Service Specifications

Service Specification No.	FINAL 23.3.23
Service	Specialised Drug Monitoring
Commissioner Lead	Lincolnshire Integrated Commissioning
Period	1st April 2023 – 31st March 2024
Date of Review	August 2023

1. Population Needs

1.1 National Context and Evidence Base

A Shared Care Protocols (SCP) is a local guideline that outlines the responsibilities of the specialist and the GP for prescribing and monitoring of medicines, once a patient is stable on that medicine.

SCPs are local policies to enable General Practitioners to accept responsibility for the prescribing and monitoring of medicines/ treatments in primary care in agreement with the initiating service. Where possible, shared care should be disease specific rather than medicine specific and link into complement local integrated care pathways and shared care policies. Medicines and conditions suitable for shared care will be identified by local medicines committees and will be classified as AMBER (AMBER 1 for Lincolnshire) through the traffic light system. The provision of shared care prescribing guidelines does not necessarily mean that the GP has to agree to accept clinical and legal responsibility for prescribing; they should only do so if they feel clinically confident in managing that condition.

1.2 Local Context and Summary Statistics

There is one Integrated Care Board (ICB) in Lincolnshire working to improve the delivery of healthcare and to improve the health of our population. The NHS Lincolnshire Integrated Care Board (ICB) is a statutory body which came into being on the 1 July 2022 with the general function of arranging for the provision of services for the purposes of the health service in England in accordance with the Health and Care Act 2022.

The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- Improving the health of children and young people
- Supporting people to stay well and independent
- Acting sooner to help those with preventable conditions
- Supporting those with long-term conditions or mental health issues
- Caring for those with multiple needs as populations age
- Getting the best from collective resources so people get care as quickly as possible.

Lincolnshire Integrated Care System ICS was created on 1 July 2022 following amendment of the Health and Social Care Act 2006 and replaced Clinical Commissioning Groups. The ICS is partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population.

The core aims of the Integrated Care System (ICS) are:

- Improve outcomes in population in health and healthcare.
- Tackle inequalities in outcomes, experience and access.
- Enhance productivity and value for money.
- Help the NHS support broader social and economic development

This enhanced service will deliver care and early reassurance to patients in GP practices, providing early identification of rhythm abnormalities and avoid unnecessary referrals to secondary care.

Lincolnshire ICB Summary Statistics

- The ICB has 82 practices.
- The total Lincolnshire ICB registered population in July 2022 was 807,813.
- Lincolnshire ICB registered population live in 7 different lower tier Local Authorities.
- Lincolnshire ICB area is slightly lower than the England average life expectancy for both females (83.3 years) and males (79.0 years) with the overall premature mortality rate (deaths<75years) higher than that in England.
- Lincolnshire ICB as a whole, sits just below the mean level of deprivation for England but has pockets of deprivation that sit in the national 20% of most deprived areas mainly around the coastal and inner urban areas.
- Lincolnshire ICB has a higher prevalence in relation to some long-term conditions for example diabetes (6.5%), COPD (2.3%) and coronary heart disease (4.1%) compared to England with 5.8%, 1.9% and 3.0% respectively.
- The main providers for the ICB are United Lincolnshire Hospitals NHS Trust for Acute, Lincolnshire Community Health Service for Community services, and Lincolnshire Partnership Foundation Trust for Mental Health.
- Key challenges facing Lincolnshire
    - Changing demographics for Lincolnshire (inward migration, increasing birth rate, ageing population, health inequalities) will place challenges upon public and community services.
    - Public perceptions and expectations of public sector services, when seeking to reduce health inequalities
    - Economic and health inequalities with low-wage economies (whether urban or rural) and ill-health being related.
    - Children's health and lifestyles e.g., breast-feeding, accidents and injuries, smoking, sexual health, mental health, and obesity.
    - Poor transport and highways infrastructure (no motorways).
    - An ageing population over the next 20 years will provide challenges in relation to Long term health conditions, residential and hospital care, and mental health, most notably dementia.
    - Inequalities for people with disabilities, including those with learning disabilities. Prevention relating to smoking, alcohol, obesity and maintaining independence is crucial.
    - Protection of the public from environmental and health emergencies remain important in Lincolnshire.

