



East Surrey CCG
Guildford & Waverley CCG
North West Surrey CCG
Surrey Downs CCG
Surrey Heath CCG
Crawley CCG
Horsham & Mid-Sussex CCG

72 MM

Surrey Interface Prescribing Policy 2017-19

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Version	Final version for 2017-19
Approved by	Surrey & North West Sussex Prescribing Clinical Network and internally through the Guildford & Waverley CCG Medicines Optimisation Group
Name of author/originator	Sarah Watkin, Associate Director of Pharmaceutical Commissioning, Surrey Downs CCG
Owner (director)	Vicky Stobbart, Managing Director, GWCCG
Date of approval	Prescribing Clinical Network on 4 th April 2018. It was agreed at the CCG through the Medicines Optimisation Group on 12 th June 2018.
Date of last review	It is reviewed annually for changes and most recently updated in April 2018 to include NHS England guidance "Responsibility for prescribing between Primary & Secondary/Tertiary Care". This policy has previously been included into provider contracts; however it is now being made available on the CCG website.
Review to be completed by	The review process for this policy commences every September, led by Sarah Watkin, Associate Director of Pharmaceutical Commissioning, Surrey Downs CCG, hence the review date on the document indicates September 2018; however the policy is applicable until 31 st March 2019.

Adapted from the NHS Surrey Interface Prescribing Policy and the South West London Interface Prescribing Policy 2016-17

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Version control sheet

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Final version for 2017-2019	03/08/18	Sarah Watkin, Associate Director Pharmaceutical Commissioning – Surrey Downs CCG	Final	This policy is applicable until 31/03/19.

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Last updated and approved by the Surrey, Crawley and Horsham & Mid-Sussex Prescribing Clinical Network: November 2016 Appendix to the National Standard NHS Contract

1 Introduction

The Department of Health requires that NHS providers establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner.

This policy has been adapted from the NHS Surrey Interface Prescribing Policy for providers of NHS services commissioned to deliver services which include prescribing and drugs.

The aim is to facilitate consistent prescribing policies in the National Standard NHS Contracts across Surrey.

It is recommended that Acute Trusts, Mental Health Trusts, Community Services, other relevant providers and Clinical Commissioning Group (CCG) contract managers seek the advice of their Chief Pharmacist/Pharmaceutical Adviser during the commissioning process and discussions to ensure that implications for pharmacy and prescribing are taken into account.

CCGs and providers to which this policy applies will jointly monitor compliance with this policy through regular review via their routine interface and contracting mechanisms.

Hospital Trusts, Mental Health Trusts, Community Services providers and other providers to which this policy applies are hereafter referred to as “providers”.

2 General Principles

The following general principles will be included in all contracts:

- 2.1 The provider will adhere to both legal and good practice guidance on prescribing in line with the Medicines Act and any other national/local guidance including shared care. All medicines will be prescribed, handled, maintained, stored, administered and disposed of in accordance with relevant legislation

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and best practice.

- 2.2 Providers will have a Drug and Therapeutics Committee (DTC) (or equivalent) in place to co- ordinate the use of medicines, dressings, appliances, enteral feeds, glucose monitoring strips and any other items that are issued on prescription in a similar way to medicines, across the primary and secondary care interface. The DTC will develop an up-to-date formulary (or equivalent) with the involvement of GPs and the CCG Pharmaceutical Commissioning / Medicines Management Team.

Processes for the DTC and any local formulary will be in line with the recommendations in NICE MPG1: Developing and updating local formularies, and Innovation Health and Wealth: Accelerating Adoption and Diffusion in the NHS. The provider will be responsible for the dissemination and implementation of the recommendations made by the Prescribing Clinical Network (PCN) via the DTC or equivalent appropriate committee (for other prescribable items).

- 2.3 Providers will publish a formulary which is compliant with the recommendations set out in NICE MPG1: Developing and updating local formularies, and Innovation Health and Wealth: Accelerating Adoption and Diffusion in the NHS.

- 2.4 Provider prescribing will be from the provider formulary (or equivalent) and prescribers will not seek to avoid formulary restrictions by asking GPs to prescribe non-formulary medicines.

