflozin, ertugliflozin) to generic dapagliflozin based on the drug tariff price for October 2025. Currently the 50% gainshare opportunity for practices stands at £500k.

Objectives:

- **Align with NICE and NHSE Recommendations**
  Ensure prescribing is consistent with NICE technology appraisals (TA390, TA679, TA902, TA1075) supporting dapagliflozin for type 2 diabetes, heart failure and CKD and in line with NHSE recommendation as per NHSE letter September 2025
- **Broaden Therapeutic Coverage**
  Optimise treatment for patients with multiple comorbidities (e.g. diabetes, heart failure, CKD) using a single agent with proven cardio-renal benefits. • Simplify Prescribing and Monitoring Streamline medication regimens and reduce complexity by standardising to a preferred agent with a once-daily dose and no need for titration.
- **Support Formulary and Cost Efficiency**
  Cost saving and good use of NHS resources. Promote use of locally preferred SGLT2 inhibitor to support formulary compliance and potential cost savings.
- **Enhance Continuity of Care**
  Facilitate consistent prescribing across primary and secondary care settings, improving communication and reducing variation.
- **Improve Patient Outcomes**
  Leverage evidence-based benefits of dapagliflozin in reducing hospitalisations for heart failure, slowing CKD progression, and lowering cardiovascular risk.



Total prescribing for *Empagliflozin* + *Canagliflozin* + *Ertugliflozin* across NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE

	Mar '26	Financial YTD (Apr '25—Mar '26)	Last 12 months (Apr '25—Mar '26)
Cost (£)	179,596	3,068,667	3,068,667
Items	4,627	78,772	78,772

Analyse | OpenPrescribing

For reference see clinical protocol here.

Semaglutide is first line GLP1 in T2DM

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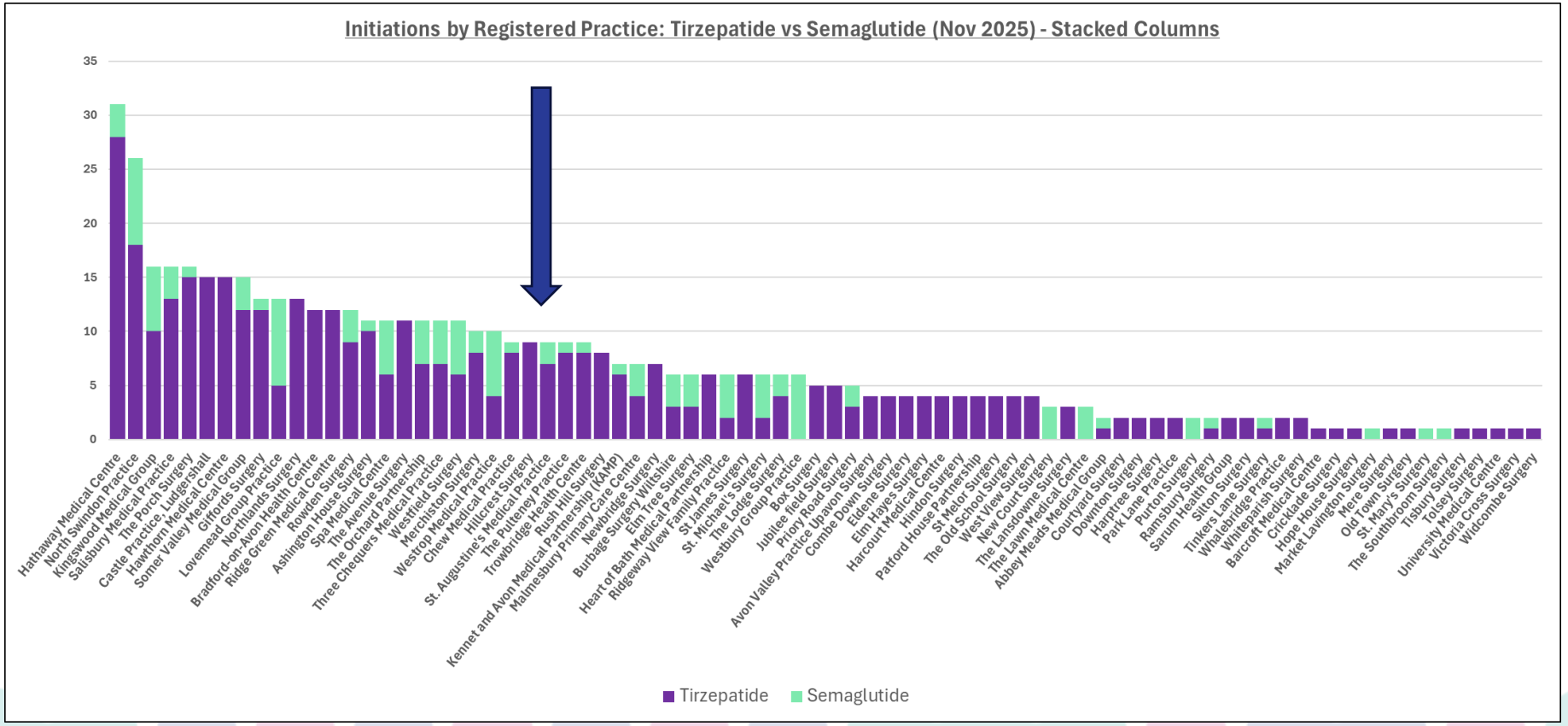
BSW has the second highest prescribing of tirzepatide compared to all GLP-1s in the country, despite BSW positioning Semaglutide 1st line for T2DM : Tirzepatide spend over 500k each month.

For Diabetes:

- **Consider adding semaglutide after metformin and SGLT2 in obesity, EOD or Atherosclerotic CVD**
- **Review if target weight and individualised HbA1c target met. Stop if become underweight or GLP1 not helping reach targets (and not being taken for CV benefits).**
- **Use Semaglutide: FIRST-LINE GLP1 (oral or Sub-cut) for T2DM in BSW (ahead of Tirzepatide GLP1/GIP) (Approved locally for BSW)**
- **Semaglutide has additional evidence that it significantly reduces major cardiovascular events in high-risk type 2 diabetes patients (PIONEER-6 / SUSTAIN-6 trials) (Both oral and subcut)**

For Obesity – Tirzepatide is available via Tier 3 specialist weight manage or/ via Obesity LCS (Via GP following prior approval)