Further information can be found at the following:

- Lincolnshire Research Observatory http://www.research-lincs.org.uk/

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓

Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	✓

2.2 Local defined outcomes

The Commissioner wishes to ensure that specialised drug monitoring services (with a shared care protocol), are readily available in Primary Care. A Practice based service will provide more convenient and timely care to the patient.

It has been recognised that the provision of specialised drug monitoring services in primary care has significant benefits to patients which include:

- Improved patient convenience, often with minimal travel requirements.
- Timely service
- Available expertise already present in primary care.
- Holistic approach to patient care.

The following principles underpin the service:

- The majority of care should take place as close to the patient's home as possible.
- Practices can work in partnership to provide a comprehensive local service.
- Where GP practices do not wish to provide the service other providers will be available to provide in the locality.

This service specification details the monitoring and prescribing of specialist medication. Providers will accept the prescribing responsibility of the detailed complex treatments which have been initiated by or on the request of secondary or tertiary care based specialists. This specification applies to drugs, currently included within the amber 1 (with shared care) section of the Lincolnshire Joint Formulary, which require a shared care guideline only. These drugs are approved for continued prescribing in primary care, subject to specialist initiation, and the transfer of prescribing responsibility between primary and secondary/tertiary care.

The Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF) make recommendations regarding the status of medications that are suitable to be included in this service. This advice is communicated to all prescribers through the Prescribing and Clinical Effectiveness (PACE) bulletin. Copies of all issues of the PACE bulletin can be found at the following web address Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF) or from members of the NHS Lincolnshire Integrated Care Board (ICB) Medicines Optimisation team. The Lincolnshire Joint Formulary site www.lincolnshirejointformulary.nhs.uk contains links to the shared care documents in the relevant section of the formulary.

Appendix 1 contains a list of all the AMBER 1 drugs included within the specialised drug monitoring service. This list will be amended regularly to reflect current PACEF recommendations, and any changes made during the course of the year will take effect from the 1st of the month following.

PACEF has advised that if GPs or other primary care based prescribers receive a request to prescribe an AMBER 1 drug either not listed in Appendix 1 or for another indication not covered by the existing shared care guideline they should contact the Lincolnshire ICB Medicines Optimisation team via email address (licb.mo@nhs.net).PACEF will continually review the range of shared care guidelines to ensure these are sufficient to meet local needs. Whilst every effort is made to remain current, it is inevitable that occasionally GPs will receive requests to prescribe medication for specific indications not yet evaluated locally.

3. Scope

3.1 Aims and objectives of service

The aim of shared care guidelines is to provide information and/or guidance to primary care based prescribers and hospital based clinicians on the roles and responsibilities relating to the potentially complex implications of sharing patient care for a specific drug between primary and secondary/tertiary care.

3.1.1 Shared Care Guidelines

These should only be considered as an appropriate option for the management of specialised drug therapy if the level of clinical competence, knowledge and resources required for the on-going monitoring of the requested therapy is available within a primary care setting.

3.1.2 Specialist Responsibilities

It is the responsibility of the specialist to decide with the patient/carer that a patient is suitable for shared care arrangements of their medication

The specialist secondary/tertiary care service will:

- Send a letter to the GP requesting that the GP participates in shared care. As part of the communication the GP should be signposted to where they can find a copy of the shared care protocol e.g. the PACEF website Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF) or the Lincolnshire Joint Formulary: www.lincolnshirejointformulary.nhs.uk
- Carry out all necessary baseline checks.
- Initiate treatment and ensure patient is stabilised on the medication before requesting transfer of prescribing responsibility to the GP
- Ensure that the patient receives adequate supplies (28 days) of the specialised drug from the hospital or it is prescribed from the hospital on FP10HP until the GP formally agrees to the shared care.
- Ensure that the patient receives any patient information leaflets and treatment monitoring booklets that are deemed necessary. It should also be communicated, to the patient, that it may take a number of working days, after a GP has agreed to take on the prescribing before a prescription can be collected.
- Confirm that the patient is optimised on the chosen medication with no anticipated changes in the immediate future
- Undertake monitoring at appropriate intervals until dose stabilised and GP has agreed to undertake routine monitoring.
- Regularly review the patient's clinical condition and communicate promptly to the GP any changes in dose or monitoring requirements.
- Advise the GP on when to adjust dose, stop treatment or consult with specialist. Dosage alterations should always be specialist led.
- Be available to give advice to the GP and ensure that clear backup arrangements exist for GPs to obtain advice and support by providing contact details to GPs of specialist team.