- 2.5 Providers will contribute to the local arrangements for the managed entry of new medicines via the PCN. This will consider the clinical and cost-effectiveness of new medicines and the impact on primary as well as secondary care. The introduction of new medicines or prescribable* items which have an impact on primary care will be agreed via the PCN and ratified by the CCGs unless an alternative local arrangement is explicitly agreed by the CCGs.

*Prescribable items include but are not limited to nutritional supplements, dressings, catheters, stoma items blood glucose monitoring strips and other items that are issued on a prescription in a similar way to medicines.

- 2.6 CCGs will not routinely commission for use, a medicine under review by NICE, for which no appraisal or guideline has yet been published, regardless of the existence of a zero-cost scheme. Any provider signing up to such an offer does so at their own risk, understanding that where the final published guidance does not recommended the therapy, or where the individual patient does not meet the NICE recommended criteria for use, the CCG would in no way be bound to fund on-going treatment.

Where a medicine receives a positive appraisal and recommendation for use

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by NICE, local procedures for adoption of NICE recommended medicines will be followed.

- 2.7 Providers will provide assurance that the recommendations made by the PCN are implemented within 3 months. If there are exceptional circumstances when a recommendation is not implemented this needs to be stated. Providers will consider making drugs classified as 'Black' on the Surrey traffic light system as non-formulary on their provider formulary (see Surrey PAD for traffic light definitions. Available at <http://pad.res360.net/>)
- 2.8 All shared care documents will be approved through the trust DTC and returned to the CCG with the trust logo and contact details for the relevant department and clinician contact details in the back-up advice and support section of the document within 3 months of their approval by the PCN.
- 2.9 Prescribers and pharmacists will prescribe and/or recommend, dispense and label by generic drug name except where this is clinically inappropriate.
- 2.10 Providers will routinely dispense medicines in patient packs, in order to comply with European Community directive 92/27/EEC on pharmaceutical labelling and the provision of information to patients. Where patient packs are not clinically appropriate, providers will make alternative arrangements to ensure patients receive such information.
- 2.11 Providers will have policies in place and approved by their DTC to cover the following:
- Medicines policy including communication and provision of medicines on discharge in line with the IPP
 - Safe and secure management and handling of controlled drugs
 - Safe and secure management of prescription forms
 - Working with the pharmaceutical industry
 - Development and maintenance of a formulary as per section 2.2 and 2.3
 - The use and disposal of patients own medicines
 - Medicines reconciliation
 - Self-administration of medicines by patients
 - Use of unlicensed medicines and medicines used for unlicensed indications
 - Non-medical prescribing
 - Patient group directives (PGDs)
 - Private patient care: NHS patients who wish to pay for additional care
 - Development and implementation of shared care protocols
 - Homecare
- 2.12 Providers will comply with principles contained in local, national and professional guidance including National Service Frameworks (NSFs), NICE Technology Appraisal Guidance and relevant Health Service Circulars (HSC), NHS Executive Letters (NHS EL) Health and Safety Guidance (HSG) and

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Audit Commission reports. In particular, prescribing responsibility between primary and secondary care clinicians will be based on the NHS England guidance: "Responsibility for prescribing between primary & secondary/tertiary care" (version 1, January 2018; publications gateway reference: 07573)

- 2.13 Legal responsibility for prescribing lies with the health care professional who signs the prescription and it is the responsibility of the individual prescriber to prescribe within their own competence. For further information see the General Medical Council's 'Good practice in prescribing and managing medicines and devices (2013)'.
- 2.14 If a GP agrees to take responsibility for continuing to supply drugs which are not normally available in the community, there will be liaison between the transferring provider pharmacy and the community pharmacy to ensure a continuity of supply of the drug.
- 2.15 Providers will be expected to prescribe and supply in a manner that minimises the potential for waste.
- 2.16 Providers are expected to implement the recommendations of NHS Patient Safety Alerts and other drug alerts within the time frames specified within the alerts and participate in any relevant audits
- 2.17 Providers wishing to prescribe any CCG-commissioned drugs excluded from Payment by Results (PbR) must adhere to the individual CCG's 'Drugs and Devices excluded from the National Tariff' document (see Section 3 for information on funding) or a specific locally agreed service.
- 2.18 Evidence of NICE guidance implementation will be publicised on the provider organisation's website and evidence of compliance may be requested.

