NHS
Lancashire and South Cumbria
Integrated Care Board

FAQs for Medicines Specifications

Pharmacy First

Q: It is very difficult for our patients to engage in Pharmacy First, how can you help?

A: We would encourage all practices to refer using the EMIS 'local services' button.
The national Pharmacy first scheme covers the 7 clinical areas of:

- Sinusitis in those aged 12 years and over
- Sore throat in those aged 5 years and over
- Earache in those between 1 and 17 years old
- Infected insect bite
- Impetigo
- Shingles in those over 18 years old
- Uncomplicated urinary tract infections (UTIs) in women aged 16-64

This have been enhanced with a supply service covering a wider range of minor ailments conditions with more details here. Which can also be referred to via the local services button. Medicines Optimisation teams can also support with individual practices discussions.

- Allergies including hayfever
- Athletes Foot
- Bacterial Conjunctivitis
- Bites and Stings
- Headlice
- Colds / Flu Temperature / fever (children only)
- Cold sores
- Headache
- Nasal Congestion (for babies 3 months-1 year)
- Constipation
- Dermatitis
- Diarrhoea
- Ear ache
- Indigestion / Heartburn Peptac Liquid (500ml)
- Scabies
- Teething
- Threadworm
- Vaginal Thrush

Finance

Q: Appreciate there will be an uplift on meds LES but as all areas have been funded differently are there financial winners/losers in this e.g. is one area receiving more funding than another currently or is it an uplift for all?

A: All areas will have consistent commissioning. This is an uplift for all areas, but will be greater in some areas than others.

SMR

Q: What SMR code should be used to measure the SMR activity?

A: The SMR code that we are using for the MO LES, and is used in the PCN Des is as follows:
Structured Medication Review – 1239511000000100

Value
Q: Value/QIPP - Will this be adjusted for changes in practice list sizes?
A: Yes, this will be considered.
Q: Supply has been an issue for a lot of low-cost medication. How we can address that as this can put our cost high and miss the funding. Sometimes patients can need a specific type or brand due to allergies or intolerances.
A: The value measure is intended to take account of each individual practice's situation – so there will be continuity based on existing patients (inc. intolerances, allergies etc). Supply chain issues (and associated costs) will affect all of England, so should not adversely affect individual practices. The national stock shortages are listed here with expected resolution times. Medicines Supply Tool – SPS Where there is a very long time to resolution a medicines review to identify an alternative may be necessary.
Q: My worry is, practices who are struggling due to their demographic, will have to work harder and will be at risk of penalty
A: The value payment is based on tracking your own growth so hopefully this will take account a variety of pressures, but the meds team can look into this also.
Q: If they are continuing, will the South Cumbria Meds Optimisation Pharmacists be working on a 'fair-share' basis - I am led to believe that we should get a session a week but are lucky to get one session a month. This means I have to rely on our PCN Pharmacists who cannot do all the work expected.
A: We are limited in the medicines optimisation team resources available, but will be responsive to areas with high need and also where we receive requests for additional support.
Q: Who is going to define what is "reasonable" if a practice disagrees?
A: The data packs will provide objective evidence of current performance metrics and will be update monthly, so objective impact will be visible. The 10% reductions (or maintain national best practice) is deemed to be reasonable in terms of movement and quality improvement. There will be a resolution process if there are disputes in delivery.
Q: Will there be any exceptions in the value targets for individual high-cost patients? One or two very high-cost patients with multiple high-cost drugs could easily tip a practice from achieving to not achieving.
A: As you are tracking your own growth this should be taken account of but happy to discuss.