Practice T2DM new initiations: semaglutide / tirzepatide



Tirzepatide to Semaglutide switch Gainshare

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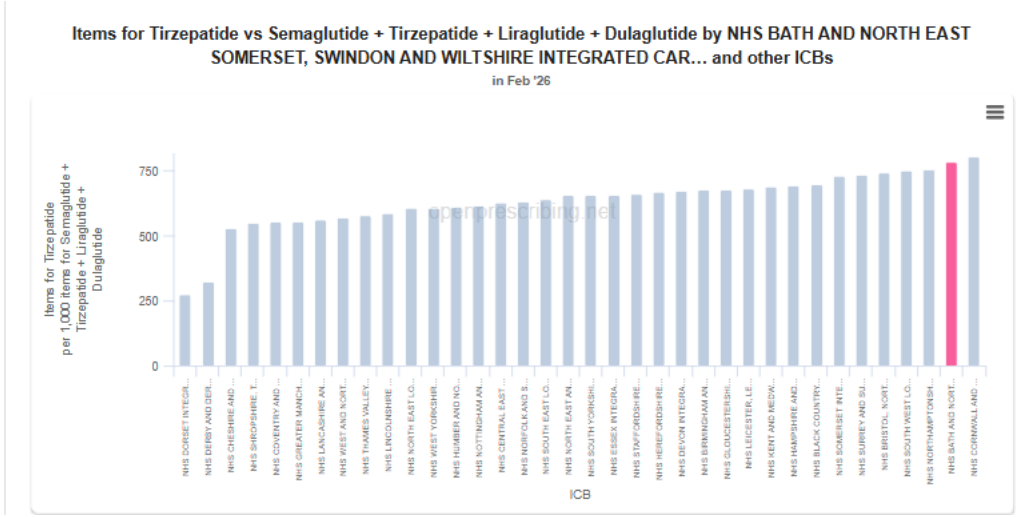
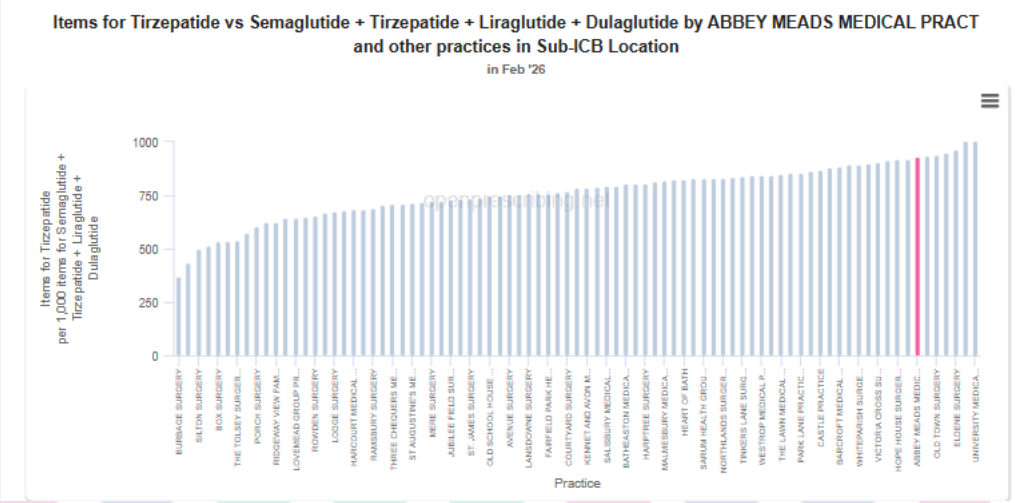
GP practices will receive £90 per patient reviewed and switched from Tirzepatide to Semaglutide in well controlled T2DM patients. Current opportunity for practices stands at £500k.

- NICE have recently published the medicines update of NG28. Within this, there are recommendations to initiate medications earlier than previously used and widening access to GLP1s & GLP1/GIP molecules for various cohorts of patients with T2DM.
- In order for the ICB to get the best value for money out of the use of these medications and to be able to offer them as recommended by NICE in an equitable manner, NHS BSW ICB in conjunction with the BSW diabetes steering group, recommend the use of semaglutide as the 1st line GLP1 for ALL patients living with T2DM (ahead of Tirzepatide (GLP1/GIP)).
- Using Semaglutide 1st line, will allow us to treat the most patients with a GLP-1 as per NG28 as its more cost effective than tirzepatide.
  The Number Needed to Treat (NNT) for semaglutide in preventing major cardiovascular events (MACE) is 125 for the 3P-MACE endpoint.[2] There is currently no CVD outcome data for tirzepatide.
- For patients that are well controlled on tirzepatide, they can be considered for a switch to Semaglutide without compromising their glycaemia control or outcomes.



No. of items of Tirzepatide versus all GLP-1 per ICB.



No. of items of Tirzepatide versus all GLP-1 per practice.

Analyse | OpenPrescribing– amend practice

Introducing Individual Practice Prescribing Budgets

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Why are we doing this?

- A first step towards strategic commissioning and greater clinical and financial autonomy for GP practices
- Supports the future direction of delegated budget responsibility , where providers have increased flexibility over how prescribing resources are used
- Enables practices to benefit from good, value based prescribing decisions, rather than being disadvantaged by historic efficiency

System context – why this change matters now

- The ICB Medicines Optimisation Team now operates with reduced headcount and capacity, working across the BSW, Dorset and Somerset Cluster
- The team is increasingly required to work strategically at system level , rather than providing routine hands-on operational support withing individual practices
- This shift reinforces the importance of practice-level autonomy in managing prescribing and identifying value-based opportunities locally

What does this mean for practices?

- Budgets are indicative and developmental, not punitive
- Practices retain freedom to decide how best to manage prescribing to meet patient need
- This year represents a very soft launch, designed to build confidence , test methodology, and refine approach collaboratively

PQS approach this year

- Only a small proportion of the PQS incentive is linked to this element
- Primary purpose is engagement, transparency and learning, not financial risk transfer

How Budgets Are Set and How Practices Can Succeed

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How were individual budgets calculated?

- Budgets calculated using PRESCQUIPP budget setting tool
- Based on blended methodology
  - 50% historic prescribing spend
  - 50% Prescribing Needs Index (PNI)

What is the Prescribing Needs Index (PNI)?

- A national NHS England population-based adjustment tool
- Accounts for demographic and morbidity-related drivers of prescribing, such as:
  - Age Profile
  - Long-term conditions
  - Deprivation and health needs
- Designed to support fair and equitable benchmarking between practices
- More information available via NHS England: search “NHS England Prescribing Needs Index (PNI)”

How can practices identify opportunities?

- Practices are expected to remain within their allocated prescribing budget or evidence reduced prescribing spend by adhering to good practice prescribing, robust medicines optimisation, and routine review of prescribing patterns.
- Prescribing should align with the **BSW formulary**, **Prescribe Well Spend Less** guidance and local/national best practice recommendations.
- Active engagement with high value medicines optimisation opportunities is required to deliver cost savings while maintaining clinical effectiveness and patient safety.
- Current priority areas include switching to **preferred biosimilar insulin (Trurapi®)**, **Denosumab biosimilar switches** in line with BSW formulary choices, and appropriate **oral nutritional supplement (ONS)** switches.