3.1.3 GP responsibilities

The GP will:

- Agree that in his/her opinion the patient should receive shared care for the diagnosed condition unless good reasons exist for the management to remain within secondary/specialist care, in which case they will notify the consultant in writing, within10 working days.
- Prescribe within own levels of competence following relevant GMC guidance[1]

[1] Good practice in prescribing and managing medicines and devices (gmc-uk.org)

- Monitor the patient's overall health and wellbeing.
- Monitor the patient for adverse drug reactions and remain vigilant to the risk of potential drug interactions.
- Regional Medicine Optimisation Committee (RMOC) guidance advises that any transfer of prescribing to primary care should follow a successful initiation and stabilisation period with the agreement/understanding of GP. At this stage, GPs should prescribe the therapy as recommended by the hospital specialist.
- Carry out monitoring tests according to guidelines specified in the monitoring section and record all results in the patient held record book, if appropriate.
- Act promptly on the results of the blood tests and adjust or stop the dose if appropriate.
- Report adverse events to the specialist service and via the MHRA Yellow Card Scheme if applicable https://yellowcard.mhra.gov.uk/.
- If in doubt stop the treatment and contact the specialist for advice - within 7 days (or as stipulated in shared care guideline)
- Ensure that he/she has the information and knowledge to understand the therapeutic issues relating to the patient's clinical condition.
- Undergo any additional training necessary in order to carry out the prescribing and monitoring.
- Prescribe the maintenance therapy in accordance with the written instructions contained within the SCP or other written information provided and communicate any changes of dosage made in primary care to the patient. It is the responsibility of the prescriber making a dose change to communicate this to the patient.
- Where applicable, keep the patient-held monitoring record up to date with the results of investigations, changes in dose and alterations in management and take any actions necessary. It is the responsibility of the clinician actioning the results from monitoring in accordance with the SCP (and thereby prescribing for the patient), to complete the patient's record with the necessary information.
- Primary care prescribers are not expected to be asked to participate in a shared care arrangement where:
    - the prescriber does not feel clinically confident in managing this individual patient's condition
    - there is a sound clinical basis for refusing to accept shared care

3.1.4 New or Reviewed Shared Care Protocols

All new or reviewed shared care protocols developed jointly by the Medicines Optimisation team for use between Lincolnshire Integrated Care System , United Lincolnshire Hospitals Trust and Lincolnshire Partnership Foundation Trust must be formally approved by the Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF). PACEF will seek assurance that the guidance complies with any national guidance where this exists.

PACEF will only approve shared care where it is satisfied that there is a strong enough case for primary care prescribing and that appropriate monitoring can be undertaken as part of the guidance.

The format of a shared care guideline may vary between NHS Trusts but the basic principle is that it should contain sufficient details on the clinical condition being treated, role and licensed indications of the drug, appropriate dose, any contraindications or cautions in use, what monitoring is required and who is responsible for this to enable the primary care based prescriber to feel confident and competent enough to assume on-going prescribing responsibility for the named medication. RMOC have provided a suite of Shared Care protocols and it is expected that the majority of NHS trust will be adopting these in the coming months.

3.1.5 When no shared care protocol is available

If there is no formal shared care guideline available (for example a neighbouring NHS acute trust may not have the same range of protocols in place), a prescriber may accept responsibility for any drug named in appendix 1 as long as they have received in writing from the clinical specialist a management plan or personalised shared care agreement for the patient which should identify the areas of care for which each partner in the agreement takes lead responsibility. See sections 3.1.2 and 3.1.3 for further details. In such situations, the Lincolnshire ICB Medicines Optimisation team should be contacted for further advice before the GP agrees to take on the prescribing responsibilities. In view of the release of national protocols, this situation is less likely to occur in the future.