3 Funding

- 3.1 All new and existing drugs and technologies will be provided within the scope of National Tariff guidance unless:
 - explicitly excluded from tariff as described by the Department of Health Payment by Results exclusion list and funding agreed with commissioners, or
 - as part of excluded services or
 - through local arrangements agreed with the commissioners Drugs and devices excluded from the National Tariff will either be:
 - Commissioned by the Specialised Commissioning Group (SCG) which is part of NHS England or
 - Commissioned by Clinical Commissioning groups (CCGs)

The CCG commissioned drugs and devices will be stated in the individual CCG's 'Drugs and Devices excluded from the National Tariff' document.

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Positive NICE Technology Appraisals for PbR excluded drugs will be funded in-year, for providers who can demonstrate competence and compliance with NICE pathways. The PCN may identify the local pathways within which the positive NICE TAs may be incorporated.

A full data set will be submitted for all drug charges and any subsequent challenges. The NHS Clinical Data Sets define the standard information requirements but as a minimum this will include:

- NHS number
- Drug name - both generic and brand (statement of brand name for biosimilar products as recommended as good practice by MHRA)
- Quantity supplied e.g. 4 x 50mg prefilled injection
- Date of issue
- Acquisition cost of drug (CCG can request invoice for verification)
- Speciality or clinical department
- Indication (preferred but not mandatory if speciality or clinical department already stated)

Any additional pre-agreed charges will be listed on a separate line to the related drug or device within the invoice.

- 3.2 The provider must give confirmation that the patient (or in the case of a minor or vulnerable adult, with the parent/legal guardian/carer) has given appropriate explicit consent for relevant personal, confidential, and sensitive information to be passed to the CCG for processing a funding request and for validating subsequent invoices. This includes the CCG Commissioning Team who are responsible for approving funding of PbR excluded drugs and IFRs, confirming continuing response to treatments and processing invoices. Consent is only required ONCE at the point of funding request.
- 3.3 Drug charges must be for the drug only and at acquisition cost or at nationally/locally procured/contracted prices, whichever is lower. There will be no additional charges automatically added to drug prices without prior discussion and explicit agreement with commissioners and in accordance with National Tariff rules.
- 3.4 It is the responsibility of the provider to ensure that all National, Surrey and Sussex wide agreed Patient Access Schemes (PAS) are put in place within the provider and all such drugs will be charged to the commissioners as per the detail of the PAS.

The provider will respond to invoice challenges within the prescribed time frame for all challenges as agreed.

- 3.5 Where separate arrangements have been agreed (see the individual CCG's 'Drugs and Devices excluded from the National Tariff' document), CCGs will agree specific funding mechanisms and treatment pathways, for

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excluded drugs, with providers. Unless otherwise stated, funding for positive NICE technology appraisals is included in the tariff.

- 3.6 Pass-through payments are additional payments for use of a particular device, technology or drug and can be made to providers over and above the relevant tariff reimbursement. CCGs and providers must agree that payment is intended primarily for new devices, drugs, treatments or technologies or to new applications of existing technology. For any pass-through payment arrangement the following criteria and conditions apply:
- The pass-through arrangement will be fixed for a maximum of 3 years
 - CCGs will have regard to the existing cost effectiveness evidence including any NICE guidance or other relevant national guidance
 - The price attached to the pass-through funding will be agreed in advance and the price will only relate to the additional costs associated directly with the device or technology and its use relative to the cost of the alternative treatment
 - Where pass-through funding for a more expensive treatment has been agreed on the basis that other costs to the health economy will be reduced, providers will be able to demonstrate that the projected benefits have been realised. Data collection criteria for this will be agreed in advance.
- 3.7 Exclusions to the contract may be subject to specific reporting requirements which will be agreed in advance.
- 3.8 Unpredicted in-year cost pressures, excluding NICE technology appraisals, will be managed by discussion between the provider and the commissioners, and will be clearly communicated to all commissioners in advance. A process is in place for considering funding for individual patients on an exceptional basis.
- 3.9 Cost pressures identified as a result of horizon-scanning, including NICE technology appraisals, will be managed by discussion between the provider and the commissioners, and will be clearly communicated to all commissioners in advance.