Key Message

- This scheme is about rewarding good prescribing, supporting sustainability and building towards future delegated responsibility at a safe manageable pace

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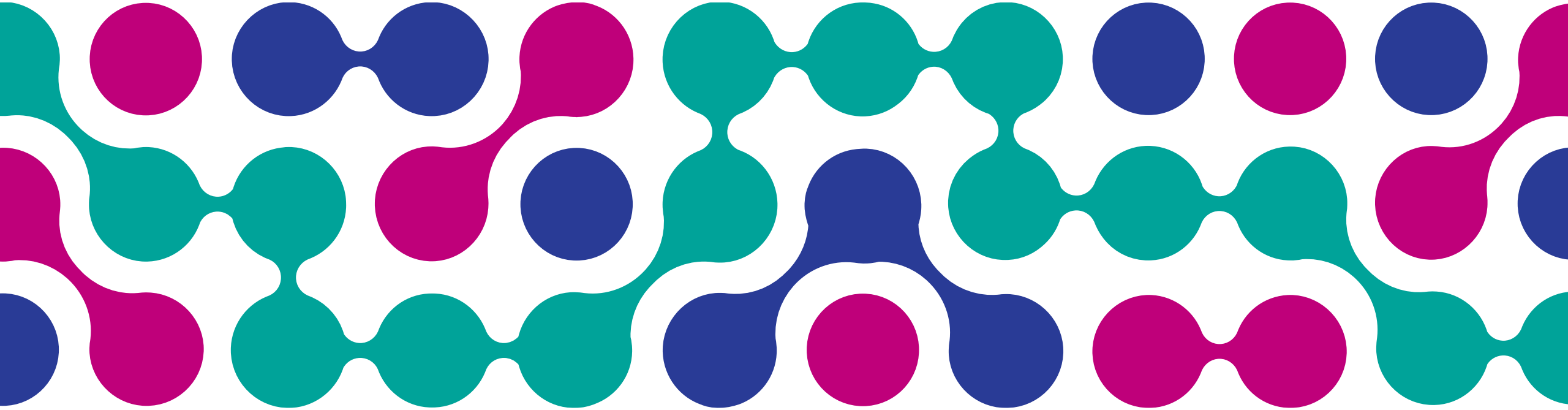
Prescribing Quality and Safety



ECLIPSE

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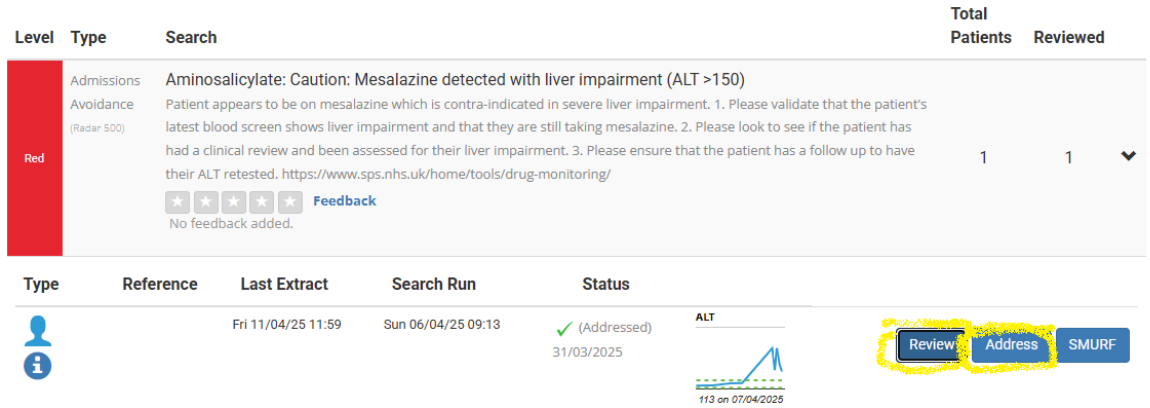
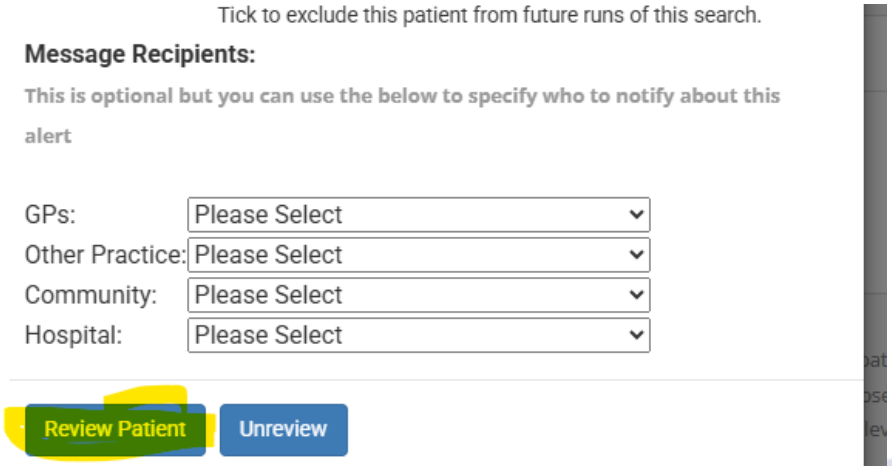
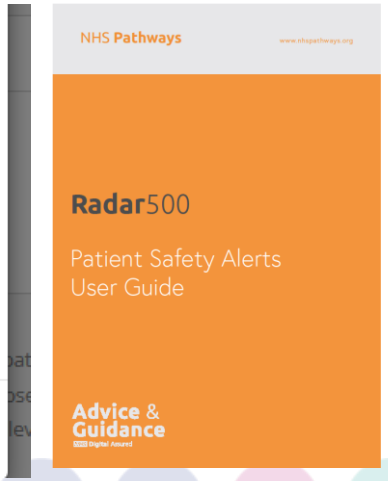
Safety Red Alerts

- Tool created by a GP to support improved medication safety
- An evaluation of 815 practices using Eclipse found a reduction of 5% in their emergency admissions (www.eclipsesolutions.org/impactassessment)
- For PQS - required to review 80% of Red Alerts - is your practice process in place
- Ongoing training and support will be provided to facilitate effective use of Eclipse – contact support@prescribingservices.org OR user guide for RADAR
- To achieve 80%, practices will need to review alerts every week.
- Once logged into NHS Pathways at https://secure.nhspathways.org/, select Eclipse Radar 500 (Red Alerts)
- Please ensure you either click 'Review' or 'Address' to mark an alert as reviewed. You can gain patient identifiable information such as the patient's name or NHS number by clicking the keyhole symbol







Antimicrobial stewardship

Antibiotics Treatment Course Length Optimisation

Antimicrobial stewardship:
Optimising 5-day course lengths.
Reach at or above target or at least a 20% improvement from baseline (% of total course durations that are 5-days):

- Amoxicillin 500mg capsules – 5 days duration (Q=15) (target 80%)
- Doxycycline 100mg capsules – 5 days duration (Q=6) (target 55%)
- Clarithromycin 500mg tablets – 5 days duration (Q=10) (target 50%)

