Lothian NHS Board

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Date 02/03/2026
Your Ref
Our Ref 11064

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Dear

FREEDOM OF INFORMATION – ADHD PRESCRIBING

I write in response to your request for information in relation to ADHD prescribing

Question:

- Please provide any information held by NHS Lothian from January 2023 to the present regarding the cessation, suspension, or withdrawal of shared care arrangements for ADHD medication for patients formally diagnosed by qualified clinicians using DSM-5 criteria or NICE-compliant assessment guidelines.

- Specifically, please include:
  - Any internal or external communications circulated to GP practices, clinical teams, pharmacy services, or Scottish Government bodies regarding changes to shared care for ADHD medication.
  - Any policies, guidance, or instructions relating to alterations of shared care prescribing arrangements for ADHD medication.
  - Any meeting minutes, reports, or decision-making documents that reference ending or changing shared care responsibilities.
  - Any data held on the number of GP practices that have stopped accepting shared care for ADHD medication.

Answer:

See enclosed, please note that we have redacted the names and details of staff below senior level and non NHS Lothian staff. This information is considered exempt under Section 38(1)(b) of the Freedom of Information (Scotland) Act 2002 – personal information.

Since January 2023 the following mentions have been made:

- **September 2023** - a committee member enquired about prescribing ADHD medications following a recommendation by a private clinic. The professional secretary raised this with the clinical director for mental health services and it was noted that there was general guidance in development for managing prescribing after a private consultation.
- **June 2024** - Adult ADHD assessment waiting times - the professional secretary wrote to the clinical director to discuss consideration of suspension of the NHS waiting list if a

referral time is exceptionally prolonged. The group expressed their concern at the long waiting times and the need for a solution to be proposed by the managed service with a recommendation to attend the appropriate drug and therapeutic advisory committee aligned with ADHD treatments.

- **September 2024**
    - ADHD referral wait times - the clinical director and chair of REAS D and T responded to previous communication from GPPC noting that the ADHD adult services are managed by the four Health and Social Care Partnerships (HSCP) and resourcing of capacity sits with these partnerships. A new group sitting under mental health and learning disability leadership was going to coordinate HSCP plans. If specific details about waiting times were required this would be best sourced from the HSCP management teams. Discussion was noted as ongoing about capacity and demand gap. A consultant psychiatrist leading work under the new choices framework was present and noted their involvement in preparing a paper for the board however no additional resource or investment into the service was anticipated. Some practices in Edinburgh were noted as trialling a decision-making tool. Waiting times are long and REAS were fully aware and working with HSCPs on solutions. The group noted a formed GPPC member and GP lead for medicines governance previously attended REAS D&T as a GP representative but this post has not been replaced. Stronger primary care engagement may be beneficial and in the absence of a GP representative, propose that GPPC and REAS could come together on a regular basis.
    - Dexamfetamine and lisdexamfetamine shared care agreements - A committee member noted a minor wording error had been highlighted and updated where the wrong ADHD medicine was noted under side effects. GPPC approved the minor amendment and no further action required. The ADHD SCAs are due for renewal and will come to GPPC in December 2024 for review and approval.
- **December 2024**
    - Clinical information requests from private providers for weight loss medicines - ADHD medicines were noted in this discussion where patients had visited a private provider and there was a need to check if the patient's other treatments would be compatible.
    - ADHD shared care agreement updates - changes in the wording, for example, specialist clinicians not consultant in recognition of the role of the wider MDT providing care.
        - Atomoxetine and lisdexamfetamine - The monitoring section has been updated and more information on blood pressure monitoring added.
        - Guanfacine - Heading changed so 6-17 not 18 years. Sections on cautions, adverse effects, and drug interactions – added information taken out and signposting to the summary product characteristics.
        - Methylphenidate - The wording for passing over to adult mental health services has been made clearer of when they will refer over from CAMHS to adult mental health service for patients that require ongoing treatment. Also

a new section added if a patient wishes to discontinue methylphenidate and withdrawal effects that might be seen.

- Comments noted:
  - Discussion on non-medical prescribers initiating. Some concerns noted with private providers diagnosing and initiating treatment. Professional secretary highlighted that the use of non-medical prescribers, eg, pharmacists and nurses has been vital to supporting capacity in services such as CAMHS. GPPC asked whether the SCA could be updated to say NHS Lothian Specialist Clinicians.
  - Is the frequency for follow up by specialist services defined for adult patients or would specialist team diagnose, initiate treatment and then hand back to GP practice? Guidance is clear for children, but not adults. Specialist pharmacist is asked to clarify as there is a NICE recommendation for annual review.
  - Are all adult ADHD treated patients being routinely recalled by general practice every six months in primary care – some members noted that they feel this is not happening robustly. Is there sufficient capacity to support this, particularly given that we know wait lists for new diagnoses are substantial. JC and AF to be contacted to raise this concern and consider resource requirements.
  - Can CAMHS commit to annual review for all patients who they have initiated treatment for, otherwise conditions of SCA not met. To discuss at REAS meeting.

- **March 2025**
  - Action log - *Clarification on ADHD SCAs* – CAMHS capacity to undertake monitoring and annual review, specialist review ongoing arrangements for adult patients, update SCA wording to say Specialist NHS Lothian Clinician – still outstanding.
  - GPPC/REAS meeting - the chair advised dates have been circulated and will be organised soon to discuss ADHD SCAs, melatonin, physical health checks for patients on antipsychotics, communications around updated lithium handbook and dementia pathway. GPPC members were asked to highlight any additional areas that they would like discussed.
- **June 2025**
  - ADHD SCA and pathway - consultant psychiatrist attended to answer the question raised at the December GPPC on ADHD SCAs and service capacity to undertake annual monitoring and review for adult patients. Annual reviews are in place, some capacity issues in South East Edinburgh due to large student population but service improvement work ongoing and the situation expected to resolve. Consultant psychiatrist confirmed a communication going out confirming the delays and agreed could do a holding statement from REAS D&T to assure GPs.

I hope the information provided helps with your request.

If you are unhappy with our response to your request, \you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive

NHS LOTHIAN
GENERAL PRACTICE PRESCRIBING COMMITTEE (GPPC)

MINUTES

Tuesday 11 June 2024
Via MS Teams
1400 – 1636
Chair: Dr Laura Montgomery

Present:

Dr Sam Abushal	GP Edinburgh HSCP
Dr Paul Bailey	GP Lead Midlothian HSCP
Dr Sophie Bennett	GP Inchpark Surgery, South Edinburgh
Dervilla Bray	Lead Pharmacist Vaccinations/Chair of MURG
Wendy Carswell	Primary Care Pharmacist (Professional Secretary)
Claire Hyslop	Advanced Clinical Pharmacist SE Edinburgh
Dr Alexander Kelly	GP West Lothian Clinical Lead
Lesley Macher	Acting Lead Pharmacist, MGG
Stephen McBurney	Associate Director of Pharmacy, Primary & Community Care, Mental Health & Associated Services
Alison McCulloch	Advanced Clinical Pharmacist
Dr Eilis McKechanie	GP Hermitage Medical Practice
Dr Laura Montgomery	GP Wester Hailes Healthy Living Centre (Chair)
Dr Joanna Smail	GP East Lothian HSCP
[redacted]	North Edinburgh HSCP Lead Technician

In attendance:

[redacted]	MGG Administrator (Minutes)
Kathryn Harvey	Specialist Clinical Pharmacist
Katie Johnston	Primary Care Pharmacist
Dr Catriona Morton	Referrals Advisor

Apologies:

Sharron Duffy	Advancing Roles and Prescribing Clinical Advisor
Mark Hunter	Head of PCCO Finance Department
Linzi Jack	Integrated Care Pharmacist
Dr Hazel Knox	GP LMC/GP Sub Committee representative
[redacted]	Assistant Management Accountant
[redacted]	Practice Nurse Team Manager

1. Committee Business
None.

2. Minutes of the meeting held on 12 March 2024
The minutes were approved electronically as an accurate record of the meeting. The final minutes of the meeting are available on the GPPC intranet page.

3. Matters arising

3.1 FAF proposal for strengthening primary care engagement

Paul Bailey presented a draft paper for final comment which will go to August ADTC for discussion and approval. The proposal outlines the need on the FAF for an additional signature from a GP in primary care if the medicine is intended for primary care prescribing. This is to facilitate early consideration of the impact and resources needed to support primary care prescribing.

GPPC was supportive of the paper going to ADTC with two points noted. Firstly, care would be required to ensure that this additional step would not unduly delay formulary panel consideration, potentially outside of 90 days from SMC approval. Secondly, a Pre-ERF panel has been established and it may address more comprehensive consideration of primary care impact without the need for additional FAF signatory.

Action: PB to submit paper to ADTC and report back on outcome

3.2 Proposed shared guidelines for masculinising and feminising endocrinising treatments

Dr Morton (CM) provided the background to these guidelines, highlighting challenges such as the UK wide evolving evidence base, and the increase in patient demand across private sector and NHS services.

Noted recall and monitoring (including phlebotomy and blood pressure measurement) will be undertaken by the Gender Identity Clinic, who will also arrange any clinical review required. The GP will then be asked to prescribe accordingly. Iain Morrison, GP Sub-Committee has agreed in principle to this process and asked for the final documents to go the GP Sub-Committee. This guidance has been signed off by the specialist service. This is for adults only, RefHelp should be consulted for the most current referral guidance for children and adolescents.