GP prescribing lead
Q: Can we appoint Clinical Pharmacist as 'Lead' as an option rather than narrow it to a GP?
A: No, we want to ensure ownership from a GP partner. Pharmacy staff will be integral to delivery.
Dependence forming medicines
Q: Is there any correlation between the Dependence forming med numbers and local waiting times etc? Also, additional services for patients to access i.e. mental health, holistic treatments
A: Not sure, we can look. In terms of safety the dose reductions will still need to happen. We are currently working with trusts and services to look at what support can be provided.
Q: Will you support us by working with our pain clinics around opioid and gabapentinoid prescribing as some of this comes from their recommendations?
A: Yes, we are working with providers through communities of practice and also developing resources for practices. We would be interested in hearing what practices would like in terms of support also. Faye Prescott faye.prescott2@nhs.net is our lead on this piece of work.
Q: Can we exempt patients who are being advised to take these meds by secondary care pain clinics and not working with practices to reduce dependence?
A: We understand the frustration, but for this to be successful long term, all HCP inc. community and secondary care pain teams, and secondary care colleagues, need to be bought into the LSCMMG position statements on opioids. This needs system collaboration. We're working with practices and pain clinics and other non-medical options e.g. pain cafes, walking groups etc as alternatives to medicines. Everyone can make a contribution and clear processes (across whole areas, trusts, practices) help provide consistency and challenge. We have set up Communities of practice in some places and others to set up this year. Many have said this is very supportive. if anyone wishes to connect on opioids. Please email faye.prescott2@nhs.net If there are repeated issues with particular clinics and providers, please share this information with the Medicines Optimisation Team who will arrange to pick this up at either a Community of Practice meeting or a specific secondary care interface meeting.
Q: It will be helpful to get medicines management team from ICB to help us regarding plans to reduce/ withdrawal of opiates and support practice rather than leaving this on the practice team
A: We are currently developing a variety of resources to support practices this will include training and reference sources and the team will support practices through meetings and action planning also. We are keen to understand what support practices think they need also. The practice packs will continue so there will be monthly data so you know how you are doing.
Q: We have already disproportionately diverted a lot of practice resource to try to manage this - given the status quo it would seem more appropriate for all high dose opiates in non-palliative patients to be prescribed and managed by pain clinic/ in specialist opiate clinics. Practices should not be put in the position of taking this ongoing responsibility from a patient safety perspective and potentially also risk losing out financially with LES
A: The value element and opioids element are separate, but reduction in opioids, gabapentinoids will help to reduce overall spend, SMRs may help this. There is substantial funding oriented towards reduction in drugs of dependence to pay for staff time. Communities of practice, resource toolkit and joint work with the pin clinics should ensure consistent messages.

Shared care
ADHD
Q: ADHD support with prescribing queries is dreadful and can take weeks - in the meantime we are left floundering in general practice. What should we do in this situation?
A: We are aware many providers as not very responsive – where they should be. If you can provide evidence to the mental health team of issues, we will follow up contractually to help get resolution.
Q: Can you provide guidelines on ADHD and private providers?
A: The approved ADHD shared care guidance is on LSCMMG which we expect NHS commissioned providers to follow including right to choose referrals. This service is intended to cover NHS shared care (including with approved right to choose providers). However, where a practice has considered the criteria in the Local Guidelines for Good Prescribing in Primary care and feel sufficiently assured to choose to agree shared care with a private provider for medications covered by the shared care agreements, this specification applies. Where a patient initiates private ADHD assessment and treatment without GP practice referral this is an entirely private arrangement and practices are under no obligation to take on care from the private provider.
Q: Shared care, is it really shared care? Sec care/MH/ADHD etc services are handing patients over without prior agreement with us....
A: We will need clear comms with provider colleagues. We are currently doing some close work with providers on improving shared care especially LSCFT and we are keen to continue and build on this. All shared care should be a request from the specialist and agreed by primary care, not an assumed transfer. LSCMMG has template letters to reply to specialist if the request is inappropriate. MOT will continue to support with individual queries.
Q: Most ADHD providers are not seeing patients F2F as requested by our current shared care - we keep bouncing back. Can this be looked at?
A: We will pick this up with commissioners. We are updating our shared care protocol to allow for a virtual assessment by the ADHD provider if a face to face is not possible.
Q: Are you NOT checking if the ADHD provider invoices are from right to choose organisations?
A: Mental health team do check and scrutinise all invoices – standards improvement required.
Q: Need to address the demands from private providers - increased ask to primary care to prescribe as patients access national services due to waiting times. How will this happen?
A: There is work going on with ADHD providers. There is also a revised document going through LSCMMG re; shared care and private providers. We agree the situation is challenging and we will continue to support. If practices have further ideas or feedback, we would welcome this.
Q: Some ADHD providers are writing to us with a list of options i.e. try this X, but you could then change to Y or Z. Incredible pushback from provider and patient when we have said no this isn't what shared care means. We are still saying no, but ICB backing and clarity about what is and isn't shared care would be helpful.
A: Prescribing should for stable treatments. Agree the scenario illustrated seems inappropriate.