Baseline is Q4 2025/2026

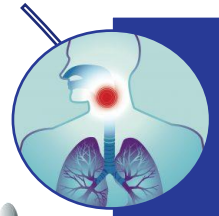
Antimicrobial stewardship

Antibiotics Treatment Course Length Optimisation

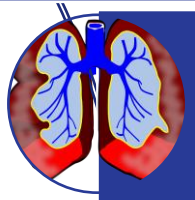
- 5-days antibiotic course duration is often as effective as longer courses for some infections. Shorter courses are associated with less side effects and less bacterial resistance to antimicrobials.
- Combatting antimicrobial resistance – the **UK second five-year national action plan** promotes optimal use of antimicrobials in humans by strengthening antimicrobial stewardship. One of the **ambitions of the plan is to reduce UK antimicrobial use in humans by 5% by 2029.** Optimising the duration of antibiotic use supports delivery of this national action plan, and NICE publish antimicrobial stewardship guidance provides evidence-based recommendations for duration of antibiotic use.
- All practices should agree and implement steps (e.g. audit, staff education) to ensure prescribers are choosing 5-day antibiotic course durations where appropriate. This infographic 5 Days for 5 Infections (Adults) and this short video Why Shorter is Better. Antibiotics in 1 minute. **highlight the common infections and key messages for 5-day course durations.**
- *Note: use doxycycline as an option for penicillin allergic adults in preference to clarithromycin in some infections.*
- **Arden's Infection Templates on SystmOne**, **The BSW Formulary on SystmOne, and BSW Guidance on Management of Infection Guidance in for Primary Care (AB Guidance)** list durations of 5 days (or less) where appropriate.
- ICB Provided Quarterly PQS Dashboard will give an update on current % of courses that are 5-days duration for the three focus antibiotics (Amoxicillin 500mg capsules, Doxycycline 100mg capsules, Clarithromycin 500mg capsules). Monthly GP Practice level data is available to support 5-days antibiotic course duration within the PrescQIPP Antimicrobial Stewardship Toolkit Optimising antimicrobial duration dashboards.

5 DAYS FOR 5 INFECTIONS (ADULTS)

NHS England

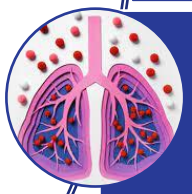


Sore Throat (if antibiotic indicated) Phenoxymethylpenicillin 500mg four times a day for 5 days for symptomatic cure **OR** clarithromycin 250mg to 500mg twice a day for 5 days **OR** erythromycin 250mg to 500mg four times a day for 5 days

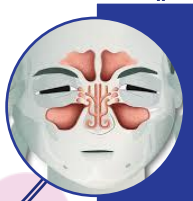


COPD (acute infective exacerbation) Amoxicillin 500mg three times a day for 5 days **OR** doxycycline 200mg day 1 and then 100mg daily on days 2-5 **OR** clarithromycin 500mg twice a day for 5 days

Acute Cough (if antibiotic indicated) Doxycycline 200mg day 1 then 100mg daily on days 2-5 **OR** amoxicillin 500mg three times a day for 5 days **OR** clarithromycin 250mg to 500mg twice a day for 5 days **OR** erythromycin 250mg to 500mg four times a day or 500mg to 1g twice a day for 5 days



Community Acquired Pneumonia Amoxicillin 500mg to 1g three times a day for 5 days **OR** doxycycline 200mg on day 1, then 100mg daily on days 2-5 **OR** clarithromycin 500mg twice a day for 5 days **OR** erythromycin (in pregnancy) 500mg four times a day for 5 days



Acute Sinusitis (if antibiotic indicated) Phenoxymethylpenicillin 500mg four times a day for 5 days OR if systemically very unwell co-amoxiclav 500/125mg 1 three times a day for 5 days **OR** for penicillin allergy doxycycline 200mg on day 1, then 100mg daily on days 2-5 **OR** clarithromycin 500mg twice a day for 5 days **OR** erythromycin (in pregnancy) 500mg four times a day for 5 days

Optimising antimicrobial duration dashboard - Amoxicillin 500mg capsules

Select Benchmarking Level
this is the level at which you want ..

Practice Name

Select Organisation Grouping
NHS BATH AND NORTH EAST SO..