The group raised a concern about the ongoing review, GPs to assess for new diagnoses and notify GIC. GPPC noted this may be challenging to robustly manage and asked if GIC could check for new diagnoses at each annual review. CM will discuss with Chalmers and update the guideline accordingly. CM confirmed that for patients moving into Lothian or seen privately, the GP should email the specialist service as per details on RefHelp for advice on ongoing management and she will ask if the guideline can reflect this.

The group agreed the normal medicine governance procedure for developing SCAs should be followed, and CM will liaise with the SCA pharmacists to confirm lead pharmacist contact, add review date and move onto the standard SCA template.

ACTION: CM/LM/SCA pharmacists

3.3 Prescribing after a private consultation update

The chair advised the document is going through a review with Policy Online and the NHS Lothian Communications team, and available on the NHSL intranet in draft form.

GPPC strongly felt the need for consistency, and a clear statement from GP Sub-Committee would be welcomed. Agreed a challenging subject for GPs in practices at a national level, and definitive guidance needed. LMo will raise with LMC and GP Sub-committee.

ACTION: LMo

3.4 SCA procedure update

Wendy Carswell (WC) advised ADTC are happy with the proposed procedure update. The preliminary checklist accepted as well as small amendments to the wording of the guideline.

In terms of the post approval process, Jeremy Chowings has agreed that once clinical content has been agreed in a SCA by GPPC, it should be forwarded to him as Deputy Medical Director and also GP Sub-Committee via the GMS mailbox. This would prompt further discussion on renumeration as appropriate via existing processes.

3.5 Adult ADHD assessment waiting times

WC confirmed she had written to Dr Andrew Watson at REAS to discuss consideration of suspension of the NHS waiting list if a referral time is exceptionally prolonged. She is awaiting his response. The group expressed their concern at the long waiting times and the need for a solution to be proposed by REAS. Agreed it would be useful for WC and LMo to attend a REAS D&T meeting to discuss.

ACTION: WC/LMo

3.6 MHRA quinolone RefHelp update

Lesley Macher (LM) will email RefHelp asking for any references to be made to the ERF and SAPG.

ACTION: LM

4. Prescribing Issues

4.1 Quetiapine - approval

WC referred to the REAS memo circulated. Noted this is not a formulary approved indication and the group were asked for comment. Chlorpromazine remains higher cost and NHS Lothian continues to see higher rates of prescribing than in other boards. LM asked if REAS would submit a formulary application due to the cost impact. Dervilla Bray wondered if this is a possible topic for MURG to review.

ACTION: WC to raise with Joan Kelly, REAS

4.2 Retinal screening on hydroxychloroquine update

WC provided further information, noting challenges following the 2020 national guideline update advising specialist monitoring for retinopathy screening. Ophthalmology do not have the funding or capacity to support the recommended monitoring and are currently unable to accept referrals. Community based opticians do not have the necessary equipment to provide. There are around 1,000 patients on hydroxychloroquine for >5 years who would be eligible for the additional screening. The shared care agreement is overdue for review and NHS Lothian needs to confirm whether it can implement the advised screening.

LM advised Rheumatology have been asked if hydroxychloroquine remains an appropriate drug to use if this monitoring is required, and awaiting their response. The Medicines Safety Group have been cited.

Agreed the GPPC chair should write formally to Rheumatology, expressing the group's concerns on safety and risk, and asking for clear advice to GP practices. A revised SCA should come to the next meeting, with an update on Rheumatology's response.

ACTION: LMo/WC/SCA pharmacists

4.3 Edinburgh HSCP acutes prescribing project

Kathryn Harvey (KH) gave a summary the project which ran from March 2023- March 2024, although the deadline was extended to end May with an incentive included. The main aim was to reduce the number of acute prescription requests by 20% or more by targeting two or more BNF sections using STU and HIS Acute Toolkit to produce a sustained change.

GPs were encouraged to request access to any of the specific protocols used via the pharmacy team member or KH. The group felt positive changes in practices and reduction in appointment times were important and welcomed the project.

4.4 Sodium valproate update

LM provided an update on NHS Lothian's local action plan for the MHRA patient safety alert, November 2023.

Sam Abushal is leading the work for primary care and will share flowchart and guidance for the group to read. GP practices will be asked to undertake an annual audit to identify specialist teams sharing care of their patients on valproate and ensure risk assessments are in place. Read coding should be used for audit trail and WC will share coding advised in 2020.

Neurology have requested a list of CHI numbers for all patients on valproate to cross-check against their patient list. GPPC welcomed their proactive approach but felt that the patients would be captured via the GP annual review, and those needing their risk assessments completed would be referred to the relevant specialist team therefore no need to duplicate effort. WC will feed back to neurology.

Action: SA/WC

4.5 Respiratory conditions – quality prescribing strategy

Katie Johnston (KJ) summarised her slide presentation on 'Respiratory conditions – quality prescribing strategy: improvement guide 2024-2027'. She highlighted the main aim of the strategy is to raise awareness that respiratory conditions are still a major contributor to ill health. The key prescribing recommendations within the guide were also noted.

The group raised a few queries, including the switch from fostair to luforbec which had been more challenging with around 10% of patients requesting to switch back. GPPC felt the report should be shared more widely with cluster leads, and supportive of approving funding for GP and community pharmacist sessional support to help implement the strategy.

KJ also confirmed that COPD patients are currently included in the SABA data as not possible currently to filter by indication using PIS or PRISMS data.

A formulary application is in progress for anti-inflammatory reliever (AIR) therapy which offers an alternative approach for patients over reliant on SABA alone.

5. Finance

5.1 Prescribing Finance report

No report available for the meeting. R McLeod recently returned from paternity leave and any important messages will be circulated.

6. DATIX incidents
Nothing to report.

7. Minutes from Lothian Prescribing Committees
The following minutes were all noted for information:
7.1 Area Drug and Therapeutics Committee 02.02.24
7.2 East Region Formulary Committee 27.03.24
7.3 UHD Drug and Therapeutics Committee 21.02.24
7.4 Paediatric & Neonatal Drug & Therapeutics Committee (nil)
7.5 Royal Edinburgh and Associated Services Drug & Therapeutics Committee 17.01.24
7.6 Primary Care Prescribing Forum 15.02.24 and 21.03.24
7.7 Medicines Utilisation Review Group 22.02.24
7.8 Medicines Homecare Governance Group 13.03.24

8. Any Other Business
None.

9. Date of Next GPPC Meeting
Tuesday 10 September 2024 via MS Teams, 2.00pm

Schedule of meetings 2024
10 December

NHS LOTHIAN
GENERAL PRACTICE PRESCRIBING COMMITTEE (GPPC)

MINUTES

Tuesday 12 September 2023
Via MS Teams
1400 – 1642
Chair: Dr Laura Montgomery

Present:

Dr Sam Abushal	GP Edinburgh HSCP
Dr Paul Bailey	GP Lead Midlothian HSCP
Dr Sophie Bennett	GP Inchpark Surgery, South Edinburgh
Dervilla Bray	Lead Pharmacist Vaccinations/Chair of MURG
[redacted]	[redacted]
Susanne Gooding	Primary Care Pharmacist (South West Edinburgh)
[redacted]	[redacted]
Dr Hazel Knox	GP LMC/GP Sub Committee representative
Lesley Macher	Acting Lead Pharmacist, MGG
[redacted]	[redacted]
Dr Douglas McGown	West Lothian HSCP
Dr Eilis B McKechanie	GP Hermitage Medical Practice
[redacted]	[redacted]
Dr Laura Montgomery	GP Wester Hailes Healthy Living Centre (Chair)
Dr Joanna Smail	GP East Lothian HSCP
[redacted]	[redacted]

In attendance:

[redacted]	[redacted]
Rebecca Grieve	Specialist Clinical Pharmacist
Peter Strachan	Lead Pharmacist

Apologies:

Isobel Bishop	Specialist Clinical Pharmacist
Mark Hunter	Head of PCCO Finance Department
Stephen McBurney	Associate Director of Pharmacy, Primary and Community Care, Mental Health & Associated Services
[redacted]	[redacted]

1. Committee Business

1.1 Welcome to new members
Noted Margot McCulloch, Nurse Prescribing Lead has joined the group.

1.2 HSCP manager
There had been no nominations from members at the Prescribing Forum.

1.3 Vice-chair

Members were asked to let [redacted] (WC) know if interested in covering should Laura be absent.

2. Minutes of the meeting held on 6 June 2023

The minutes were approved electronically as an accurate record of the meeting. The final minutes of the meeting are available on the GPPC intranet page.

3. Matters arising/action log

3.1 Feminising and Masculinising Endocrine Treatment SCAs

The chair advised discussions are still ongoing with LMC and the Chalmers Team. A local enhanced service (LES) may be the preferred route. It has been proposed that Chalmers would initiate, monitor, and follow up and GPs would prescribe under the guidance of a SCA. Prescribing guidance documents are available on RefHelp.

The group discussed the merits of a local enhanced service or a shared care agreement. Noted a LES would provide additional income for those practices who felt able to support. Generally felt 'workload creep' and resourcing for SCAs are not considered.

Lesley Macher (LMa) reminded the group of the process for requesting new SCAs for new or rarely prescribed medicines. The group agreed that a clear agreement on how these requests are made by NHS Lothian is needed. There was discussion about the visibility and awareness of SCAs across the interface.

LMa noted that the current procedure for SCAs can be reviewed but noted that where GPs decline to provide the shared care described, they must support the patient in accessing the medicine. This may mean referring them back to the specialist and can present issues around accessing medicines.

Members were encouraged to refer to the East Region Formulary (ERF). If listed as a Specialist Use Only medicine, then GPs should not be asked to prescribe. If Specialist Initiation, then use professional judgement.