Q: Where a patient is under the care of mental health and who are demonstrating signs of e.g. ASD/ADHD why can't they refer patients on the right to choose for ADHD ASD? They are delegated to GPs for forward referral for diagnostic confirmation
A: Sorry not aware of this Mental health team should be able to respond
Q: ADHD - having problems with a right to choose provider, who is dividing the assessment and medication initiation. Unless you agree for a shared care delivery to start with, they are refusing to provide the treatment. At the start, don't know if the patient needs treatment, or if justified, so cannot agree. But from their point of view, we should be agreeing that if the patient needs treatment that shared care agreement will be taken. Should also be a right to choose from the primary care side too, and they should write to us to report it. Feels this is inappropriate. What is the correct process?
A: We are working with the mental health team to make improvements. Not aware of this particular case, but happy to look into this separately. Correct in that you shouldn't be taking on shared care until the patient is stable, and inappropriate for a GP to initiate. Not in line with the shared care protocol.
Q: The issue with all of these problems is the 'problem' is attributed to the GP practice. We are the ones having to say no - having to tell the patients - and it's us who gets the kicking via satisfaction surveys/forums/complaints etc. All taking up time. It's so soul destroying. ADHD patients go private as the NHS provision is worse than pointless (waiting times) - and then we can't take on the prescribing. Patient (or parents in children) then stuck in total limbo - with schools etc pushing for diagnosis and treatment to trigger funding in their institutions. Same happening with Weight Loss drugs with regards noise. How do we manage this?
A: Private ADHD where initiated by the patient, and paid for by the patient, is different to right to choose. Right to choose is a referral by practice to an independent provider as the NHS doesn't have sufficient capacity locally. If it is an NHS right to choose, they may request shared care, and you would need to be assured that is occurring. There should also be an annual ADHD review of the patient by the specialist provider, with ongoing prescribing by primary care. If a self-referral, that's the patient's private arrangement with that organisation, and you don't need to have any involvement. However, where a practice has considered the criteria in the Local Guidelines for Good Prescribing in Primary care and feel sufficiently assured to choose to agree shared care with a private provider for medications covered by the shared care agreements, this specification applies.
Q: Is it possible to regularly update us on the ICB INTRANET regarding up to date right to choose providers list?
A: We can look at this with Mental health team - it is ever changing and NHSE gave feedback when a GP refers to RTC they need to be aware about share care agreements before they send referral. We do however agree this cannot be an unconditional agreement prior to diagnosis and prescribing presupposes an outcome which may or may not be known at referral.

Shared Care general
Q: Slight alert here might be if secondary care see this - they will almost 'increase' the amount of shared care 'dump'. We obviously know it has to be agreed - but everyone on here shouts about how often this is just 'done' to us. So, it needs to be very clear to Secondary care - this is not a license for them to just pass on monitoring onto us?
A: Agree we will need clear comms with provider colleagues. We are currently doing some close work with providers on improving shared care especially LSCFT and we are keen to continue and build on this.
Q: Psychiatric shared care is not paid at all. We are getting minimal payment for Shared care and work is significant and without any support mostly. How are we going to change this?
A: All current specifications are ceasing, and the new ones will include a new ask and price as negotiated with the LMC. All shared care drugs will now be paid for, including psychiatry and ADHD drugs.
Q: Can we cancel the shared care agreement and send the patients back to specialist if the patients are not attending for monitoring despite multiple invitations? This cohort can be a difficult group to engage!
A: We are currently working with LSCFT specifically re; how shared care is working if you have individual patient challenges, please raise with your MOT practice pharmacist and we will pick up with LSCFT. We have had a good response with many of our queries and we are meeting with them monthly to try and improve shared care.
Q: Will there be clear handover expectations on secondary care? I.e. completing formal shared care handover form and reviewing the patient at least annually? This is not currently happening.
A: We will need clear comms with provider colleagues. We are currently doing some close work with providers on improving shared care especially LSCFT and we are keen to continue and build on this. MOT will continue to support with individual queries. A consistent shared care form can be proposed.
Q: You need to explain shared care to psychiatry - they just discharge everyone and then expect us to titrate which isn't shared care
A: We are doing this now and meeting with lead clinicians at LSCFT monthly. If you have specific problems, please raise them with your MO team and we will facilitate a response. I agree that improvement is required.
Q: What is being done to stop 2nd care discharging patients for GP to take over with no shared care agreement. This happens all the time and we are left with an unhappy patient when we can't take over prescribing. There seems to be a lack of knowledge regarding shared care agreements in 2nd care.
A: We will need (and expect) clear comms with provider colleagues. We are currently doing some close work with providers on improving shared care especially LSCFT and we are keen to continue and build on this. MOT will continue to support with individual queries. A consistent request to accept shared care form can be proposed.
Q: Can we have a written statement on Amber drugs initiation position from the ICB?
A: We do have a written statement. If we have evidence that this isn't being adhered to then teams will be happy to pick that up. If you think the statement needs to be changed, then please let us know. Colour Classification - Lancashire and South Cumbria Medicines Management Group