Show Old Boundaries
No - current locations only

Location
All

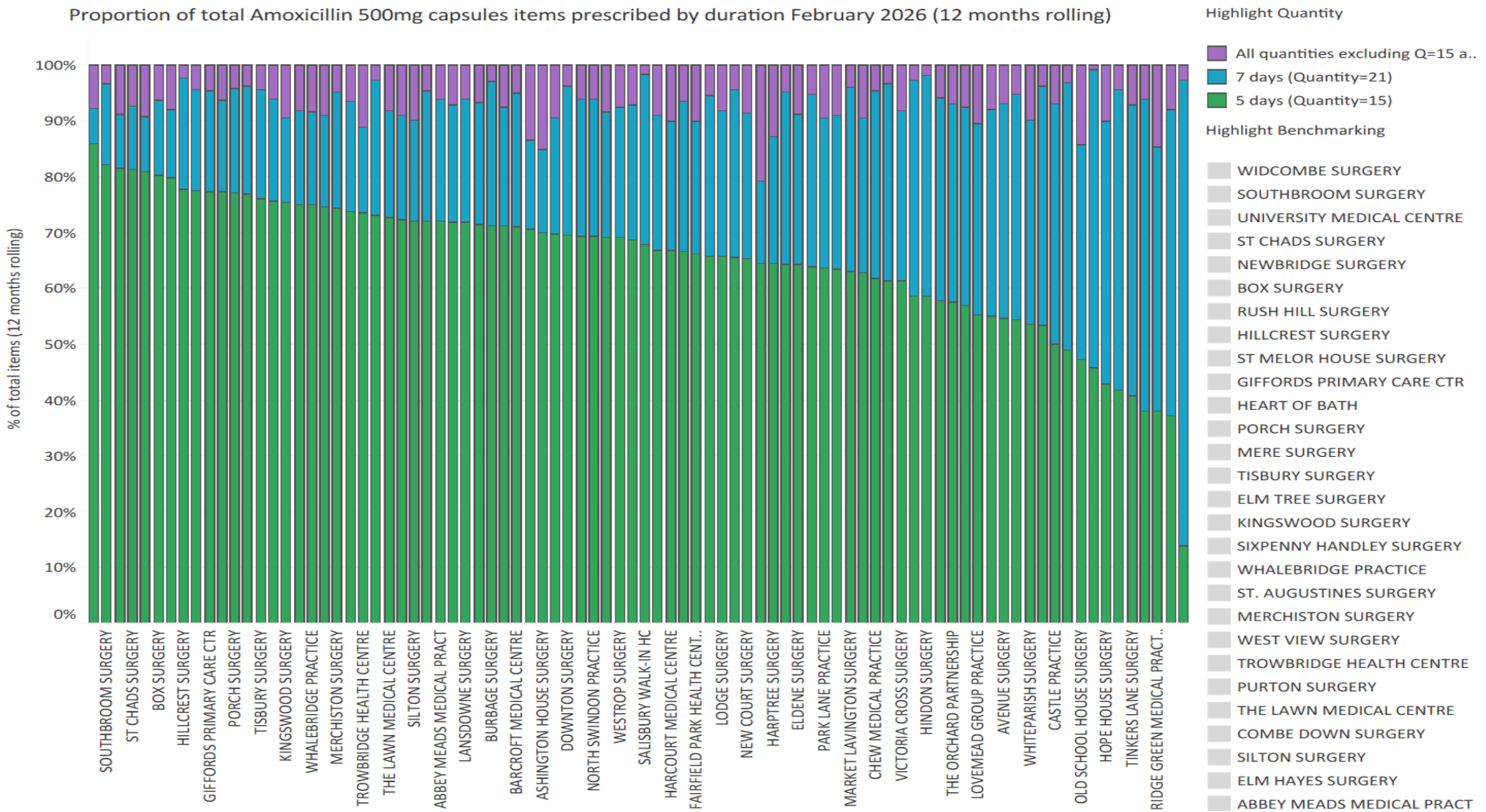
PCN/Cluster
All

Practice
All

Select Sort Order (largest to small..
5 days (Quantity=15)

Select Monthly Prescribing Type
12 months rolling

Age Band Years
All



Optimising antimicrobial duration dashboard - Doxycycline 100mg capsules

Select Benchmarking Level
this is the level at which you want ..

Practice Name

Select Organisation Grouping
NHS BATH AND NORTH EAST SO..

Show Old Boundaries
No - current locations only

Location
All

PCN/Cluster
All

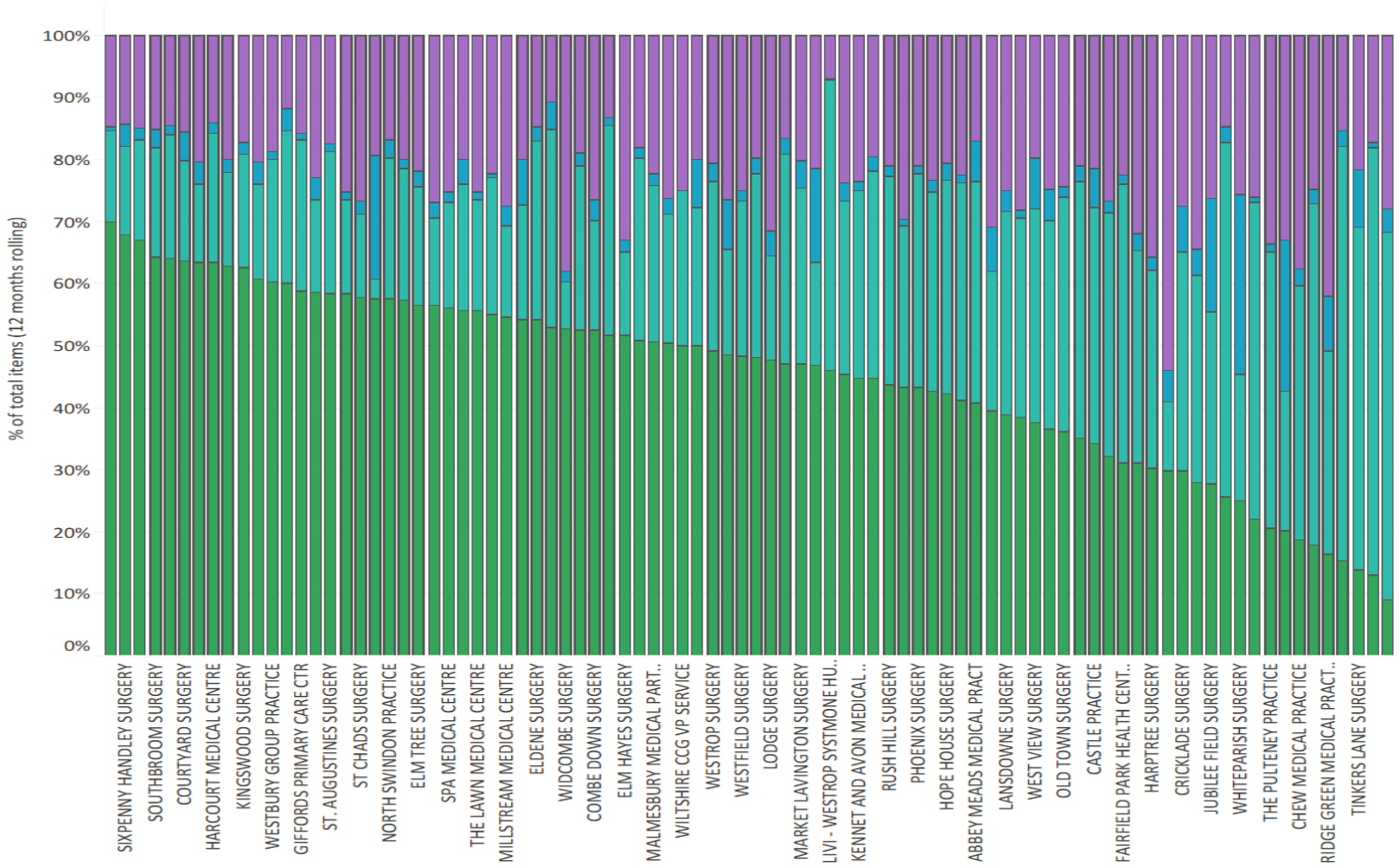
Practice
All

Select Sort Order (largest to small..
5 days (Quantity=6)

Select Monthly Prescribing Type
12 months rolling

Age Band Years
All

Proportion of total Doxycycline 100mg capsules items prescribed by duration February 2026 (12 months rolling)



Highlight Quantity

- All quantities excluding Q=6, Q..
- 7 days high dose (Quantity=14)
- 7 days (Quantity=8)
- 5 days (Quantity=6)

Highlight Benchmarking

- NORTHLANDS SURGERY
- SIXPENNY HANDLEY SURGERY
- BOX SURGERY
- SOUTHBROOM SURGERY
- HATHAWAY SURGERY
- COURTYARD SURGERY
- ST MELOR HOUSE SURGERY
- HARCOURT MEDICAL CENTRE
- TROWBRIDGE HEALTH CENTRE
- KINGSWOOD SURGERY
- AVON VALLEY PRACTICE
- WESTBURY GROUP PRACTICE
- SALISBURY WALK-IN HC
- GIFFORDS PRIMARY CARE CTR
- TISBURY SURGERY
- ST. AUGUSTINES SURGERY
- PORCH SURGERY
- ST CHADS SURGERY
- MERE SURGERY
- NORTH SWINDON PRACTICE
- WILTSHIRE HCRG SERVICES
- ELM TREE SURGERY
- HEART OF BATH
- SPA MEDICAL CENTRE
- ST. JAMES SURGERY
- THE LAWN MEDICAL CENTRE
- NEWBRIDGE SURGERY

Optimising antimicrobial duration dashboard - Clarithromycin 500mg tablets

Select Benchmarking Level
this is the level at which you want ..