ACTION: Hazel Knox will feedback discussions to LMC

3.2 Communication form for compliance aid changes

The standard form has been approved and in process of being rolled out via pharmacy teams and GMS facilitators. There will be an article in the Lothian Prescribing Bulletin forthcoming.

3.3 Fondaparinux SCA

NHS Lothian view is patient numbers likely to be low therefore an SCA not necessary. If supporting prescribing, this would be undertaken with individual agreements with explicit monitoring requirements. Noted this medicine is not new to the formulary but the change in classification from Specialist Use Only to Specialist Initiation as an anticoagulant used in patients with heparin induced thrombocytopenia (HIT). There will be new patients but use likely to be short term.

3.4 Melatonin

Noted the ERF status is Specialist Initiation. However this can mean the specialist initiates or can be the specialist advises a GP to initiate, which has caused confusion. There is guidance from CAMHS

approved by GPPC in March 2023 which outlines how to initiate and review patients. The melatonin pathway is currently under review by CAMHS. WC asked the group to highlight any concerns as an opportune time.

The group raised concerns that melatonin reviews are not routinely happening at three months and patients often do not have clear management plans in place. CAMHS have noted ongoing issues with capacity. Noted the guidance does suggest when to discontinue and has been previously raised at REAS and MURG. NHS GG&C have SCA in place. NHS Lothian rescinded SCA but unclear why and when.

WC will feedback to CAMHS. SCA pharmacists to search historical information to check why and when SCA was rescinded.

ACTION: WC/SCA Pharmacists

3.5 Paediatric eLJF

LMa reassured the group that chapters are being updated and reinstated after going through the governance process. Respiratory and infections sections are in progress. A new project lead, Nikki Gilluley is now in post. Limited analgesics and antibiotics are being added in the interim in response to feedback.

3.6 Data sharing guidance/awareness

Following Sadia Naeem's presentation at the last meeting, WC had met with [redacted] lead data analysts. They have delegated Caldicott authority and are classed as data controllers. If requests come in to access prescribing data from NHS Lothian, they can provide that approval and no requirement to bring to GPPC.

GPPC had no concerns with this data sharing.

4. Prescribing Issues

4.1 Shared Care Agreements

4.1.1 tacrolimus (uveitis)

Peter Strachan (PS) referred to the draft circulated. Noted a very small subset of patients. The group raised queries on changes in dosage, the duration and monitoring requirements. Minor edits on adverse effects and review interval sections noted. Some wider issues on service delivery and pressures raised.

GPPC supportive and this SCA was agreed in terms of content, subject to the minor amendments. Queries were raised on an SCA being the most appropriate pathway given currently only applicable for two patients in Lothian.

4.1.2 CF meds – update on supply via homecare

WC advised historically these were supplied under SCA but planning now to provide these via homecare so specialist teams can more closely monitor medicines adherence. The hospital will supply directly. Respiratory team have suggested maintaining a hybrid model initially, with an aim to switch all patients to homecare. This will be initiated over the next few months led by Douglas McCabe Respiratory Pharmacist, with support from Linzi Jack and Rocio Toribio, Primary Care Pharmacists.

4.1.3 Entecavir – update

GPPC had agreed in 2020 an SCA was not necessary, however now around 15 patients across NHS Lothian on this treatment, and a recent incident had occurred where a GP was asked to take over prescribing without supporting guidance on monitoring. WC asked the group whether they felt an SCA is now required. LM reminded the group that GPPC's constitution is to review and approve, not request SCAs. As an advisory committee dedicated resource for SCAs is limited. It was noted however that a mechanism to provide feedback would be beneficial.

Suggested a review of the SCA procedure would be useful. The Chair is happy to discuss with LMC/GP Sub Committee. She advised a review of prescribing committees' governance, and recognition of budget and resource issues is ongoing. Noted a reminder that the Shared Care Agreement links are on the top and bottom of the ERF website homepage.

LM/LMa/WC to organise a review of SCA process from formulary decision to SCA development, benchmarking with other Boards and considering steps in the process for consultation with stakeholders. Paper to come to December GPPC.

ACTION: LM/LMa/WC

4.2 Vision upgrade issues

WC summarised the paper circulated which highlighted two prescription management issues for out of practice supplied medication that have arisen, following an INPS Vision upgrade. Both issues are customisable at a practice level by adjusting Vision default settings. The issues are not customisable at patient/drug level.

On discussion, the group felt the role of GPPC would be to highlight awareness locally of this national decision, but not propose any changes. WC will disseminate information to practices.

ACTION: WC

4.3 Prescribing Indicators

Susanne Gooding (SG) highlighted two issues with prescribing data both at national and Lothian level. Main concern is that the data is not robust enough for PIs to be used for incentivisation for 2024-25 as there has been a delay with uploading current data. [redacted] (RM) advised PHS are moving to a new Data Capture Validation Pricing (DCVP) system that has caused multiple delays in processing and it is unclear when this will be resolved. A new approach for 2024-25 will be needed, and various options being considered. Noted a new data analyst has been recruited but has little capacity to build new PI searches at this stage.

GPPC noted concerns on suspending the PIs for 2024-25 as data for East and Mid, where PIs are no longer incentivised, suggests slippage in performance. Agreement that assurance needed on the availability and validity of data for PI incentivisation.

STU indicators may offer an alternative however this cannot be monitored centrally. The integrated STU tool may offer centralised monitoring but is still in pilot phase. SG will explore further.

GPPC happy with the recommendation to utilise the National Therapeutic Indicator data on ShinyApp for providing a measure of prescribing activity and reporting upon the PIs, as the reporting mechanism for PIs next year, noting the risk with data delays. Utilising the NTIs, all 2023/24 PIs could remain,

except for antibiotics, which would need to look at 4c's collectively instead of quinolones and co-amoxiclav separately. A proposal will be worked up for December GPPC.

ACTION: SG

5. Finance

5.1 Prescribing Finance report
RM summarised the paper previously circulated.

6. DATIX incidents

Nothing to report.

7. Minutes from Lothian Prescribing Committees

The following minutes were all noted for information:
7.1 Area Drug and Therapeutics Committee 14.04.23 and 02.06.23
7.2 East Region Formulary Committee 07.06.23 and 09.08.23
7.3 UHD Drug and Therapeutics Committee 26.04.23
7.4 Paediatric & Neonatal Drug & Therapeutics Committee (nil)
7.5 Royal Edinburgh and Associated Services Drug & Therapeutics Committee 08.03.23 and 19.04.23
7.6 HSCP Prescribing Forum 18.05.23 and 15.06.23
7.7 Medicines Utilisation Review Group 04.05.23
7.8 Medicines Homecare Governance Group 21.03.23

WC highlighted saxenda has been approved and pathway being considered. Also ADTC approved the switch from longtec to oxypro which will be piloted in a few practices initially.

Sophie Bennett queried the pathway for ADHD medications recommended by private clinics. WC will check with Andrew Watson at REAS as guidance was in development for managing prescribing after a private consultation but not ratified yet. WC to update at December GPPC.

ACTION: WC

8. Any Other Business

None.

9. Date of Next GPPC Meeting

Tuesday 5 December 2023
Via MS Teams, 2.00pm

NHS LOTHIAN
GENERAL PRACTICE PRESCRIBING COMMITTEE (GPPC)

MINUTES

Tuesday 10 December 2024
Via MS Teams
1400 – 1632
Chair: Dr Laura Montgomery

Present:	
Dr Sam Abushal	GP Edinburgh HSCP
Dr Sophie Bennett	GP Inchpark Surgery, South Edinburgh
Isobel Bishop	Specialist Clinical Pharmacist
Dervilla Bray	Lead Pharmacist Vaccinations/Chair of MURG
Wendy Carswell	Primary Care and Community Pharmacy Coordinator (Professional Secretary)
Rebecca Grieve	Advanced Clinical Pharmacist
Claire Hyslop	Advanced Clinical Pharmacist SE Edinburgh
Linzi Jack	Integrated Care Pharmacist
Dr Alexander Kelly	GP West Lothian Clinical Lead
Dr Hazel Knox	GP LMC/GP Sub Committee representative
Lesley Macher	Acting Lead Pharmacist, MGG
Alison McCulloch	Advanced Clinical Pharmacist
Dr Eilis McKechanie	GP Hermitage Medical Practice
[redacted]	Assistant Management Accountant
Dr Laura Montgomery	GP Wester Hailes Healthy Living Centre (Chair)
Dr Joanna Smail	GP East Lothian HSCP
[redacted]	North Edinburgh HSCP Lead Technician
In attendance:	
[redacted]	MGG Administrator (Minutes)
Katie Johnston	Primary Care Pharmacist
Alison Neilson	Pharmacist
Seona Stalker	Specialist Clinical Pharmacist
Apologies:	
Dr Paul Bailey	GP Lead Midlothian HSCP
Mark Hunter	Head of PCCO Finance Department
Stephen McBurney	Associate Director of Pharmacy, Primary & Community Care, Mental Health & Associated Services

1. Committee Business

1.1 GPPC Chair and Prof Secretary nominations

Laura Montgomery (LMo) and Wendy Carswell (WC) have completed their two-year tenures and nominations are invited. LMo asked if anyone is interested to contact her or WC.

2. Minutes of the meeting held on 10 September 2024

The minutes were approved electronically as an accurate record of the meeting. The final minutes of the meeting are available on the GPPC intranet page.

2.1 Action Log

The outstanding points will be addressed in item 3.