4 Admission arrangements/medicines reconciliation

- 4.1 The GP referral letter will be sent at or before admission and must include:
- Medicine history
 - Current medicines – drug, form, strength, dose, frequency and indication (also to include length of treatment if applicable).
 - Any previous adverse reactions or allergies
 - Any significant medical history
 - Reason for referral / suspected diagnosis

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Electronic record sharing systems will be used to facilitate the transfer of information on medicines where available.

- 4.2 All providers will have medicines management arrangements in line with national guidance (NICE NG5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes) on medicines reconciliation on admission which will include:
- Provision of information to patients before planned admissions about the arrangements in the providers e.g. for bringing in own medicines, self-administration, use of patients own medicines, dispensing for discharge.
 - Arrangements for medicines history taking and pharmacist review of medication.
 - Exclusions for day cases
- 4.3 GPs will not be asked to prescribe medicines and other items which are intended to be used/administered in hospital or required as part of a planned procedure. It is the provider's responsibility to ensure that arrangements are in place to ensure any treatments are available as appropriate.

5 In-patients

- 5.1 CCGs encourage the use of patients own medicines in hospital in line with the Audit Commission report 'A Spoonful of Sugar' (2001). GPs and other primary care professionals should encourage patients to take their own medicines with them into hospital. If the patient has brought their own medicines into hospital with them and they are suitable for use, these can be used on the wards in line with the provider's local policy.
- 5.2 CCGs and providers encourage the use of "green-bag" and "message in a bottle" schemes.
- 5.3 The provider is responsible for the supply of any new medicine or continuation of existing medicines to in-patients when the patient's own supply drops below 14 days. This may exclude specified continuing care units.

6 Discharge Arrangements

The general principle is that all providers will ensure patients will be discharged with access to a minimum of 14 days in line with local policy, of **all** their medicines (including pre-admission medicines).

- 6.1 The provider must supply that quantity of medication to the patient, except to the extent that the patient already has an adequate quantity and/or will receive an adequate supply via an **existing repeat prescription** from the patient's GP or other primary care provider.

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- 6.2 Patients will normally be discharged from providers **in line with local policy**, with a **minimum supply of 14 days** or an original pack, whichever is the higher (including trusts employing dispensing for discharge systems) unless:
- The full course of treatment is less or
 - The patient is palliative when a quantity appropriate to the patient's need will be supplied.

This also applies to existing pre-admission medicines when the patient's own drug supply is less than 14 days on discharge but not if there is a minimum of 14 days of patient's own drug supply left.

6.3 The requirement to supply a minimum of 14 days of medication on discharge also applies to patients requiring adherence support, including patients requiring multi-compartment compliance aids (see section 6.9 for further details). A working group will be set up to review this requirement and make best practice recommendations.

- 6.4 The GP will be provided with the following information about the patient's medicine:
- Diagnosis and reason for admission
 - Medicines on discharge (including dose and frequency) with clear instructions as to whether or not the medicine should be continued after the initial supply
 - Any monitoring required including anticipated increase/decrease in dose
 - For all new medication, the specific reason for starting the new medication will be stated and the duration of treatment will be indicated where appropriate (e.g. clopidogrel, PPIs, antibiotics)
 - For any existing medication which is stopped, the specific reason for stopping will be stated.
 - For any pre-admission medicine which is changed, the specific reason for the change will be stated
 - For any drugs classified as red on the traffic light system and initiated on the current admission, arrangements for ongoing supply must be in place and this will be communicated on the discharge summary (see Surrey PAD for traffic light system definitions)
 - If patients are initiated on nutritional supplements or feeds, dressings or appliances (e.g. stoma appliances, catheters), the provider is expected to provide communication from the initiating clinician to the GP regarding the patient's clinical care plan and quantities required for ongoing prescribing/supply.
 - Clear instructions on medications (reasons for taking them, dosage, when to take them, and any other additional instructions)
 - Details of medicines tried in hospital but which proved unsuitable
 - Details of any compliance aids issued e.g. reminder charts
 - Any information on allergies in line with NICE CG 183 Drug allergy: diagnosis and management from September 2014

- 6.5 For patients admitted for a reason unconnected with their previous medication

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regimen, e.g. for surgery, the discharge information must list any drugs added and still in use at discharge. If the remaining drugs are unchanged then the discharge notification can state "Other drugs as at pre-admission".