Practice Name

Select Organisation Grouping
NHS BATH AND NORTH EAST SO..

Show Old Boundaries
No - current locations only

Location
All

PCN/Cluster
All

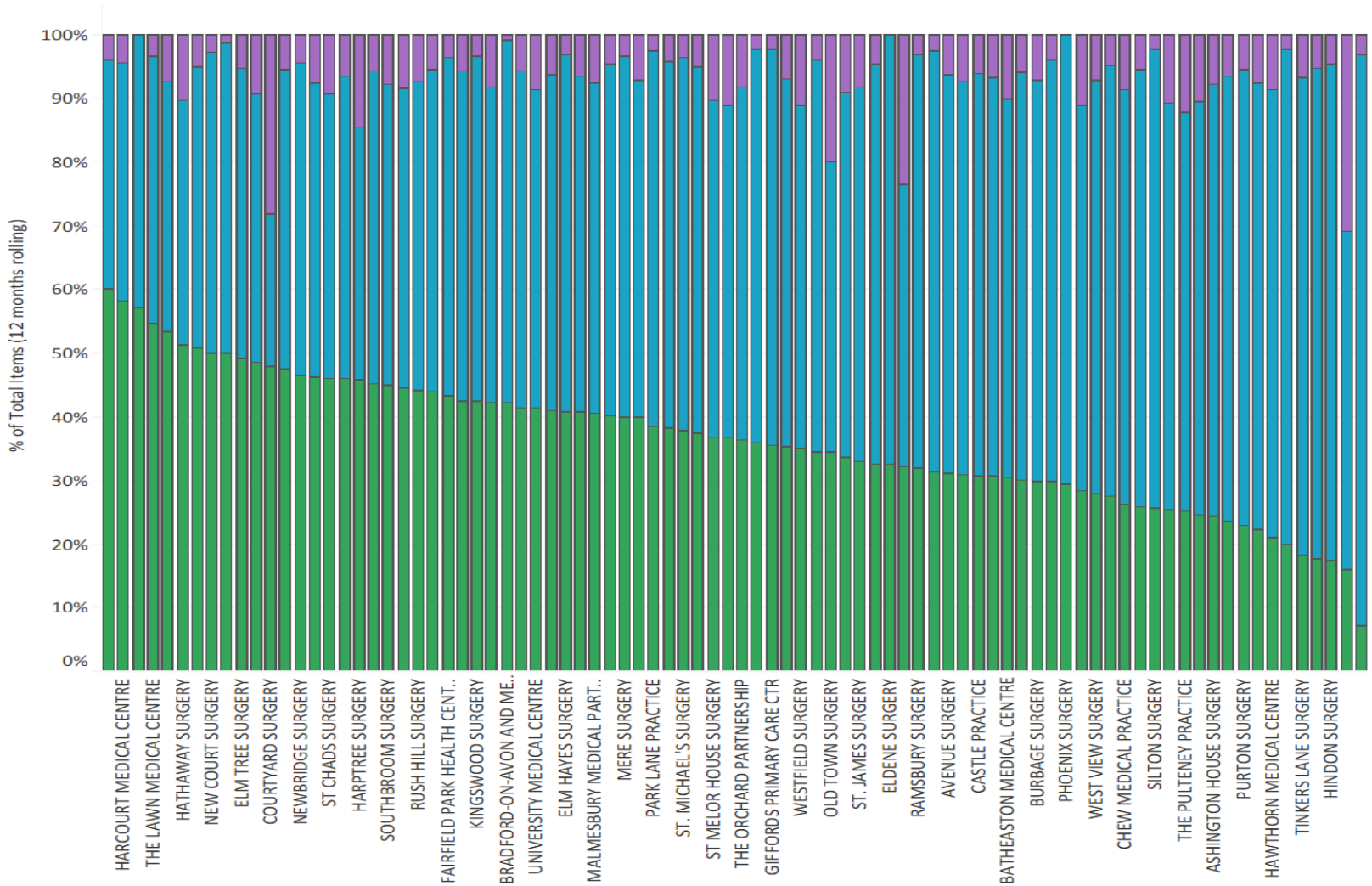
Practice
All

Select Sort Order (largest to small..
5 days (Quantity=10)

Select Monthly Prescribing Type
12 months rolling

Age Band Years
All

Proportion of total Clarithromycin 500mg tablet items prescribed by duration February 2026 (12 months rolling)



Highlight Quantity

- All quantities excluding Q=10 a..
- 7 days(Quantity=14)
- 5 days (Quantity=10)

Highlight Benchmarking

- TISBURY SURGERY
- HARCOURT MEDICAL CENTRE
- SIXPENNY HANDLEY SURGERY
- THE LAWN MEDICAL CENTRE
- BOX SURGERY
- HATHAWAY SURGERY
- TROWBRIDGE HEALTH CENTRE
- NEW COURT SURGERY
- WIDCOMBE SURGERY
- ELM TREE SURGERY
- ST. AUGUSTINES SURGERY
- COURTYARD SURGERY
- NORTHLANDS SURGERY
- NEWBRIDGE SURGERY
- WILTSHIRE CCG VP SERVICE
- ST CHADS SURGERY
- PORCH SURGERY
- HARPTREE SURGERY
- COMBE DOWN SURGERY
- SOUTHBROOM SURGERY
- BARCROFT MEDICAL CENTRE
- RUSH HILL SURGERY
- HILLCREST SURGERY
- FAIRFIELD PARK HEALTH CENT..
- ROWDEN SURGERY
- KINGSWOOD SURGERY
- MERCHISTON SURGERY
- BRADFORD-ON-AVON AND ME..