Shared care guidelines are designed to cover the treatment of a particular medical condition with a specific drug. PACEF has advised that if clinicians are approached to prescribe a specialist drug for an indication not covered by an existing protocol they are advised to first contact a member of the Lincolnshire ICB Medicines Optimisation team for further advice. **PACEF will be informed of all such requests and will review existing protocols and issue additional guidance to all practices if appropriate. See appendix 1 for contact details.**

3.1.6 The Patient Record

It is recommended that practices should ensure that a copy of the shared care guidance or individual management plan or personalised shared care agreement is kept in the patients notes. All communications regarding the shared care agreement should be kept in the communications section of a patient's records. As a minimum, it is recommended practices should ensure that there is an individual management plan for each patient, indicating the reason for treatment, the planned duration, the monitoring timetable and, if appropriate, the therapeutic range to be provided. If the patient is not registered for primary medical services with the provider of this service, the prescriber must send this information to the patients registered General Practitioner for inclusion in their lifelong medical record.

In the event that an individual patient has been prescribed a specialist drug listed in Appendix 1 for a considerable time and there is no record of any existing shared care agreement every effort should be made to contact the responsible hospital specialist for advice on the on-going management of the individual in particular with regards to specialist review, duration of treatment and on-going monitoring.

3.2 Service description/care pathway

The primary care-based prescriber will notify the secondary/tertiary care based specialist in writing within 10 working days that they agree to participate in the proposed shared care.

The specific responsibilities of the primary care-based prescriber will vary depending on the individual shared care guideline but will generally include:

- Deliver the service remaining cognisant of the described responsibilities in section 3.1.3 at all times
- Prescribe the maintenance therapy in accordance with the written instructions contained within the SCP or other written information provided, and communicating any changes of dosage made in primary care to the patient. It is the responsibility of the prescriber making a dose change to communicate this to the patient.
- Carry out monitoring tests as specified within the shared care guidance. Any blood test that is required as part of this can be done as part of the phlebotomy service.
- Act promptly on the results of any monitoring tests adjusting or stopping the treatment and contacting the specialist for further advice as appropriate.
- Practices undertaking this enhanced service will maintain the following:
    - An up-to-date register of patients receiving this enhanced service.

- A call and recall of patients on this register indicating that the service is taking place either in a hospital or general practice setting.
- A system for identifying and flagging up those patients who do not turn up for monitoring / review and to ensure any repeat prescription are stopped until the patient has been seen by the GP
- Where appropriate to refer patients promptly to other necessary services and to the relevant support agencies using locally agreed guidelines where these exist.

3.2.2 Data Collection and Record Keeping

The primary care prescriber will ensure a robust monitoring system is in place to ensure that the patient attends the appropriate appointments for follow up and monitoring, and that defaulters from follow up are contacted to arrange alternative appointments. It is the primary care prescriber's responsibility to decide whether to continue treatment for a patient who does not attend appointments required for follow up and monitoring, and to inform the specialist of any action taken.

Providers should record all the required information detailed on the data reporting template form provided for payment for all enhanced services and submit on a quarterly basis to the Commissioner, no later than the date detailed on the template, normally by the 10th of the month following the quarter being reported on.

It is recommended that the practice use the following codes when recording the delivery of this enhanced service; which should be recorded in the patient's clinical record; these include:

Procedure	READ codes	SNOMED codes
Near patient testing enhanced services administration	XaKA3	166381000000102

Adequate recording should be made regarding the patient's clinical history, with reference to the Shared care arrangements with the patient's secondary care consultant.

In each case the patient must have been fully informed of the proposed shared care by the secondary care consultant. The shared care protocol must be detailed within the patient's record.

The Provider must ensure that details of the patients monitoring as part of this enhanced service is included in his or her lifelong record. If the patient is not registered for primary medical services with the Provider of this service, the Provider must send this information to the patients registered General Practitioner for inclusion in their clinical records.