3. Matters arising

3.1 Clinical info requests from private providers for weight loss medicines

Claire Hyslop (CH) circulated a paper for the meeting. The paper has been developed to address an issue about clinical responsibility for out of practice medication. At present, notifications for medicines initiated and managed by other providers are frequently processed by pharmacotherapy teams and added as out of practice medicines to the patient's record. A full check to confirm clinical appropriateness is not routinely undertaken by the pharmacotherapy team, and it is assumed that this has been comprehensively undertaken by the external provider. CH asked the Committee for views on this, noting that there is risk if any potential contraindications are present but not identified. Clarity is needed on where the liability sits. It was also noted that there is an increasing trend for private providers (particularly for ADHD and weight management consultations) to notify practices of medicines that they have prescribed and ask them to notify them of any contraindications for prescribing.

The Committee felt that a standardised approach to manage this activity is important. A standard operating procedure could be developed which includes an outline of roles and responsibilities and this discussed/approved by pharmacotherapy implementation group (and then back to GPPC if needed).

GPPC discussed emerging concerns with wider prescribing of weight management treatments and noted that a death in Scotland has been reported. Safety concerns may be linked with inappropriate prescribing of the medicines. GPPC acknowledged that adverse events should be recorded via the Yellow Card reporting scheme, and any emerging concerns should be disseminated via MHRA.

If GP practices have concerns about an external provider, there is a mechanism to report concerns to Healthcare Improvement Scotland. Raising concerns to Healthcare Improvement Scotland – Healthcare Improvement Scotland.

ACTION: CH

3.2 GPPC/REAS meeting

Dr Andrew Watson, Chair of REAS D&T would like to meet in the new year with LM/WC and Paul Maguiness, Lead Pharmacist, Mental Health and Associated Services, and highlighted some areas for discussion:

- Scottish Government report on antidepressants and benzodiazepine prescribing
- ADHD waiting times
- Melatonin and sleep guidance
- Antipsychotic monitoring roles and responsibilities.

3.3 Varenicline roles and responsibilities

Quit Your Way service are keen to restart prescribing varenicline due to good outcome data for quit rates. GPPC were asked to consider the paper circulated which outlines how the quit your way service will identify patients suitable for varenicline and refer to general practice to consider prescribing. An alternative route to access varenicline via Community Pharmacy under PGD is in development. The national PGD is expected in January and then will go through local governance sign off prior to roll-out.

GPPC were happy with the document as outlined.

3.4 eLJF clinical Paediatric

The suggestions were accepted with the exception of:

- 2.2.5 Clarithromycin tablet formulation - clarity on 250mg and 500mg tablet options.
- 2.3.2 Flucloxacillin 125mg QDS - age filters require review and clarification.
- 2.6.1/2.6.2 Miconazole oromucosal gel - licensing information needs to be added to reflect cautions and contraindications in infants from birth to six months. This will be redrafted and returned to the committee for review. This was noted after the meeting.
- 2.8.2 Mebendazole chewable tablet - standard labels when dispensing should be checked for advice on chewing or crushing. This can be added to the one-click prescription.
- No additional requests were made for diclofenac, codeine or co-codamol. The 'twice daily' penicillin one-click option was also not favoured due to the risk of subtherapeutic prescribing. Committee members acknowledged that in the case where asplenic/dysplenic patients and those with Scarlet fever required twice daily penicillin, the prescribers would cross check their dose, frequency and duration with a suitable reference source.
- A typographic error in 2.2.4 noting clarithromycin as 1250mg in 5ml will be corrected to 125mg/5ml on publishing as the files on the eLJF are auto-populated in a drop-down menu.

3.5 Benzodiazepines (and related medications) for flying

WC spoke on behalf of Stephen McBurney (SMB). An information sheet had been adapted by a GP practice in Edinburgh and shared via clusters and published on policy online. A patient complaint had been received on the statements in the leaflet. GPPC were asked to review the content and consider if they were supportive of the leaflet used within NHS Lothian.

The Committee was unable to support the leaflet in its current form. GPPC asked that information provided in the leaflet should be referenced, and that the NHS Lothian logo should be reserved for documents that have been through an appropriate NHS Lothian Medicines Governance Group. It was acknowledged that prescribers may have different views on the use of benzodiazepines for this indication, given their side effect profile and duration of use. Some practices may choose not to prescribe and provide advice on alternative strategies to manage the condition. It was noted however that NHS Lothian has not taken a Board wide position on this.

GPPC would be willing to consider the patient information leaflet if resubmitted and fully referenced. Feedback to be shared with SMB.

ACTION:WC

3.6 Hydroxychloroquine SCA retinal screening

WC noted it had been proposed that the pathway for retinal screening would be through community optometrists. However, Kevin Wallace (KW) the Community Optometric Advisor, had been contacted following the September meeting and had advised verbally that community optometrists do not have the appropriate equipment or training to manage this robustly.

A consensus has therefore not been reached on how patients on hydroxychloroquine can be adequately monitored, and further discussion with rheumatology is needed to manage this risk.

WC will ask KW to provide his comments in writing. WC/LMo will write formally back to rheumatology to provide guidance on next steps and will report back at the March GPPC.

ACTION: WC/LMo

4. Prescribing Issues

4.1 Shared Care Agreements summary for review

4.1.1 evolocumab (update)

Alison McCulloch (AM) highlighted a few changes under assessment and initiation, with the initial consultation review period moved to 12 weeks. [redacted] has added a statement to say the annual lipid monitoring not mandatory. Minor admin of communication details noted.

The minor changes were noted and accepted.

The Committee raised concerns on the resourcing of the SCA which is not covered by GP LES. GPPC asked that these concerns are highlighted to Jeremy Chowings (JC) and [redacted] (AF) in line with the updated SCA procedure.

ACTION: WC/LMo

4.1.2 hydroxycarbamide (update)

Linzi Jack (LJ) noted the review date changed to three years, and the contact details have been updated. The changes were noted and accepted.

4.1.3 octreotide and lanreotide (agromegaly)

LJ noted the brand to be prescribed has been specified. WC queried TFT monitoring and ultrasound examination, and LJ will check with the clinical pharmacist and confirm.

ACTION: LJ

4.1.4 mercaptopurine (update)

Isobel Bishop advised this was a review update, the secondary care contact details have been updated. Dervilla Bray and Naomi Scott are finalising the standardised sentence for vaccinations, and all the DMARDs will be updated once this has been agreed.

WC queried whether rheumatology needs to supply pre-labelled blood test forms at the point of initiation. Felt not needed with everything electronically uploaded on ICE if the correspondence from secondary care is clear. GPPC noted that the paper forms ensured that the results were sent back to the specialist team to review and therefore felt there was a need to retain this step. WC will feedback this position to Naomi Scott, Lead Pharmacist Rheumatology.

ACTION: WC

4.1.5 lanreotide and octreotide (neuroendocrine)

The contact details, reference to the LJF, and brand names have been updated. GPPC noted and accepted the changes. WC queried the ultrasound examination and LJ will check with the clinical pharmacist and confirm.

ACTION: LJ

4.1.6 mexiletine (new)

[redacted] (SS) summarised the background to the draft, highlighting it has been used for many years for a small patient group of 10-15 patients across NHS Lothian. It was added to the East Region Formulary under Specialist Initiation this year for refractory ventricular arrhythmias only initiated in a hospital setting by a cardiology consultant.

Primary care are being asked to prescribe on this direction only to allow the patient to access medication closer to home. This is currently happening and the aim of the SCA is to strengthen governance and provide support around the prescribing.

Comments noted:

- GP to refer patient back to specialist after two years if not under active review – GPPC understood that all patients would remain under ongoing review and specialist teams should action the recall. Clarity needed.
- BNF notes that electrolytes should be monitored before and during treatment – who will undertake this? SS noted that a change to electrolytes is unlikely to alter treatment decision as mexiletine used as a last treatment option and therefore monitoring not routinely required. GPPC asked that this needs to be added to the SCA, noting rationale and risk assessment.

This is a new SCA and therefore consensus that JC and AF should be sighted on this prior to publication. SS also to address electrolyte monitoring and recall points noted above.

ACTION: SS/WC/LMo

4.1.7 ADHD (update)

AM advised that Heather Kelly, Lead Pharmacist in Mental Health had made changes in the wording, for example, specialist clinicians not consultant in recognition of the role of the wider MDT providing care.

Atomoxetine and lisdexamfetamine

The monitoring section has been updated and more information on blood pressure monitoring added.

Guanfacine

Heading changed so 6-17 not 18 years. Sections on cautions, adverse effects, and drug interactions – added information taken out and signposting to the summary product characteristics.

Methylphenidate

The wording for passing over to adult mental health services has been made clearer of when they will refer over from CAMHS to adult mental health service for patients that require ongoing treatment. Also a new section added if a patient wishes to discontinue methylphenidate and withdrawal effects that might be seen.

Comments noted:

- Discussion on non-medical prescribers initiating. Some concerns noted with private providers diagnosing and initiating treatment. WC highlighted that the use of non-medical prescribers, eg, pharmacists and nurses has been vital to supporting capacity in services such as CAMHS. GPPC asked whether the SCA could be updated to say NHS Lothian Specialist Clinicians.
- Is the frequency for follow up by specialist services defined for adult patients or would specialist team diagnose, initiate treatment and then hand back to GP practice? Guidance is clear for children, but not adults. Heather Kelly asked to clarify as there is a NICE recommendation for annual review.
- Are all adult ADHD treated patients being routinely recalled by general practice every six months in primary care – some members noted that they feel this is not happening robustly. Is there sufficient capacity to support this, particularly given that we know wait lists for new diagnoses are substantial. JC and AF to be contacted to raise this concern and consider resource requirements.
- Can CAMHS commit to annual review for all patients who they have initiated treatment for, otherwise conditions of SCA not met. To discuss at REAS meeting.