- 6.6 For patients admitted for a reason unconnected with their previous medication regimen, e.g. for surgery **and** where there is no change in any medicine at discharge, the discharge information can state "no changes made".
- 6.7 Discharge information will be sent to the patient's GP at the time of discharge. Discharge information will be electronic and sent within 24hrs of patient discharge to the GP and copied to the patient (or sent to the GP within 1 working day in cases where the patient has died).
- 6.8 Patients will be provided with appropriate information about obtaining further supplies of medicine.
- 6.9 **Monitored Dosage Systems and other Compliance Aids**
Providers are encouraged to develop discharge planning arrangements for vulnerable patients. The use of monitored dosage systems and other compliance aids are not routinely supported unless clinically required - an assessment for appropriateness will be undertaken in line with the Royal Pharmaceutical Society's 2013 guidance on better use of multi-compartment compliance aids before a monitored dosage system is initiated. Where the supply of a monitored dosage or other similar system is appropriate there will be a policy in place for its use including making appropriate arrangements for continuity after discharge.
- 6.10 **Dispensing for Discharge (One Stop Dispensing)**
Providers are encouraged to employ a dispensing for discharge system in line with the Audit Commission report 'A Spoonful of Sugar' 2001.

7 Out-patients/Day Case

- 7.1 Medication will be provided for outpatients in line with local policy.

In some providers this may include writing to the GP and suggesting medicines if **not** required for immediate treatment i.e. initiation not required within 14 days. When recommending treatment, the consultant where possible, will recommend a therapeutic class of drug, rather than a specified product.

Patients will be provided with written information telling them that the medicine is not urgent and that they should contact their surgery in approximately 14 days when the surgery will inform them when to collect their prescription.

Full information will be received by the GP to enable a prescription to be issued – the advice letter from the provider will normally be received within 7 days. Where this is not possible, patients will receive supplies from the

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provider.

- 7.2 The following categories must be prescribed by the providers:
- Medicines required for immediate treatment (i.e. initiation required within 14 days)
e.g. antibiotics
 - Drugs agreed with the CCG as provider/specialist only (Red drugs)
 - Drugs requiring continued monitoring or where an agreement to shared care is pending (Amber or Amber-star/ Blue Drugs)
 - Provider based clinical trials
 - Compassionate supply medicines
- 7.3 Where a prescription is issued the quantity provided will be in line with local policy. Patient packs will normally be dispensed unless the full course of treatment is shorter (e.g. antibiotics, short-term analgesia or short-course corticosteroids). A longer supply may be indicated e.g. where the dispensed pack cannot be easily divided; for diabetics receiving insulin, or when the consultant feels there are clear medical reasons why they will supply the whole course (monitoring requirements) or when ongoing drug treatment is part of a commissioned service (in which case the drug will be included within tariff).
- 7.4 Providers will ensure that their outpatient prescription form clearly states that the prescription can only be dispensed at the provider's own pharmacy and cannot be taken to any other pharmacy or to the patient's GP to request a prescription. Providers must ensure that patients are made aware of this.
- 7.5 GPs will not be asked to prescribe medicines and dressings which are intended to be used/administered/demonstrated in provider out-patient clinics or day-care surgery. (e.g. intrauterine levonorgestrel, implants). Note: this does not apply to those medicines which have been prescribed by the GP for patient's use at home and which the patient has brought into the provider as a "patients own medicine" for an in-patient stay.