3.2.2 Reporting and Audit

The provider must conduct an annual review as a minimum and this should include an audit of:

- The register of patients receiving specialised drug monitoring services
- Non-compliance with therapy
- DNA for appointments and monitoring
- Adverse events or complaints which relate to the commissioned service
- Learning events which related to the commissioned service – e.g. patients reviewed without blood tests, prescriptions issued without monitoring, interface issues between secondary/primary care, inappropriate prescription requests

The Provider will agree to participate in any formally notified additional audit / information requirements which will be used to improve the quality of both the existing and future opportunities of this scheme.

3.3 Population covered

Any patient registered with the provider practice.

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance:

Any patient deemed appropriate, by the Secondary/Tertiary care/specialist Health Care Professional, for the administration of the detailed drugs under a shared care protocol.
Patients that are housebound should be offered domiciliary care

Exclusions:

There are no exclusions as this is a secondary care led service any patient deemed inappropriate will not be referred to the practice for shared care.

3.5 Interdependence with other services/providers

The provider is expected to work within the Lincolnshire Health Economy. Partners within this pathway include (but not limited to):

- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Partnership Foundation NHS Trust
- Other Secondary Care providers i.e. NUH, NWAFT, NLAG
- GPs
- Private providers

Providers are expected to cooperate and share information with others involved in a patients care, treatment and support while having regard to the patients' rights to confidentiality.

All requests to GPs to participate in shared care should come from an appropriate qualified prescriber.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

This specification intends and expects compliance with the relevant standards of quality and safety across all provided regulated activities. This will be through registration with the Care Quality Commission. The new system is focused on outcomes and places the views and experience of people who use services at the centre. The new regulations are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009. These regulations replace 1) National Minimum Standards and 2) Standards for Better Health.

Providers should also be cognisant of guidance that is published by Regional Medicines Optimisation Committees (RMOC) which defines the principles for a national system of shared care for medicines, and aims to provide a framework for the seamless sharing of care between the patient, specialist service and primary care prescriber in circumstances where this is appropriate, benefits the patient, and is supported by them. Further information can be found on the RMOC website (Regional Medicines Optimisation Committees)

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

- Responsibility for prescribing between Primary & secondary/Tertiary care
- Good practice in prescribing and managing medicines and devices - GMC
- RMOC-Shared-Care-for-Medicines-Guidance-A-Standard-Approach

4.3 Applicable local standards

4.3.1 Facilities

Providers must have policies in place that comply with current national guidelines. Safe and suitable facilities should be available and include:

- Infection control
- Disposal of clinical waste
- Provision of an appropriate room fitted with a couch and adequate space and equipment for resuscitation.
- Provision of sterile surgical equipment and other consumables

Provide safe & suitable facilities for the administration of specialised drugs with a shared care protocol. This may include home administration.

4.3.2 Staffing

The Provider will identify a key co-ordinator to ensure that all aspects of this service are delivered as appropriate and through which the Commissioner can liaise with regards to the service.

The provider will ensure that its employees and agents comply with all relevant legislation; codes of practice and regional and national Guidance; and when required provide evidence of such compliance and the providers documentation.

The Provider will be responsible for employing adequate numbers of suitably trained and qualified staff to execute this contract and involve continuing professional development and registration.

4.3.3 Protocol

The contractor should have in place a protocol which outlines the actions and systems necessary to undertake the specialised drug monitoring service. This should define the roles and responsibilities of each individual involved in the programme and the timescales for delivery.

In order to minimise risk to both staff and patients and to deliver a safe service the following procedures should be in place:

- Incident reporting including serious untoward incidents
- Complaints reporting
- Safeguarding adults and children

4.3.4 Accreditation and Training

The Provider will have a nominated GP Clinical lead for shared care who will ensure that all staff undertaking monitoring and assessments as specified by the shared care guidelines are adequately trained and supervised when required to do so. It is the Providers responsibility to ensure the training and competencies of clinicians delivering this service are kept up to date

It is expected that the provider will be able to demonstrate compliance with all relevant National Guidance including National Patient Safety Alerts that directly relate to the treatments being prescribed as covered by this enhance service.