Q: Would it be possible for the ICB to produce a document/letter that we can bounce back to secondary care for if they try to pass on things inappropriately? Even just the writing back with reasons takes time and we often get a letter back arguing that we should do it...
A: Yes, we can consider a template letter as part of the shared care work Current version is **Generic Shared Care Agreement Form**
Q: Communication in terms of handing over shared care is not always clear. It is expected. How can you help this?
A: We will need clear comms with provider colleagues. We are currently doing some close work with providers on improving shared care especially LSCFT and we are keen to continue and build on this. MOT will continue to support with individual queries. A consistent shared care form can be proposed.
Q: Important for sec care colleagues to understand that dose adjustments and corresponding transient increase in monitoring is back under their care and not arranged/managed by general practice under shared care agreements. The agreement requires a stable dose and monitoring for managing in general practice under the agreement.
A: We will need clear comms with provider colleagues. We are currently doing some close work with providers on improving shared care especially LSCFT and we are keen to continue and build on this. MOT will continue to support with individual queries. A consistent shared care form can be proposed.
Q: Some of the SCA paperwork do not need a signature yet some do. Can they please be reviewed? Ideally be signed by the Acute colleagues so they know they have to support prescribing as well when asked.
A: Yes, we will pick this with through LSCMMG, consistency would help. However, as we are mostly using electronic communication, a wet signature feels like a backward step. Could the LSC shared care record be used to communicate and record request/ accept/ refuse for SCPs?
Q: It's impossible to tell when they move to our practice from another area. Sometimes we refer but they go privately before so again hard to tell if NHS. Is there anything that can be done to help this?
A: Assume ADHD - We will need clear comms with provider colleagues. We are currently doing some close work with providers on improving shared care especially LSCFT and we are keen to continue and build on this. MOT will continue to support with individual queries. A consistent shared care form can be proposed.
Q: Is there scope in these contracts for practices to say no - or say that they are at capacity because I can see a LOT coming our way through this
A: the new shared care LES allows for additional fees per patient, so work is remunerated.
Q: Who will monitor that it is definitely SHARED care?
A: We have audited shared care as a team in some parts of the ICB and have fed the issues back to providers. We also work with medicines co-ordinators to feed back issues.
Q: Who decides when someone is stable?
A: There is some detail regarding when a patient is stable in the shared care guidance, but I agree this is sometimes an issue and we need to work with providers. We would define this generically and biologically stable – but physical and mental health stability should also be considered.

Q: Some providers shift the lines and interpret shared care guidelines as per their interpretation. How can we manage this?
A: Happy to work with providers if there is an issue. Work with LSCFT particularly is going well and lead clinicians are very engaged. Happy to be contacted or please speak to your local MO team
Q: How up to date is the data we will receive in the support pack each month? If this is based on epact data, it makes it difficult to make changes in a timely manner
A: Practice packs are based on epact which is 6 weeks behind. There may be potential to use Eclipse or EMI searches for further support and more timely information. We will follow this up.
Q: Are you saying no funding for warfarin for 25/26? Who is funding consumables for those on warfarin that we are monitoring? We have done a lot of work on this and those still on warfarin are unlikely to be moved over to DOAC
A: Yes, this was covered - Anticoagulation spec will continue in 25/26 and review for following year.
Q: Is the meds mgmt. traffic light site going to be maintained going forwards? It gives us an idea of the ICB's position on traffic light drugs
A: Yes, this will continue to be maintained monthly on the LSCMMG website and in the LSC joint formulary
Q: Growing interpretation in secondary care and other providers that assume that as long as a secondary care colleague says it is ok to prescribe, then they expect us in primary care to prescribe the first script which is not our understanding. Our understanding in primary care is that amber is initiated by specialist, stabilised & then passed over to primary care. Can you assure us that is the correct interpretation?
A: Would expect patients to be initiated & stabilised before passing over to primary care. Time can vary due to drugs & circumstances. If you have any queries, contact MO team through local contact in your practice.
Q: The number of shared care patients vary from practice to practice, and some will have a higher workload than others. Is the payment on the practice population, or on the individual numbers?
A: Payment on workload and the number of patients that you have.
Q: Do we have guidelines on all the shared care in place and the monitoring for this? Possibly a summary of medication used, frequency of monitoring required and what is monitored?
A: A summary of information is available.
Q: If I have agreed shared care but the secondary care provider isn't meeting the requirements of them stated in the agreement, what should I do?
A: If this is the case, and you are unable to resolve this with the provider concerned (e.g. by prompting them to arrange a delayed review appointment), then it is reasonable to hand back prescribing to that provider due to the clinical and medicolegal risk. However, we would expect you to give a 3-month (84 day) period of notice to withdraw from your part of the agreement and in the meantime continue prescribing and monitoring as appropriate. Please also notify the Medicines Optimisation Team so they can address this with the provider concerned and identify any themes
Q: What if a medication is listed in this specification, but I don't feel confident to prescribe it safely?