ACTION: AM/WC/LMo

4.2 Weight loss injections/medicines
Covered with Claire Hyslop's report.

4.3 CGRP inhibitors formulary and RefHelp update
LMo highlighted the Primary Care Contracts team weekly email (21.11.24) on the RefHelp update, advising atogepant and rimegepant can now be prescribed directly in primary care without the need for input from secondary care. LMa reassured the group it is an opportunity to prescribe these drugs when triptans fail, but there is no expectation. They are new to the market in the last year.

The group welcomed the extra options for migraine management and noted no longer Specialist Initiation.

4.4 Prescribing Indicators
Rebecca Grieve summarised the SBAR papers. The NTI ShinyApp prescribing indicator data has been used this year, and available to everyone. Data analysts have been running quarterly reports against the targets agreed in March 2024. The analysts have suggested a preference to continue to use the ShinyApp data, as it is a convenient and more robust way to run data rather than developing reports locally. There is analyst capacity to run reports and look at local target setting. The group therefore agreed to continue to use the ShinyApp as the data source.

On deciding Prescribing Indicators for 2025-26 two options outlined in the paper. Either keep the PI measures the same as this year, or the other option to change slightly. Currently 8 indicators. By introducing a polypharmacy indicator, it would align well locally and nationally with prescribing guidance and focus on polypharmacy. GPPC felt that a non-age-related polypharmacy indicator may be preferred as this may be more meaningful for practices in deprived areas, where life expectancy lower and multimorbidity more common at lower age. With respiratory indicators, suggest keep high dose inhaled corticosteroid, >3 SABAs (as per national position to move to tighter review of SABA use) and add salbutamol only indicator (which will be a useful indicator with the formulary introduction of anti-inflammatory reliever therapy). Indicators will be used for benchmarking and shared at clusters and practice visits. Not all HSCPs will incentivise.

In summary, the group supported the introduction of a polypharmacy indicator, ideally not linked with age and remove more than 6 SABA per year (more than 3 SABA per annum will remain) and replacing with SABA alone.

5. Finance

5.1 Prescribing Finance report
Ross McLeod noted data available up to August 2024 and now forecasting £18.6m overspend for 2024/25 which is unprecedented. Discussion that this position will be influenced by budget allocation noting rising demands and minimal uplift. September prescribing data shows slight improvement in terms of level of spend, largely driven by fluctuations and an improvement in the price for apixaban. A more detailed finance report will be shared which describes some of rationale for why the position has changed from £9m overspend at the start of the year.

Some of the drivers include item growth, treated patients in Lothian growing at a quicker rate than any other health board. In terms of drug spend, the endocrine chapter has been identified as one of the areas with largest growth, specifically new antidiabetic drugs, eg, semaglutide. Freestyle Libre device sits with appliances and the biggest spend item in Lothian with rising demand. PEAT team doing

a deep dive into this. Pharmacy team continue to deliver against the efficiency target. Scottish Government have published the list of medicines of low clinical value. More scrutiny on prescribing than ever been, challenging position but making progress in some areas.

WC reported that an efficiency planning event took place in November and has generated a range of options to scope further. GPPC will be included in taking plans forward, eg. medicines waste and implementation of recommendations for medicines of low clinical value. Acknowledgement that a whole system approach is needed.

6. DATIX incidents
Nothing to report.

7. Minutes from Lothian Prescribing Committees
The following minutes were all noted for information:
7.1 Area Drug and Therapeutics Committee 07.06.24 and 02.08.24
LMa will confirm the outcome of the FAF application process. **ACTION: LMa**
7.2 East Region Formulary Committee 02.10.24
7.3 UHD Drug and Therapeutics Committee 21.08.24
7.4 Paediatric & Neonatal Drug & Therapeutics Committee nil
7.5 Royal Edinburgh and Associated Services Drug & Therapeutics Committee 25.06.24
7.6 Primary Care Prescribing Forum nil
7.7 Medicines Utilisation Review Group 22.08.24
7.8 Medicines Homecare Governance Group nil

8. Any Other Business
8.1 Valproate
MHRA given additional guidance for male patients prescribed valproate. An MHRA letter to communicate potential risks is available. Pharmacy teams plan to send CHI numbers to GP practices in January. There will be two lists this year, one will be the female patients (to confirm risk assessment and Pregnancy Prevention Programme in place) and the second list for male patients (to ensure that they are aware of valproate risks as per MHRA letter).

GPPC were happy with this approach and the information will come out in January.

8.2 Penicillin allergy potential recording error
Local communications highlighted an issue with how patients have been coded in hospital for penicillin allergy. For many patients, penicillamine rather than penicillin allergy has been inadvertently recorded as penicillamine appears as the first drop down option. HEPMA team have identified this as a risk. 1,300 patients who attended NHS Lothian acute sites have been coded with penicillamine allergy and this information will have been copied over at discharge. GP practice pharmacy teams have been asked to identify patients with a penicillamine allergy and review them in collaboration with GPs. This work was to be completed by early December.

Mitigations have been implemented with HEPMA to minimise the risk of this error reoccurring. A retrospective review of patients however will not be undertaken by the acute sites.

9. Date of Next GPPC Meeting
Tuesday 11 March 2025 via MS Teams, 2.00pm

Schedule of meetings 2025

10 June

9 September

9 December

NHS LOTHIAN
GENERAL PRACTICE PRESCRIBING COMMITTEE (GPPC)

MINUTES

Tuesday 10 June 2025
Via MS Teams
1400 – 1629
Chair: Dr Jo Smail

Present:	
Dr Sam Abushal	GP Edinburgh HSCP
Debbie Alexander	Lead Pharmacist, Controlled Drug Governance Team
Paul Bailey	GP, Midlothian
Isobel Bishop	Specialist Clinical Pharmacist
Wendy Carswell	Primary Care and Community Pharmacy Coordinator (Professional Secretary)
Claire Hyslop	Advanced Clinical Pharmacist SE Edinburgh
Linzi Jack	Integrated Care Pharmacist
Dr Hazel Knox	GP LMC/GP Subcommittee representative
Lesley Macher	Acting Lead Pharmacist, MGG
Stephen McBurney	Associate Director of Pharmacy, Primary & Community Care, Mental Health & Associated Services
Dr Eilis McKechanie	GP Hermitage Medical Practice
Dr Laura Montgomery	GP Wester Hailes Healthy Living Centre
Dr Joanna Smail	GP East Lothian HSCP (Chair)
[redacted]	North Edinburgh HSCP Lead Technician
Sandy Watson	Lead Pharmacist, Lead Midlothian HSCP
In attendance:	
Fiona Benzies	Specialist Clinical Pharmacist
Catherine Collinson	Consultant Anaesthetist
[redacted]	MGG Administrator (Minutes)
Laurie Eyles	Dietetic Service Lead
Alison Neilson	Pharmacist
Karen Reid	Advanced Clinical Pharmacist
Claire Ross	Chief AHP, Midlothian HSCP
Sharon Smith	Consultant Psychiatrist/Clinical Director, REAS
Apologies:	
Dr Sophie Bennett	GP Inchpark Surgery, South Edinburgh
Mark Hunter	Head of PCCO Finance Department
Dr Alexander Kelly	GP West Lothian Clinical Lead
Alison McCulloch	Advanced Clinical Pharmacist
[redacted]	Assistant Management Accountant

1. Committee Business

Dr Jo Smail (JS) is taking over as Chair with support from Laura Montgomery (LMo). Fiona Benzies observing today's meeting with a view to gradually taking over from Wendy Carswell (WC). Both LMo and WC will remain members on the group. Sandy Watson will be attending as the Midlothian representative.

2. Minutes of the meeting held on 11 March 2025

The minutes were approved electronically as an accurate record of the meeting. The final minutes of the meeting are available on the GPPC intranet page.

2.1 Action Log

- Prescribing after a private consultation - on Policy Online and approved. Lesley Macher (LMa) will disseminate through the weekly GMS communication email. WC will also circulate to pharmacy teams.

ACTION: LMa

- GPPC/REAS meeting – a suitable date to be agreed shortly.

3. Matters arising

3.1 Hydroxychloroquine SCA retinal screening

WC advised progress made but no definitive solution to date. From a local perspective, nine patients identified as highest risk and the patients' rheumatologists have been alerted, and asked to work with the GP to devise an individual plan. Meanwhile, there are ongoing discussions with Scottish Government that include optometry and ophthalmology.

Naomi Scott (NS) has produced an SBAR on local actions taken which will be circulated through the GP weekly communications and this group (see attachment). Work on a solution is ongoing.

ACTION: WC/NS

3.2 SCAs from December GPPC – points to clarify from action log

- *Clarification needed on mexiletine about the recall. Review after two years, electrolyte monitoring* – the clinicians have asked that wording is retained to ensure any patients lost to follow up is referred back in. Cardiology will amend SCA to note that they will take responsibility for any indicated ongoing monitoring.
  GPPC accepted the changes and the SCA to go to GP Subcommittee for resource considerations – outcome of this to be minuted at September GPPC.
- *Clarification on ADHD SCAs* – covered later in the agenda.

3.3 SCA Sign off procedure post GPPC

WC and Stephen McBurney (SMcB) will meet with Jeremy Chowings (JC) on 17 June to define the final step of the process.

SMcB reminded the group that GPPC is a subgroup of ADTC. Part of GPPC remit is to agree clinical content on what is safe and effective care, and where the responsibilities lie. Any resource implications in a SCA would be referred to the medical director, JC, and chair of LMC who would discuss and take to the GP Subcommittee for consideration.