8 Homecare

- 8.1 Providers will fully implement their responsibilities as described in the Hackett report. Suitable arrangements for setting up homecare services, including the responsibilities of providers and CCGs and funding arrangements will be clearly identified prior to setting up the service.
- 8.2 The provider will have a strategy for homecare medicines developed with the local DTC and an annual homecare plan which the Chief Pharmacist will have responsibility to deliver in line with the recommendations of the Hackett Report – Homecare Medicines 'Towards a Vision for the Future'.

9 Nutritional supplements, dressings, glucose monitoring strips and

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appliances

- 9.1 The provider will work with the commissioner when contracts are negotiated for the procurement or supply of items such as continence or stoma devices, glucose monitoring devices or feeds which may require ongoing prescription in primary care.
- 9.2 In the case of Oral Nutritional Supplements (ONS) providers will only supply feeds on discharge if accompanied with a nutritional management plan including a MUST score completed by a dietician.
- 9.3 Suitable local arrangements will be in place for the supply of dressings and appliances. A minimum of five days' supply will be provided. Sufficient information about a patient's dressing and appliance treatment will be provided to ensure continuity of care in the community. See also section 6.4 regarding communication with the GP.
- 9.4 Providers will not request GPs to prescribe dressings outside of the CCG's dressing formulary.
- 9.5 No arrangements will be made by the providers with appliance contractors for ongoing supplies of dressings or appliances in the community without involving patients in the decision about where their prescriptions are dispensed.

10 Patients attending Accident and Emergency

- 10.1 If a prescribed medicine is necessary and the required treatment course is ≤ 14 days, the full course will be supplied. Where longer term medication is required, a minimum of 14 days treatment will be supplied. This is to allow the GP sufficient time to receive the information about the patient's A&E attendance and arrange a continuing supply. In all other circumstances, 7 days treatment should be supplied (unless the treatment course is shorter).
- 10.2 Information will be sent to the GP within 3 working days and will include a minimum data set as specified in section 6.4

11. People at risk of harm

- 11.1 When making arrangements for the prescribing of medicines for someone who may be at risk of self-harm or have the potential to misuse the medication, the arrangements should fit within the overall care plan for the individual service user. In addition the safe use of some medicines requires specific information resources; such as the patient guide, prescriber checklist and patient card for girls and women of childbearing age who may be taking or considering

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taking certain medicines such as valproate.

12. Unlicensed Medicines or medicines used outside of their licensed indication(s) (see also PCN's document 'Recommendations to Prescribers on the Use of Unlicensed Medicines and Licensed Medicines for Unlicensed Indications')

- 12.1 Prescribing of unlicensed medicines or medicines used outside their licensed indications will usually remain the responsibility of the clinician initiating treatment. The provider will accept full responsibility for the continued sourcing, quality and supply, which will be under the control of the provider pharmacy department. In these cases, information must be given to patients explaining that they must obtain continuing supplies of their medicine only from the provider, not their GP.
- 12.2 Where there is a substantial body of evidence to support the use of an unlicensed medicine or a licensed medicine outside of its licence (e.g. in paediatrics), the GP may be asked to prescribe. However the GP must be fully informed and made aware of the licensing status. The GP will refer to the BNF / Children's BNF as a guide for prescribing of unlicensed medicines / licensed medicines outside of licence. The full agreement of the GP concerned must be obtained before prescribing is transferred.
- 12.3 Informed consent for the use of unlicensed medicines or the use of licensed medicines outside their licensed indications will be obtained from patients before the prescription is written.

13 When Responsibility for Prescribing Remains with Providers
Note: this applies to CCG commissioned drugs only, not those commissioned by NHS England Specialised Commissioning.

- 13.1 The provider trust is expected to retain prescribing responsibility for the following:
- Medicines requiring ongoing specialist intervention and specialist monitoring.
 - Patients receive the majority of ongoing care, including monitoring, from the provider and the only benefit of transferring care would be to provider costs.
 - Medicines that are unlicensed or are being used outside of the product license e.g. for an unlicensed indication or at an unlicensed dose unless there is a recognised evidence base and/or it is standard treatment. In terms of paediatric medicines, inclusion of dosage guidance in the children's BNF provides a suitable evidence base. (see section 12.2 for clarification)
 - Medicines that are only available through the provider i.e. are not available on FP10 including certain 'borderline' products when used outside approved indications.