DOAC Safety

Anticoagulant prescribing safety:

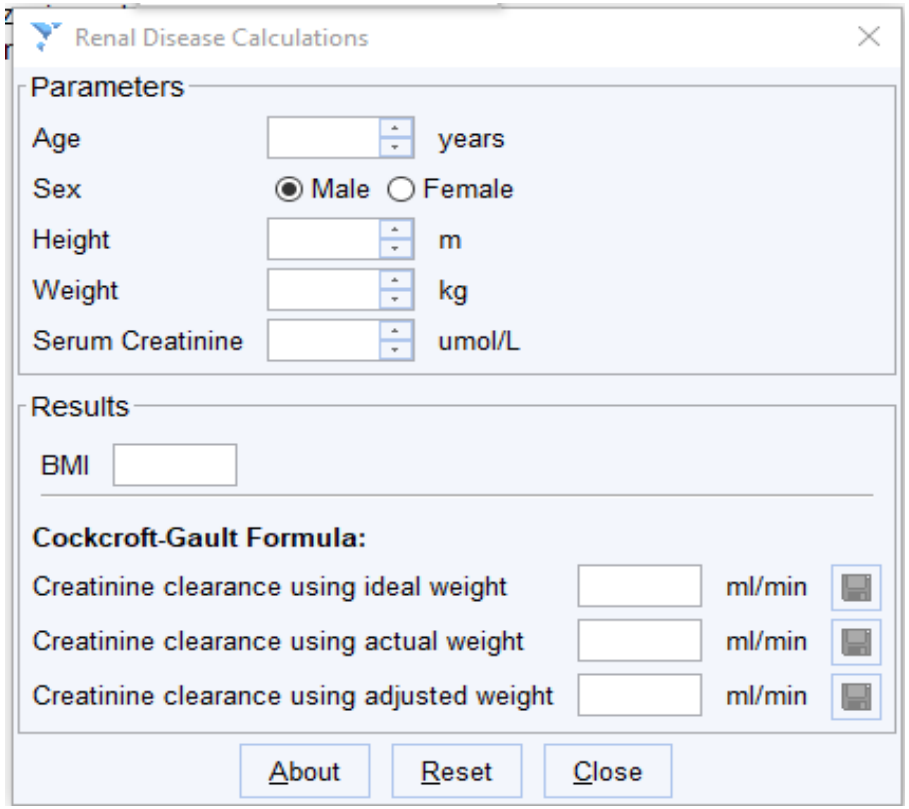
DOAC monitoring – annual calculated creatinine clearance.

Reach at least 80% or above, and for practices already ≥80% at baseline, show an improvement in percentage (optimal target 100%) **by 31st of March 2027.**

DOAC Safety

- The MHRA and SmPC for the relevant DOACs recommend that calculated creatinine clearance should always be used for direct-acting oral anticoagulants (DOAC) dose calculations and NOT eGFR. Use of eGFR for dosing of DOACs is known to increase risk of bleeding events as a consequence of overestimating renal function (MHRA Prescribing medicines in renal impairment: using the appropriate estimate of renal function to avoid the risk of adverse drug reactions - GOV.UK).
- To ensure patients prescribed DOACs have the correct dose an accurate calculated creatinine clearance should be undertaken *at least annually* and coded within the patient's clinical record to prompt clinical decision making. **Most GP Practices have a standard operating procedure/pathway to ensure that this happens consistently.**
- Use either the SystmOne renal disease calculator or MD+Calc for calculating creatinine clearance. **Using the SystmOne renal disease calculator ensures that the correct information is coded within the patient's clinical record.**
- There is **no national guidance or consensus on which body weight should be used in creatinine clearance** calculator. Based on several papers (Winter et al 2012 and Brown et al 2013) and local expert opinions, BSW ICB support an adjustment to the Cockcroft-Gault equation based on the patient's body mass index (BMI), as it appears to become less accurate in weight extremes (underweight and particularly overweight/obesity).
- See BSW Guidance for electronic tools used for creatinine clearance calculation here and screen shots below.

DOAC Safety - SystmOne renal disease calculator



	Body Mass Index (kg/m²)	Adjustments and Estimates
Underweight or Normal weight or Overweight	BMI < 30	Calculate CrCl by using **actual** body weight
Obese	BMI ≥30	Calculate CrCl by using **adjusted** body weight

SystmOne renal disease calculator within Ardens® DOAC Initiation and Monitoring Templates