SMcB will update at the GPPC September meeting.

ACTION: SMcB

4. Prescribing Issues

4.1 Shared Care Agreements summary for review

4.1.1 tirzepatide (Mounjaro) and semaglutide (Wegovy) (update)

Claire Ross (CR) referred to the draft SCAs circulated and provided some background. The obesity short life working group (SLWG) was established in March 2025, following the addition of tirzepatide and semaglutide to the East Region Formulary (ERF) for Specialist Initiation.

The SLWG meets monthly, and the initial focus been on initiating and developing the SCAs. Further work will refine the pathway to support phasing of the medicines.

The focus of the SCAs initially is to support management of the two priority cohorts. Cohort 1 of 70 individuals currently on a waiting list, previously referred for saxenda prior to shortage, and will take one month to onboard. Cohort 2 of 450 patients on Tier 3 pathway or maintenance programmes who have privately initiated the drugs, and will take four months to onboard. With the importance of evaluation and learning, a significant amount from the two cohorts will help shape and inform the pathway going forward.

The group welcomed the draft updates in general, noting the clearer alignment of the roles and responsibilities section. Several points were raised:

- The group were concerned that engagement from secondary care would be needed to support appropriate phasing for the pathway, regardless of specialities. LMa reassured the group that communications have been developed for secondary care (ADTC letter).

- The group expressed concerns around support and information for patients. They felt it would be helpful if the clinic letter included a patient information leaflet giving warnings of side effects and risks, particularly relating to pregnancy. Suggestion was also made under Monitoring to state a specific time frame of review, rather than leave open-ended. Laurie Eyles (LE) confirmed the review period would follow the very standard pathway of monthly review up to six months and then a weight check at 9 and 12 months. At 12 months, WMS would discharge the patient back to the care of either the patient's GP or specialist.

- LE acknowledged the gap in robust patient and professional information on GLP1s. A national group is reviewing information available. A weight management hub is planned on NHS Inform to be available within the next six weeks, with the aim of counteracting misinformation on social media. On a local level, a patient leaflet is being produced by NHS Lothian WMS which may also help patients initiated on GLP1s for diabetes.

- With regard to adverse effects, LE confirmed WMS would not be able to take on a clinical assessment of medical symptoms, for example gallstones/pancreatitis, and the patient would be routed back to the usual Out of Hours, A&E, GP or NHS24. There will be a helpline for patients to contact WMS with symptoms or questions on titration, but will be clear where the boundaries are on what the dietician/independent prescriber can do before escalated as medical issue. The helpline will be given to patients at initiation, and they will also attend a group session covering information about GLP1s and side effects.

- Noted that there is no specific guidance on stopping treatment. Some evidence suggesting that many patients may require long term, and more evidence may emerge with time. LE confirmed that WMS will be contactable for advice and guidance with ongoing care for patients as needed.

- CR acknowledged this SCA is different in orientation. It needs to enable safe and effective, accessible use of this medicine and the aim is to support it with sessional medical/non-medical prescribers with wraparound support from dieticians. Ganesh Arunagirinathan, Consultant Endocrinologist, is supporting development of the pathway on an advisory basis. He is part of the MDT and supports the wider prescribing team with advice on complex cases, although will not be case holding.

- CR advised the service would like to start delivering as soon as possible, but there are challenges with being a hosted service. The focus initially will be on the two priority cohorts and prescribers recruited to support the pathway (for which planning is already underway).

Minor edits were noted:

- In the 'Roles and responsibilities' section, under 'Consultant or Specialist Prescriber' the bullet point stating 'Issue the prescription of semaglutide' has been omitted. JS also asked for a brief reference to the new guidance on HRT prescribing to also be added. LMa suggested reference could be made to the Faculty for Sexual Reproductive Health statement and the PIL available in the SCAs. Also reference to the standard drug interactions, and any specific could point to the BMS guidance.

- Under 'Support and Advice for the GP' to delete the line 'Specialist secondary care teams can be contacted in the usual way' to prevent any confusion.

The group agreed for the edits to be made and emailed to JS/WC over the next few weeks, and then aim to circulate again to GPPC and approve by email. GPPC acknowledged a need to balance expediency with the clinical safety and clarity on the pathway.

ACTION: CR/LE

4.1.2 mycophenolate mofetil (MMF) Paeds (new)
Isobel Bishop asked this to be postponed until the GPPC September meeting.

4.2 ADHD SCA and pathway
Sharon Smith (SS) attended to answer the question raised at the December GPPC on ADHD SCAs and service capacity to undertake annual monitoring and review for adult patients. Annual reviews are in place, some capacity issues in SE Edinburgh due to large student population but service improvement work ongoing and the situation expected to resolve. SS confirmed a communication going out confirming the delays and agreed could do a holding statement from REAS D&T to assure GPs.

ACTION: SS

SS also confirmed that patients who have accessed private providers for diagnosis can be referred into NHS for ongoing support, however the adult service will only consider patients with moderate or severe symptoms.

GPPC approved the updates.

Post meeting note: on discussion with JC, these updated SCAs can be published if GPPC approved as there is no change in monitoring requirements for general practice.

5. Pharmacy Teams - How we share outcomes of polypharmacy review cross sector
Alison Neilson (AN), Primary Care pharmacist, made a presentation on how the primary care team could report and document polypharmacy reviews to support the wider healthcare team accessing key details from the review. Karen Reid (KR) was present to support on any further information.

A proposal was made to capture as a priority 1 issue to allow information to transfer to ECS and KIS. The group noted concern with highlighting it as priority 1 as it could clog a basic summary and may be of little relevance if the review occurred a number of years ago.

Dr Eilis McKechanie suggested capturing significant information under the relevant major diagnostic code (for example, AF – declined anticoagulation) as this may make record keeping neater and more concise.

AN/KR will explore further and come back to the GPPC September meeting.

ACTION: AN/KR

6. Medicines of Low and Limited Clinical Value – Lidocaine medicated plasters

WC shared slides circulated in the papers and gave an update of reviews of prescribing across primary care and acute, and actions proposed.

Key points were highlighted:
- Forecasting an annual spend on lidocaine plasters in primary care of 2.5 million per annum
- That is cost for about 9,500 patients
- It represents about 1.3% of our overall prescribing spend
- Each patch costs about £2.41.

GPPC noted that the patient cohort is challenging to manage, often with very limited options for effective analgesics. GPPC noted the evidence, and that lidocaine is considered of limited benefit outside of approved indications.

The reference to safety in the SPC about uncertainty of long term safety and risks identified in animal studies may support implementing change.

GPPC suggested the following further actions – share key messages via GP weekly communications and clusters, or could consider incentivising as an invest to save project to address 9,500 existing patients. GPPC were supportive of stronger messaging around use and approved indications.

WC will consider further actions and update the group as it progresses.

ACTION: WC

7. Opioid stewardship

Debbie Alexander (DA) and Catherine Collinson (CC) were present to inform the group of the alerts process in NHS Lothian.

The Medicines Safety and Risk group (MSRG) sits under ADTC and have overall governance for medicines alerts in general. CC has taken the initiative to form a new Opioid Stewardship Group (OSG) at the Royal Infirmary which has grown with representation from all the major sites, including primary care, and meets every other month.

The recent MHRA drug safety update is about prolonged use opioids and the removal of the indication within their licence for relief of post operative pain. This will have an impact on patients discharged from secondary care, and the OSG is working to ensure prescribers are aware and actioning the

recommendations. There is acknowledgement that some off label prescribing may continue at an individual patient level where clinically appropriate.

One focus area is to ensure that the communication and the discharge letters are clear to support transfer of care, and the team are liaising with colleagues in NHS Fife where this work has already been progressed.

The group felt this MHRA update was not widely known in primary care and welcome most patients not being discharged on them. The emergence of the new opioid group felt positive, and Dr Sam Abushal indicated his interest in joining the OSG. Noted the pain forum in primary care could communicate more closely as a way of addressing interface issues, and that Aileen Ramsay is on the OSG.

CC asked how GPPC recommend communicate effectively with primary care to get this message about the withdrawal of the license, because the post operative period extends to that period where the patient has been discharged from hospital.

The group suggested through the weekly email distribution from GMS Contract or via the East Region Prescribing Bulletin. Possibly ScriptSwitch could be utilised for safety messaging but may be limited as not able to link to clinical indication. Noted all drug safety updates go to the ERF for review, there is a broad look across the interface and suggested a link with the ERF could be added under responsibilities on the Terms of Reference for the OSG. Another suggestion would be through GP cluster meetings for pharmacy update, if slides could be shared in that forum as an update.

A final suggestion was made on immediate discharge letters from high risk admissions or planned surgical wards, to use template wording to not continue on discharge. CC advised an NHS Fife document gives detailed information on intended length of opioid prescribing, and could add MR opioids no longer licensed for post operative pain, which was thought a good idea.

ACTION: DA/CC

8. Finance

8.1 Prescribing Finance report

None available.

9. DATIX incidents

9.1 SAE Paracetamol – caution in low body weight

WC highlighted the May 2024 East Region Prescribing Bulletin (here). Information was shared with committee.