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- Medicines that are part of a provider initiated clinical trial or the continuance of a provider initiated clinical trial or compassionate use, where no arrangement has been made in advance with the purchaser to meet the extra cost of the treatment.
- The GP does not feel confident in taking on clinical responsibility for the prescribing of a drug and there is no shared care guideline for that drug.
- Medicines and other items e.g. dressings which are intended to be used/administered in the provider's outpatient clinics or day-case surgery e.g. intrauterine levonorgestrel implants, local anaesthetic creams.
- Medicines subject to High-tech Hospital at Home guidance (EL(95)5).
- Medicines and other prescribable products, which have not been approved for addition to the provider's formulary.
- A medicine under review by NICE, for which no appraisal or guideline has yet been published
- Drugs that have not gone through due consideration processes at the CCG
- All anti-cancer medicines except where shared care prescribing or other arrangements exist.
- All other treatments funded by NHS England unless specifically agreed to be provided through a shared care prescribing agreement or other agreed process
- Where there has been no collaboration or agreement with the patient and/or carer.
- Packages of care:
 - CCG commissioned injectable antibiotics, antifungals and antivirals (unless special local arrangements exist)
 - Drugs for IVF (see local CCG policy)
 - All orphan drugs* commissioned by CCGs
 - Insulin pumps (package of care)

* Orphan drugs are those designated by the EMA to promote development of drugs to treat rare diseases or conditions. They have marketing exclusivity for 10 years with assistance from the EMA in optimising drug development and applications for marketing approval.

13.2 If there is disagreement about where prescribing of an individual patient's treatment should best take place the case will be referred to the CCG, via the Medicines Management team who will seek resolution between the parties concerned. Disagreements over the principles of prescribing responsibility, not individual disagreements that are resolved case by case, are probably best resolved at the Prescribing Clinical Network. Care will be taken to ensure that the patient does not suffer as a consequence of the NHS decision-making process and co-operation on both sides is sought in achieving resolution in difficult situations.

Adapted from the NHS Surrey Interface Prescribing Policy and the South West London Interface Prescribing Policy 2016-17

Agreed at the Surrey, Crawley and Horsham & Mid-Sussex CCGs Prescribing Clinical Network (PCN) meeting: November 2016

Review: September 2018 (updated April 2018 reflect NHS England guidance "Responsibility for prescribing between Primary & Secondary/Tertiary Care")

- 13.3 Repeat prescriptions for specialist drugs will not incur an attendance tariff charge unless the patient receives a clinical review. The provider will make arrangements for issuing medication in between clinical reviews as appropriate e.g. implementation of a trust repeat dispensing scheme.
- 13.4 GPs will be informed of any drugs which continue to be prescribed by the specialist. Discharge and outpatient letters will clearly state that these drugs are to be supplied by the provider and that the GP is not expected to prescribe.
- 13.5 GPs will ensure that patient medication records include and accurately record any medicines for which prescribing remains the responsibility of secondary or tertiary care providers in order to provide a complete medication record.

14 Transfer of Prescribing - Medicines Requiring Specialist Monitoring (drugs that are classified as Amber or Amber*/Blue on the Surrey traffic light system)

Increasingly, patients with continuing specialist clinical needs can be cared for at home or in the community. There are medicines which could be prescribed by GPs if sufficient support, review and information are shared between the GP and consultant.

- 14.1 It is the responsibility of the specialist to request shared care with a GP.

The key principle is that the GP is provided with information and given the opportunity to accept prescribing responsibility before informing the patient and before the transfer takes place.

Under no circumstance will the patient be used as the mechanism for informing the GP that prescribing will be transferred to them.

- 14.2 It would not normally be expected that a GP would decline to prescribe on the basis of cost. Likewise if the patient is to receive the majority of their on-going care through the provider then prescribing must remain with the provider and must not be transferred solely on the basis of cost.
- 14.3 The following conditions will be met before shared care takes place:
- The initial specialist responsibilities set out in the shared care guideline have been fulfilled
 - Treatment is in accordance with a patient-specific shared care protocol / information leaflet which clearly defines the responsibilities of all parties. This document must have been approved by the Trust DTC and by the CCG Medicines Management Committee (or equivalent) and must contain the trust logo and contact details for the relevant department and clinicians in the back-up advice and support section of the document.