Clinicians who have previously provided similar services and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for this service shall be deemed professionally qualified to do so.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4)

6. Location of Provider Premises

It is the obligation of the provider to secure premises for service delivery. The provider has the opportunity to use their own facilities within a practice or access current NHS accommodation in Lincolnshire managed and accessed through NHS Property Services (to include premises owned by Lincolnshire Community Health Services, United Lincolnshire Hospital Trust and certain GP practices).

7. Individual Service User Placement

APPENDIX 1 - As April 2023

Copies of shared care protocols developed jointly by NHS Lincolnshire Integrated Care Board Medicines Optimisation team and the specialist service initiating the treatment covered by the shared care protocol for use within Lincolnshire Integrated Care System, United Lincolnshire Hospitals Trust and Lincolnshire Partnership Foundation Trust can be found on the Prescribing And Clinical Effectiveness Forum (PACEF) website Shared Care protocols (lincolnshire-pacef.nhs.uk).

Copies of all issues of the PACE bulletin can be found at the following web address https://lincolnshire-pacef.nhs.uk/ or from members of the NHS LICB Medicines Optimisation team (email: licb.mo@nhs.net)

Where it has been possible links are included to external sites for protocols developed by neighbouring NHS organisations.

All drugs included within this list are included within the Service Specification for the Prescribing of Specialist Drugs approved for prescribing within a primary care setting for the clinical indication listed below within the context of an appropriate shared care guideline. **PLEASE NOTE: This drug list is under review, and as a result, may change. Providers should access the PACEF website for current shared care agreements.**

In the absence of a formal shared care protocol prescribers may prescribe the drugs included in the list below for the stated clinical indication if they can satisfy the following conditions:

They must be in possession of a copy of a written or electronic document from the clinical specialist providing details of a management plan or personalised shared care agreement for the patient. The management plan/ shared care agreement should clearly state what the responsibilities are for both the specialist service and the primary care based prescriber in terms of:

- Initiation and duration of treatment
- Continued supply of medication including details of who has the authority to adjust and stop treatment,
- Ongoing monitoring
- Details as to what arrangements are in place for the communication of results and whose responsibility it is to act upon these if they fall outside of the required normal range.
- Monitoring and acting upon any side effects

This list will be updated in accordance with the recommendations made by the Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF) which meets monthly. It will be the responsibility of the planned care lead for each of the commissioning organisations to ensure there is a process in place to ensure any updates are communicated to providers by issuing a revised appendix 1.

	Drug	Indication
1	Apomorphine injection (APO-go) Shared care protocols will be provided by specialist centre initiating treatment.	Parkinson's disease
2	Atomoxetine capsules	Attention Deficit Hyperactivity Disorder (ADHD)
3	Azathioprine tablets	Immunosuppressant, Dermatology and Inflammatory Bowel Disease.
4	Calcium based phosphate binders. Calcium acetate preferred brand in Lincolnshire Renacet® (other centres may use Phosex®, PhosLo® Calcium carbonate –preferred brand in Lincolnshire is Adcal®	Hyperphosphataemia associated with renal disease
5	Ciclosporin capsules, oral solution (Capimune, Capsorin, Deximune, Neoral) Lincolnshire protocol covers use for dermatology indications and for renal transplant patinets under the care of ULHT based services. For all other indications shared care protocols will be provided by specialist centre initiating treatment.	Immunosuppressant transplant patients also used in dermatology
6	Cinacalcet tablets	Secondary hyperparathyroidism associated with end stage renal disease requiring dialysis and hypercalcaemia of primary hyperparathyroidism or parathyroid carcinoma.
7	Colomycin nebulised therapy - colistimethate sodium (Colobreathe®, Promixin®) Treatment usually initiated by centre outside of Lincolnshire. Shared care protocols will be provided by specialist centre initiating treatment.	Adjunct to standard antibacterial therapy in patients with cystic fibrosis
8	Denosumab (Prolia®) Treatment usually initiated by centre outside of Lincolnshire. Shared care protocols will be provided by specialist centre initiating treatment.	Postmenopausal osteoporosis
9	Dexamfetamine tablets	ADHD