10. Minutes from Lothian Prescribing Committees

The following minutes were all noted for information:

7.1 Area Drug and Therapeutics Committee 07.02.25
7.2 East Region Formulary Committee 02.04.25
7.3 UHD Drug and Therapeutics Committee 18.12.24 and 19.02.25
7.4 Paediatric & Neonatal Drug & Therapeutics Committee nil
7.5 Royal Edinburgh and Associated Services Drug & Therapeutics Committee 15.01.25 and 05.03.25
7.6 Primary Care Prescribing Forum 20.02.25 and 20.03.25
7.7 Medicines Utilisation Review Group 20.02.25
7.8 Medicines Homecare Governance Group nil

11. Any Other Business
Primary care involvement in pre-ERF meeting – Paul Bailey will ask SMcB for an update.

12. Date of Next GPPC Meeting
Tuesday 9 September 2025 via MS Teams, 2.00pm

<u>Schedule of meetings 2025</u>
9 December

NHS LOTHIAN
GENERAL PRACTICE PRESCRIBING COMMITTEE (GPPC)

MINUTES

Tuesday 11 March 2025
Via MS Teams
1400 – 1631
Chair: Dr Laura Montgomery

Present:	
Dr Sam Abushal	GP Edinburgh HSCP
Dr Sophie Bennett	GP Inchpark Surgery, South Edinburgh
[redacted]	Primary Care and Community Pharmacy Coordinator (Professional Secretary)
Rebecca Grieve	Advanced Clinical Pharmacist
Claire Hyslop	Advanced Clinical Pharmacist SE Edinburgh
Linzi Jack	Integrated Care Pharmacist
Lesley Macher	Acting Lead Pharmacist, MGG
Dr Eilis McKechanie	GP Hermitage Medical Practice
Dr Laura Montgomery	GP Wester Hailes Healthy Living Centre (Chair)
Dr Joanna Smail	GP East Lothian HSCP
Stephen Walker	North Edinburgh HSCP Lead Technician
In attendance:	
Dr G Arunagirinathan	Consultant Physician & Endocrinologist
Helen Christie-Thom	MGG Administrator (Minutes)
Laurie Eyles	Dietetic Service Lead
Dr Sally McNeill	GP, Edinburgh University HC
Karen Reid	Advanced Clinical Pharmacist
Gillian Walker	Dietetic Service Lead
Apologies:	
Dr Paul Bailey	GP Lead Midlothian HSCP
Isobel Bishop	Specialist Clinical Pharmacist
Mark Hunter	Head of PCCO Finance Department
Dr Alexander Kelly	GP West Lothian Clinical Lead
Dr Hazel Knox	GP LMC/GP Sub Committee representative
Stephen McBurney	Associate Director of Pharmacy, Primary & Community Care, Mental Health & Associated Services
Alison McCulloch	Advanced Clinical Pharmacist
[redacted]	Assistant Management Accountant

1. Committee Business

1.1 GPPC Chair and Prof Secretary nominations

Laura Montgomery (LMo) advised she will be handing over as chair to Dr Jo Smail (JS) for the June meeting. In terms of vice-Chair, LMo will take that up in the interim. Noted no interest in Prof Secretary nominations to date, another advert will be issued. [redacted] (WC) happy to continue for another meeting and to support a handover.

1.2 GPPC membership

Noted a few gaps in the representation according to the constitution. Lesley Macher (LMa) suggested to review the Terms of Reference and resource of membership, with a view to deputies also coming forward.

ACTION: WC/LMo/JS

2. Minutes of the meeting held on 10 December 2024

The minutes were approved electronically as an accurate record of the meeting. The final minutes of the meeting are available on the GPPC intranet page.

2.1 Action Log

Outstanding:

12.9.23 Prescribing after a private consultation guidance approval

LMa confirmed the document is nearly ready for submission to the Policy Group.

The rest of the outstanding points are covered in item 3.

3. Matters arising

3.1 Need for pre-labelled blood forms on DMARD initiation

WC updated GPPC that Rheumatology are not dependent on pre-labelled bloods forms to ensure that their team review results, and had been asked to clarify that these are still required. GPPC noted that they are necessary to direct the phlebotomist to take necessary bloods and to annotate why they are being taken and how results will be reviewed. WC will feedback to Naomi Scott, Lead Pharmacist Rheumatology.

ACTION: WC

3.2 Hydroxychloroquine SCA retinal screening

WC/LMo had written formally to Rheumatology acknowledging that the retinal screening issue has not yet been resolved. [redacted] (NS) and [redacted] (SR) gave WC an update, advising they had met with [redacted] t Scottish Government, who accepted this is a national issue requiring support and will be further explored. NS/SR hope to give another update in April.

GPPC noted the update. The group felt wider communication to the rest of GP practice network would be helpful, noting the challenges and providing guidance on who is most at risk, and how to manage patients in the interim as options for retinal screening being explored.

WC to write back to NS/SR requesting communications for GPs. Update at June GPPC.

ACTION: WC

3.3 SCAs from December GPPC – points to clarify from action log

WC raised three clarification points of concern:

1. *Clarification on monitoring requirements for octreotide (thyroid functions tests and ultrasound)* – LJ provided an update that this has been actioned and GPPC approved.
2. *Clarification needed on mexiletine about the recall. Review after two years, electrolyte monitoring* – still outstanding;
3. *Clarification on ADHD SCAs* – CAMHS capacity to undertake monitoring and annual review, specialist review ongoing arrangements for adult patients, update SCA wording to say Specialist NHS Lothian Clinician – still outstanding.

WC will chase the two outstanding points.

WC raised the issue about the next steps post-approval of SCAs, as some recent SCAs are waiting to be published for example, evolocumab and mexiletine. Moira Ross, Information Officer MGG, hadn't had any feedback and highlighted several SCAs awaiting upload to the East Region Formulary (ERF) website.

LMo advised she had met [redacted] recently, acknowledging the complexities. LMo confirmed the process is for SCAs to go to the chair of GP Subcommittee, and the Deputy Medical Director, Jeremy Chowings, who consider the resource implications for general practice. Ongoing concerns were raised on GPs being asked to do unfunded work. GPPC welcomed this step but noted concerns from the SCA team on delays in SCA updates and publication whilst this final step is implemented. Clarity is needed on how the LMC Chair and Deputy Medical Director will feedback to SCA Team or GPPC when discussions concluded.

WC will take back to Stephen McBurney and Jeremy Chowings to explore how to address.

ACTION: WC

3.4 Clinical info requests from private providers for weight loss medicines

Claire Hyslop had been exploring options for the pharmacy team to support adding out of practice supplied medicines such as GLP1s on notification by a private provider. There had been consideration whether this should be managed as an administrative task or whether it required clinical review. The situation was discussed at a primary care pharmacy clinical meeting and the consensus was that these situations can be quite high risk, and that clinical oversight is needed. Examples were discussed on GLP1s which had been prescribed inappropriately for weight management for patients not meeting licensed eligibility criteria or with contraindications. In such situations there are concerns where liability could sit.

A recent article published in PULSE was also shared for noting. GPs could face legal risk if they ignore weight-loss jab information requests, says MDO - Pulse Today.

Noted Andy Forder, chair of LMC, is trying to get consensus across Scotland on how to manage work generated by private providers asking GP practices to review suitability of medicines for patients. GPPC felt more discussions needed at national level. GPPC aware that concerns about private providers can be raised via HIS as needed. LMo summarised that this is a complicated issue and no easy answer.

3.5 GPPC/REAS meeting

LMo advised dates have been circulated and will be organised soon to discuss ADHD SCAs, melatonin, physical health checks for patients on antipsychotics, communications around updated lithium handbook and dementia pathway.

GPPC members asked to highlight any additional areas that they would like discussed.

3.6 eLJF clinical Paediatric

Dr Sally McNeill was present to take comments on the clarification of the points raised at the December meeting.

WC asked whether it is clear from eLJF clinical that use of miconazole gel in <4 month olds or <6 months (pre-term infants) is unlicensed. LMa suggested that separate boxes could be introduced for

these age groups to provide more clarity. All other points raised previously had been addressed and were approved.

ACTION: SMcN

4. Prescribing Issues

4.1 Shared Care Agreements summary for review

4.1.1 buprenorphine (update)

Linzi Jack (LJ) highlighted a few changes. In GP responsibility, ongoing review and assessment of compliance and stability changed from six monthly to at least once in 12-month period for stable patients. Ongoing monitoring of LFTs changed to only required and added more resources. Monitoring table amended. Toxicology – lfts only required if evidence of liver disease. Links added. GPPC approved the update.

4.1.2 erythropoiesis (minor update)

LJ noted change of contact and email addresses for two others. GPPC approved the update.

4.1.3 tirzepatide (Mounjaro) (for discussion)

Laurie Eyles (LE), Gillian Walker (GW) and Ganesh Arunagirinathan (GA) attended to provide an update on the GLP1 pathway for weight management and proposed SCA.

LE provided an update noting SMC has approved semaglutide (Wegovy), liraglutide (Saxenda) and tirzepatide (Mounjaro) for weight management. It is acknowledged that patient access needs to be prioritised and phased to manage capacity and in terms of prescribing spend. A national group, chaired by LE reached consensus to prioritise patient with a BMI over 38 and one clinical weight related co-morbidity. In March 2025, the ERF accepted tirzepatide for use in weight management in line with the national consensus statement for prioritisation.

LE noted that SMC stipulates that for patients initiated on liraglutide (Saxenda) and semaglutide (Wegovy), they should be managed in a specialist weight management service, but this recommendation is not included for tirzepatide.