A: It is important that GPs only take on prescribing where they feel competent and confident to do so. There is no obligation to take on shared care prescribing. If you identify a training team or need further support to gain confidence and experience, please get in touch with the Medicines Optimisation Team for support.
Q: There are some primary care requirements in the shared care agreements that I feel are unclear or unnecessary. How can I address my concerns?
A: Some of the shared care drug specifications have been in place for some years and would benefit from review. Please pass on any concerns to the Medicines Optimisation Team, who will arrange a review process, which may involve the specification being formally reviewed via LSCMG if necessary. Speak to a member of the team locally or use mlcsu.lscformulary@nhs.net.
Q: I have identified other medications that I think ought to be subject to formal shared care arrangement, but they aren't mentioned in this specification.
A: If you feel there are additional medications that meet the criteria for shared care from a clinical safety or excess workload perspective, please highlight your concern to the Medicines Optimisation Team, who will assess the request and add it to the LSCMMG workplan for discussion if appropriate. Speak to a member of the team locally or use mlcsu.lscformulary@nhs.net.
Q: I have asked secondary care to complete the formal shared care agreement forms at the point of handover, but they are refusing. What should I do?
A: The ICB Team considers that use of the formal shared care agreement paperwork is best practice. We understand that, historically, it wasn't agreed that use of them was compulsory for secondary care. We will work with the secondary care trusts to communicate the primary care perspective that this should be a standard expectation in future. It would be reasonable for practices to decline to take over shared care prescribing without a properly completed form in place.

Shared care – drug queries
Q: Dronedarone requires monthly monitoring at first so is intensive, rather than 6 monthly
A: Shared care should only be requested once the patient is stable i.e. moved to 6 monthly monitoring. The guidance document will be reviewed.
Q: Is testosterone for male or female and menopause libido management?
A: Both shared care guidance below. testosterone-shared-care-guideline-female-sexual-dysfunction-v12-sep24.pdf testosterone-shared-care-guideline-february-2024.pdf
Q: I am a GP with a special interest in women's health. Does the fact that testosterone is covered by shared care for menopause in this spec mean that I shouldn't be starting it?
A: If a GP with a special interest feels sufficiently competent and experienced to initiate testosterone for menopause, we are happy for you to continue doing it. This specification only applies to stable shared care at the usual point of handover to primary care.
Q: Is there any guidance available to support monitoring for drugs designated Amber level 0?
A: The ICB is currently developing resources to help identify and outline any monitoring for drugs that are currently designated as Amber level 0. We will distribute these resources as soon as they are available. In the interim, we advise practices to refer to the SPS drug monitoring tool, BNF, and SPCs for further information.
Anticoagulation
Q: Is there going to be any attention given to DOACs? Numbers of patients on warfarin are dropping rapidly meaning much less pressure on anticoagulation clinic, but Practices are having to pick up DOAC monitoring which is huge
A: There is an anticoagulation LES which encourages reduced warfarin usage and increased best value DOAC (Apixaban, rivaroxaban). We will review the anticoagulation spec within 25/26 to inform 26/27 based on what we expect will be a substantial decrease in warfarin usage.
Non-LES questions
Q: Re Tirzepatide (Mounjaro) - can we please get and ICB holding statement out there - that we can refer to (link to) in responses to the patients now pretty much demanding the drug following NHSE/NICE comms?
A: LSCMMG will send out an agreed position to help practices. Commissioned pathways are being discussed to address the national roll-out plan.