10	Donepezil tablets, orodispersible tablets, oral solution	Alzheimer's disease
11	Dornase alfa nebuliser solution Treatment usually initiated by centres outside of Lincolnshire. Shared care protocols will be provided by specialist centre initiating treatment.	Cystic Fibrosis
12	Dronedarone tablets	Non-permanent atrial fibrillation
13	Erythropoietins & Epoetin beta (Neo Recormon®), Darbepoetin alfa (Aranesp®), Epoetin alfa (Eprex®) Treatment usually initiated by centre outside of Lincolnshire. Shared care protocols will be provided by specialist centre initiating treatment.	Subcutaneous administration only.
14	Galantamine tablets, oral solution, modified release	Alzheimer's disease
15	Guanafacine tablets	ADHD
16	Hydroxychloroquine tablets	Rheumatoid arthritis
17	Ketamine oral solution	Palliative care
18	Lanreotide injection Treatment usually initiated by centre outside of Lincolnshire. Shared care protocols will be provided by specialist centre initiating treatment.	Carcinoid tumours
19	Lanthanum tablets or sachets	Hyperphosphataemia associated with renal disease
20	Leflunomide tablets	Rheumatoid arthritis / psoriatic arthritis
21	Lisdexamfetamine mesilate capsules	ADHD
22	Melatonin tablets, capsules and oral solution.	Sleep disorders in children with neuro-developmental disorders.
23	Memantine tablets and oral solution.	Alzheimer's disease
24	Mercaptopurine tablets	Inflammatory bowel disease

25	Methotrexate tablets	Rheumatology/dermatology/respiratory
26	Methylphenidate (generic or modified release oral formulations)	ADHD
27	Mycophenolate mofetil Lincolnshire protocol covers use for renal patients under care of ULHT. For all other indications shared care protocol will be provided by specialist centre initiating treatment.	Immunosuppressant (post-transplant)
28	Mycophenolic acid (Myfortic®) Lincolnshire protocol covers use for renal patients under care of ULHT. For all other indications shared care protocols will be provided by specialist centre initiating treatment.	Immunosuppressant (post-transplant)
29	Nabilone capsules Treatment usually initiated by centre outside of Lincolnshire. Shared care protocols will be provided by specialist centre initiating treatment.	Neuropathic pain
30	Octreotide injection Treatment usually initiated by centre outside of Lincolnshire. Shared care protocols will be provided by specialist centre initiating treatment.	Symptomatic relief malignant obstruction/ Acromegaly
31	Riluzole (generic, Rilutek) Treatment usually initiated by centre outside of Lincolnshire. Shared care protocols will be provided by specialist centre initiating treatment.	Motor neurone disease
32	Rivastigmine capsules, oral solution, patches	Alzheimer's disease
33	Sevelamer carbonate (Renvela®) Sevelamer hydrochloride (Renagel®)	Hyperphosphataemia associated with renal disease
34	Sirolimus tablets or oral solution (Rapamune®) Lincolnshire protocol covers use for renal patients under care of ULHT.	Immunosuppressant (post-transplant)

	For all other indications shared care protocol will be provided by specialist centre initiating treatment.	
35	Somatropin injection – Growth Hormone Treatment usually initiated by centre outside of Lincolnshire. Shared care protocols will be provided by specialist centre initiating treatment.	Synthetic Growth Hormone – protocols cover use in both children and adults.
36	Sulfasalazine tablets	Rheumatoid arthritis – shared care protocol and inflammatory bowel disease (prescribing guidance)
37	Tacrolimus capsules (Adoport® or Prograf®) Lincolnshire protocol covers use for renal patients under care of ULHT. For all other indications shared care protocol will be provided by specialist centre initiating treatment.	Immunosuppressant (post-transplant)
38	Tacrolimus modified release capsules (Advagraf® or Envarsus®) Lincolnshire protocol covers use for renal patients under care of ULHT. For all other indications shared care protocol will be provided by specialist centre initiating treatment.	Immunosuppressant (post-transplant)
39	Tobramycin nebulised therapy Shared care protocol will be provided by specialist centre initiating treatment.	Chronic pulmonary pseudomonas infection in cystic fibrosis patients.

Last updated March 2023

Contact Details

Lincolnshire ICB Medicines Optimisation Team

For all queries please email the MMO team mailbox at the email address below.

licb.mo@nhs.net