The draft tirzepatide SCA is at an early stage and has been adapted from the previously approved saxenda SCA, but LE noted that discussions on the optimal patient pathway were ongoing and not yet confirmed locally. The SCA circulated suggested that patients would be started and titrated on tirzepatide by the weight management service (WMS) and then prescribing would transfer to GP practice after around six months. LE noted potential challenges with this as the WMS does not currently have prescribers, many patients could be seen virtually or have telephone follow ups, HBP prescribing is admin heavy and would involve handwriting scripts and posting out, not every patient will require WMS wraparound. LE is keen to explore alternative models including an option for WMS to make a recommendation to prescribe and tirzepatide being initiated by a GP. GA and LE noted that GLP1 prescribing is currently widely undertaken in general practice for patients with diabetes, and therefore prescribers are familiar with the medicines. Weight reduction will also impact weight related co-morbidities such as HT and this is managed by primary care.

LE noted that the SCA circulated needed significant further discussion and refinement, and advised that there was no value in discussing it in its current form but welcomed opening up discussions about an SCA with GPPC.

GPPC noted the developments. The Committee raised concerns on patient numbers and GP workload if clinical assessment for suitability of medicine and all prescribing was transferred to general practice, without support from a prescriber in the WMS. GPPC was interested to understand patient numbers in the initial eligibility cohort. GA confirmed 4,818 patients per year for Mounjaro pathway.

GPPC acknowledged that although the ask for ongoing monitoring of weight management treatment was minimal, there could be significant workload on managing co-morbidities and follow up. It was also noted from the draft SCA that the definition of specialist weight management service was broad, suggesting that other specialties with dietetic input could initiate, and clarity was needed on the pathway in line with formulary decision. LMo noted the value of support from WMS in terms of ongoing behavioural support. Also raised management of queries and adverse effects, and LE noted that WMS is considering whether a helpline and point of contact could be set up for patients.

GPPC asked for an update on stakeholder involvement for pathway development. LE advised that a short life working group (SLWG) was being established and welcomed members of GPPC to join. Members to contact LE by email if they would like to join the SLWG.

LJ offered to work with LE to help with key content and formatting of the SCA as it progresses. Further updates to come to the June GPPC.

4.2 Prescribing Indicators and payments

Alison Neilson gave an update noting an ongoing delay in the data so only Q2 2024/25 data available. Payments for this year will therefore be based on Q2 data pending HSCP agreement. Rebecca Grieve (RG) is confident that any impact from seasonal variation has been taken into account where performance is incentivised but will confirm.

GPPC is supportive of the data being based on the NTIs on ShinyApp. It is proposed that targets will be set using Q2 data and use average as the threshold.

WC suggested discussing antibiotic targets with [redacted] as these are usually tightened year on year to promote antimicrobial stewardship. There is also a need to discuss with HSCP leads to understand if PIs incentivised and if so how this could influence target. RG will clarify with HSCP leads.

GPPC was supportive of this approach and the points raised above will be followed up with pharmacy team via business meeting and prescribing forum as needed.

WC noted that the Medicines Safety and Risk Group are scoping safety metrics that are available and had asked about the NTIs. There is now a large suite of >70 indicators and WC suggested that these could be shared with GPPC annually for oversight and discussion. WC will share at the June meeting.

ACTION: RG/WC

4.3 High risk toolkit

Karen Reid (KR) gave a brief presentation.

The SG high risk toolkit was piloted in 2021 with results presented to GPPC in September 2022. Due to GP IT reprovision and local processes for IG assurance, further implementation was delayed, but recent progress has been made and toolkit launched Lothian-wide for INPS Vision practices in February 2025. A steering group has been formed to support implementation. SB noted a few initial issues with

some alerts but these have been quickly resolved. Tayside are also implementing and researchers at Dundee University will evaluate impact.

5. Finance

5.1 Prescribing Finance report

MH unable to attend GPPC but provided the following update:

From the December Meeting when forecasts were at £18.5m overspend, have seen a steady fall in expected volumes and a reduction in average prices. December data leads us to predict the outturn will now be £14.7m overspend which is a significant improvement but is still considerably over the £162.5m budget. We are aware that budget increases have been low and expect uplifts in 2025/26.

Growth projections for 2025/26 have been developed with Medicine Management colleagues. The main unknown is the growth in weight management through use of drugs also used in Diabetes, Semaglutide and Tirzepatide. Clarity is required on initial pace of change and the dietetics capacity. The growth will eventually be significant.

Efficiencies will continue to be looked for especially in reducing waste and medicines of low and limited clinical value, as well as traditional interventions and switching, and GP/Prescribers input is key.

5.2 Efficiency plan (draft)

Primary care prescribing efficiency plan to deliver £7.1m efficiencies shared for information. List of proposed medicines switches also shared. No objections noted.

6. DATIX incidents

6.1 Increase in incidents with dosette changes

WC highlighted an emerging issue with a rise in the number of DATIX reports relating to changes to medicines within a dosette box. GPPC has previously approved a change to medicines form to support communication and robust audit trail between community pharmacy and general practice.

Further analysis of the issues will be undertaken by the community pharmacy development team and any relevant actions and recommendations brought back to a future GPPC.

7. Minutes from Lothian Prescribing Committees

The following minutes were all noted for information:

7.1 Area Drug and Therapeutics Committee 04.10.24 and 06.12.24

7.2 East Region Formulary Committee 04.12.24 and 05.02.25

7.3 UHD Drug and Therapeutics Committee 23.10.24

7.4 Paediatric & Neonatal Drug & Therapeutics Committee nil

7.5 Royal Edinburgh and Associated Services Drug & Therapeutics Committee 11.09.24, 30.10.24 and 11.12.24

WC noted that REAS are suggesting that the SI flag is removed from memantine. GPPC will seek further clarity on this at joint meeting with REAS, as this differs from previous discussions between GPPC and REAS on the dementia drug pathway.

7.6 Primary Care Prescribing Forum 18.07.24, 15.08.24, 19.09.24, 24.10.24, 21.11.24 and 16.01.25

7.7 Medicines Utilisation Review Group 21.11.24

7.8 Medicines Homecare Governance Group nil

8. Any Other Business
None.

9. Date of Next GPPC Meeting
Tuesday 10 June 2025 via MS Teams, 2.00pm

Schedule of meetings 2025
9 September
9 December

ADHD and shared care with private providers

NHS Lothian has shared care agreements for some of the drugs used to treat ADHD in children and young people over 6 and adults. These agreements are between NHS Lothian specialist services and GP practices in Lothian. **These agreements are designed to support GPs and specialist teams in providing safe and accessible care for patients.** The agreements details what part of the care should be provided by specialist/hospital consultant teams and which parts are the responsibility of the General Practitioner and their team and are agreed by representatives of the specialist service, GPs, and pharmacists.

There are no similar agreements between GP practices and private providers. As independent contractors GP practices can choose to share care with private providers but there is no requirement to do so.

If a practice chooses to share care with a private provider, they will normally require the private provider to provide the same level of specialist input as the NHS specialist services; in other words, to follow the NHS Lothian shared care agreement. This is sensible as the shared care agreement is there to support safe and effective care.

Details of the NHS Lothian shared care agreements for AD(H)D medicines:

For patients under 6 years of age

- All of the care would be provided by specialist services including prescribing and they are not part of the shared care arrangements.

For patients over 6 but under 18

- The specialist team (usually CAMHS) is required to undertake, assessment, diagnosis, titration of medicine dosage **and all monitoring including – height, weight, pulse, BP at baseline, 3 monthly, then 6 monthly in the longer term**.
- **Only prescribing is done by GPs** and then only if the CAMHS have confirmed that the ongoing monitoring is in place and supports continued prescribing of the medication.
- When the young person reaches 18 and is transferred to adult services the specialist team are required to facilitate this transfer.

For adult patients

- The specialist team (usually adult mental health teams) is required to undertake, assessment, diagnosis, titration of medicine dosage including - height, weight, and family history of cardiovascular disease at baseline and refer patient for ECG if required, monitor BP and pulse during dose titration.

- The specialist team are also responsible for a re-evaluation of continued need for medication beyond one year.

- The GP is responsible for 6 monthly monitoring of weight, pulse, and blood pressure every 6 months once the patient is stable and for prescribing. The GP would require the 12 months re -evaluation by a specialist to take place to continue the monitoring and prescribing in primary care.

Common issues that arise between GPs and private providers and difficulties for patients:

- Not all private providers are able to offer the monitoring required.
- Not all private providers offer the 12 months re -evaluation.
- It is often extremely expensive for patients and parents who need to pay for the private part of the care.
- There has been doubt cast on the validity of diagnoses made in the private sector. Many private providers are providing a high-quality service, but it is difficult for GP teams to identify concerns of this nature when they have such limited contact with the providers. This has led many GPs and GP practices to decline to enter into shared care arrangements with private providers.
- Recent publicity and some negative local experiences have increased this concern. The BMA, that represents doctors, has advised doctors not to enter into these arrangements and it is likely that the number of practices willing to do so will fall even further if the current difficult situation remains unchanged.
- Often private providers work across a number of regions of Scotland or indeed the UK where subtly different shared care agreements will be in place. This can cause confusion for patients, parents and the clinicians involved.

Waiting times in NHS Lothian for specialist assessment and care in this area are long and this is a pattern seen across the UK. Representatives of both specialist services and General Practitioners have argued that much greater resource is needed, in both sectors, for significant improvements in this situation to be made.

NHS Lothian, and the GP practices we work with, recognise the extreme challenges faced by patients and their families who are concerned about the possibility of an ADHD diagnosis. GP practices work very hard with colleagues in other specialist services using shared care agreements that have been carefully designed to provide high quality care, but do not have the capacity to enter into multiple bespoke arrangements with other providers. NHS Lothian is working hard to continue to improve the quality and accessibility of ADHD care but like other regions of Scotland and the UK is struggling with an unprecedented increase in need in this area.

Dr Jeremy Chowings
Deputy Medical Director Primary Care NHS Lothian
December 2025