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- The written agreement of the patient's GP is given prior to the transfer of prescribing.
- The GP is sufficiently informed and able to monitor treatment and identify medicines interactions.

All prescribers will be aware of their responsibilities to develop their own and the expertise of others in the managed introduction of new medicines.

15 Tertiary Care Referrals

- 15.1 It is expected that the care and treatment of patients referred to tertiary care will remain the responsibility of the tertiary centre while they continue to require specialist care or as indicated within NHS England service specification.

If NHS Specialised Commissioning Services are providing an advisory service for the assessment and development of a treatment plan only, the referrer is responsible for making prescribing decisions in relation to the referral.

GPs will only be asked to prescribe drugs initiated by tertiary care referrals if this is compliant with the IPP.

- 15.2 Where it is clinically appropriate for the patient to be cared for at home, under the supervision of the tertiary centre, the centre will make appropriate arrangements for prescribing and supply of specialist medicines (e.g. 'Purchasing high-tech healthcare at home' EL95/5 or using FP10(HP)s).
- 15.3 In some circumstances it may be appropriate to transfer prescribing to a more local provider trust or more rarely a GP. In all situations there will be robust processes in place between the tertiary centre, provider trust and GP to ensure timely and accurate transfer of a patient's medication details to appropriate professionals responsible for the patient's care.

16 Patient Group Directions

- 16.1 Providers wishing to use Patient Group Directions (PGDs) to deliver any part of the service are required to develop and use PGDs within the appropriate clinical governance framework as outlined in national guidelines (e.g. NICE Good Practice Guidance MPG2) and obtain appropriate medical and pharmaceutical advice in drawing up the documents. Where the legal framework does not allow this, the provider may seek advice from the Commissioner. Providers are reminded that PGDs will not be used to supply unlicensed medicines.

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17 Non-Medical Prescribing

- 17.1 Nurses, pharmacists and other allied health professionals who become qualified prescribers are expected to work within the policies and guidelines of their employing organisation and the established agreed local prescribing guidelines.
- 17.2 The provider must ensure that non–medical prescribers will:
- Be accountable for, and prescribe within, their own level of competence and expertise
 - Seek advice and make appropriate referrals to other professionals with different expertise, when required
 - Adhere to the Code of Conduct and Ethics of their regulatory body, ensuring they have sufficient professional indemnity insurance, by means of membership of a professional organisation or trade union which provides this cover
 - Ensure competencies are maintained through continuous professional development and clinical supervision.

18 Clinical Trials & Ethics Committees

- 18.1 All clinical trials must have been subject to Research Ethics Committee approval, when the arrangements for consulting and informing will be considered. Trials should also have been through the Provider Trust's Research Governance process. This will take account of whether or not the trial is in line with strategic objectives of the organisation (for research and clinical care) and continued supply of medicines at the end of the trial.

From 31 March 2016, Health Research Authority (HRA) Approval is the process for applying for approvals for all project-based research in the NHS led from England. Therefore all project-based research is subject to approval from HRA Approval.

- 18.2 In order to respond appropriately to any suspected adverse events that occur outside the provider setting, following patient consent, the GP will be adequately informed if a patient is participating in a clinical trial.
- 18.3 Prescribing and supply of clinical trial medicine is the responsibility of the provider. Standard out-patient or in-patient treatment costs will be met for patients on a trial as required by HSG(97)32; this will not include the cost of the trial medicines either during or after the trial unless specifically agreed with the relevant commissioner. Any Excess Treatment Costs (ETCs) need to be agreed with the commissioner and will be considered in line with the latest national guidance on funding ETCs related to non-commercial research studies.

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- 18.4 Patients participating in a clinical trial must be made aware that there is no guarantee that the medicine will be continued at the end of the trial, irrespective of the results. Where trial results indicate that treatment will continue, post-trial costs will only be considered for funding by CCGs where exceptional circumstances exist.