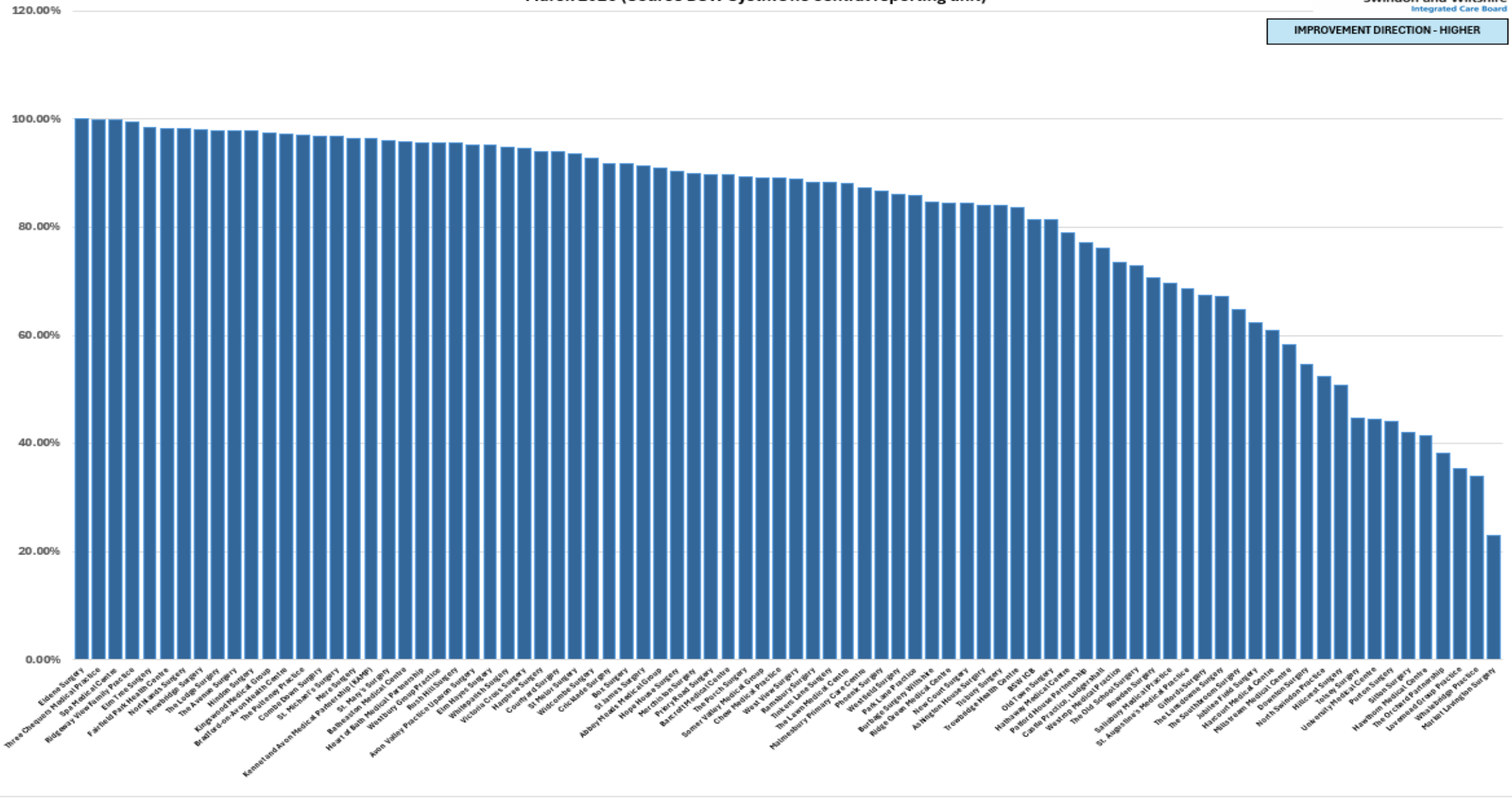
DOAC Safety

- Consider the trend of CrCl changes rather than point estimated values while making any relevant dosage adjustment.
- When interpreting BMI, ensure an up-to-date **weight (in last 12 months)** and **height (in last 5 years)** are documented. Clinical judgement.
- Caution in clinical judgement and careful interpretation is required when the range falls within a dose adjustment boundary. Specialist Anticoagulant advice for these patients should be obtained from our local hospitals' anticoagulant teams.
- **Use the Ardens® reports available to help you identify patients at your practice who may be taking an excess dose od DOAC or being under-dosed.**
- Reports can be found here: *Reporting -> Clinical Reporting -> Ardens Ltd -> Prescribing | Alerts -> Anticoagulants*
- **Specialist Pharmacy Services provide further useful guidance here and note that for creatinine clearance calculation in renal impairment (creatinine clearance below 60mL/min); expert opinion suggests the frequency of renal function monitoring (in months) may be guided by creatinine clearance divided by 10.**
- Note this is an areas of focus within the **CQC for GP Practice Assessments** GP mythbuster 92: Anticoagulant monitoring in primary care - Care Quality Commission & GP mythbuster 12: Accessing medical records and carrying out clinical searches - Care Quality Commission

% Patients Prescribed a DOAC with a Creatinine Clearance Calculated and Coded within the last 12 months
March 2026 (Source BSW SystmOne central reporting unit)

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

IMPROVEMENT DIRECTION - HIGHER



Dependence Forming Medicines

Dependence forming medicines:

Complete one Quality Improvement (QI) Project. Choose either reducing high dose opioid prescribing (chronic non-cancer pain) ***or*** reducing anxiolytics and hypnotics prescribing.

Proposed QI project plan to be agreed by peers at a PCN meeting.

Submit QI template (appendix 2) by 31st of March 2027

Quality Improvement (QI) reporting template

It is anticipated that the responses noted here should total no more than 1 A4 sides in Arial font size 11.

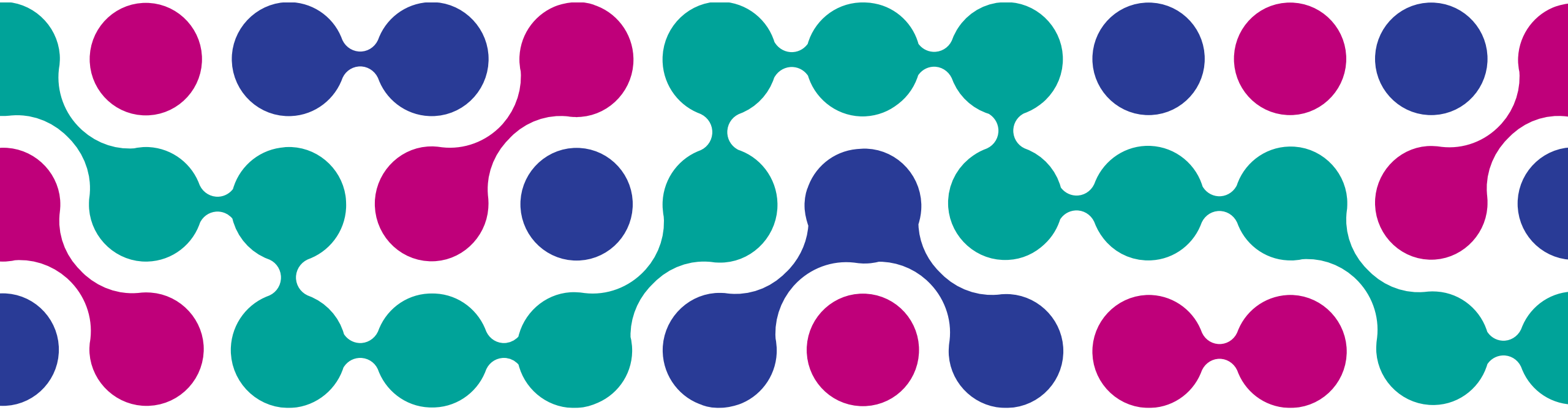
Practice name and ODS code
<Practice Name>
1. Area of audit from part 1 of prescribing report
a. Which area did the practice choose to audit
<Comments here>
b. Date Project Plan agreed by PCN Peers e.g. PCN Clinical meeting <D/M/Y>
c. What issues if any did the practice identify related to this area of audit
<Comments here>
2. Outcome of audit
What action/changes will/ have been embedded into practice systems to improve prescribing in this area e.g Use of templates/protocols/education/information sharing across PCN etc.
<Comments here>

Dependence Forming Medicines

- **The Faculty of Pain Medicine Opioids Aware recommended oral morphine equivalent (OME) threshold has been reduced from 120mg to 90mg/day, with an ideal target of 50mg/day. This change is based on new evidence highlighting increased harm at higher doses without proportional benefit.**
- The ICB GP Practice Quarterly Report includes GP Practice level data for high dose opioids and anxiolytics and hypnotics. Home | OpenPrescribing produce monthly benchmarking data at GP Practice level. First select your practice and then choose prescribing measures 'Safety' to see a range of comparative measures with related evidence and links to guidance including high dose opioids and anxiolytics and hypnotics.
- Resources to support improvements in prescribing for these areas can be found within various PrescQIPP Webkits and Bulletins here All GP Practices within BSW can register to access PrescQIPP resources for free.
- Other useful resources to support quality improvement are widely available including examples from, Opioids Aware | Faculty of Pain Medicine Oxford University Hospital Primary Care Resources and please visit our cluster ICB partner Somerset ICB website here for a wealth of resources to support a Skills not Pills approach, including a Pain Deprescribing Toolkit developed by a GP in Frome which can be found under the 'Skills not Pills' tab.

NHS
Bath and North East Somerset,
Swindon and Wiltshire
Integrated Care Board

Where is my data?



Introducing the GP Practice Prescribing Dashboard

- The new **Power BI GP Practice Prescribing Dashboard** is being rolled out to support practices with **timely, accessible prescribing insights**
- The dashboard replaces previous **email-based quarterly reports** and provides up-to-date, interactive data
- It allows practices to review performance across key prescribing areas, including:
  - Safety and optimisation
  - Antibiotic stewardship
  - Long-term conditions
  - High-cost and low-value medicines

Access and support

- Practices will receive and email shortly with:
  - **Instructions on how to access** the dashboard via Power BI
  - A **step-by-step user guide** explaining how to navigate, filter and export data
- The dashboard is practice-level only and can be filtered to show your own practice data

Please look out for the access email and keep the user guide for future reference.