South West London Interface Prescribing Policy

Key Messages

- The South West London Interface Prescribing Policy outlines the contractual requirements for providers of NHS services and aims to facilitate consistent prescribing policies in National Standard NHS Contracts across South West London.
- This factsheet aims to provide a summary of the expectations from the provider and GP as patients transfer between primary and secondary/ tertiary care.
- Advice is included on the following areas:
  1. Admission arrangements/medicines reconciliation
  2. In-patients
  3. Discharge Arrangements
  4. Adherence Support
  5. Out-patients / Day Case
  6. People at risk of harm
  7. Dressings, Appliances, Enteral Feeds and Glucose Monitoring Strips
  8. Patients Attending Accident and Emergency
  9. Unlicensed Medicines or Medicines Used Outside of their Licensed Indication(s)
  10. When Responsibility for Prescribing Normally Remains with Providers
  11. Shared Care Prescribing
  12. Transfer of Care: Transfer of care and prescribing responsibilities for medicines requiring additional information to ensure the transfer is considered and safe
  13. Patient Group Directions (PGDs)
  14. Non-Medical Prescribing
  15. Tertiary Care

Introduction:
The South West London (SWL) Interface Prescribing Policy outlines the requirements for providers and GPs to ensure safe and effective medicines management when patients transfer between primary and secondary care.
Providers are expected to put active systems in place to ensure that the SWL Interface Prescribing Policy is adhered to by all clinicians and are required to provide assurances to CCGs.

1. Admission arrangements/medicines reconciliation:
A GP referral letter should be sent at or before admission and must include:

- Medicine history
- Current medicines - name, form, strength, dose, timing, frequency and indication (also to include length of treatment if applicable)
- Medicines advised for self-care
- Date and time of the last dose, such as for weekly or monthly medicines, including injections
- Known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced
- Any significant medical history
- Reason for referral/ suspected diagnosis
- Any relevant compliance issues (including sight, cognitive impairment or any support the person needs to take their medicines)
- Any other information needed – for example, when specific medicines are due for review or monitoring. Additional information may be needed for specific groups of people, such as children.

The Summary Care Record (SCR) should be used to facilitate the transfer of information on medicines.
Primary care professionals should encourage patients to take their own medicines with them into hospital.

GPs should 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.

2. In-patients

- If the patient's own medication is suitable for use, it can be used on the ward.
- The provider is responsible for the supply of any new medicinal resources and continuation of existing medicines to in-patients when the patient's own supply drops below 14 days.

3. Discharge Arrangements
Patients should be discharged from hospital with a minimum supply for 14 days unless the full course of treatment is less, the patient requires a multi-compartment aid (see 'Adherence Support' below), a smaller supply is deemed appropriate on mental health grounds or the patient is palliative when a quantity appropriate to the patient's need should be supplied (also applies out of hours, at weekends and on bank holidays). Where appropriate, NHS England guidance on prescribing over the counter medicines should be implemented at discharge.

The GP should be provided with the following information:

Essential
- Diagnosis and reason for admission
- Medicines on discharge (including name, strength, form, dose, timing, frequency) with clear instructions whether or not the medicine should be continued after initial supply
- Medicines advised for self-care
- For all new medication, the duration of treatment should be indicated where appropriate
- Where applicable, date and time of the last dose, such as for weekly or monthly medicines, including injections
- For any new medicines classified as 'hospital/specialist only' arrangements for on-going supply should be communicated on the discharge summary
- If patients are initiated on nutritional supplements or feeds, dressings or appliances, the provider must communicate from the initiating clinician to the GP the patient's clinical care plan, quantities required for on-going prescribing/supply and information about review
- Any review/monitoring of medicines required including anticipated increase/decrease in dose
- Changes to medicines, including medicines started or stopped, or dosage changes, and reason for the change
- Any new drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced
- Any other information needed e.g. any support the person needs to carry on taking the medicines, including details of any compliance aids issued e.g. reminder charts. Additional information may be needed for specific groups of people, such as children.

Recommended as good practice
- Details of medicines tried in hospital but which proved unsuitable
- Details of any compliance aids issued

Discharge information should be sent to the patient's GP at discharge, should be electronic where available and sent within 24 hours of discharge.

4. Adherence Support
- Providers are encouraged to develop discharge planning arrangements for vulnerable patients where a need for adherence support is identified.
- The requirement to supply a minimum of 14 days of medication on discharge applies to patients requiring adherence support, including multi-compartment compliance aids. If this is not possible, a multi-compartment compliance aid containing a minimum of 7 days supply should be provided and ensure arrangements are in place for on-going supply following discharge, including availability of discharge information on the day of discharge.

5. Out-patients / Day Case
- GPs should advise patients to take a list of all current medicines to all outpatient consultations.
- Medication should be provided for outpatients in line with national and local policy and take account of the NHS England guidance on prescribing over the counter medicines.
- This may include writing to the GP and suggesting the required medicines if treatment is not urgent. Patients should be told that the medicine is not urgent and to make a routine appointment with their GP after 14 days. Patients should be provided with written information explaining this and that the provider will be writing to their GP. Full information must have been received by the GP. Patients should be copied in to correspondence with their GP wherever possible.
- Where a prescription is issued, the quantity provided should be a minimum of 14 days supply, unless a longer supply is clinically necessary or when on-going treatment is part of a commissioned service.

The following categories must be prescribed by the provider (see also 'When Responsibility for Prescribing Normally Remains with Providers' below)
- Medicines for immediate treatment (i.e. initiation required within 14 days)
- Hospital / specialist only drugs

- Drugs agreed with the CCG as hospital/specialist only
- Drugs requiring continued monitoring or where an agreement to shared care is pending
- Provider based clinical trials

GPs should not be asked to prescribe medicines and other items which are intended to be used / administered in provider's out-patient clinics or day-care surgery or in patient's home if provided as part of a package of care or medicines required as part of a planned procedure.

6. People at risk of harm

- When making arrangements for the prescribing of medicines for someone who may be at risk of self-harm or has the potential to misuse the medication, the arrangements should fit within the overall care plan for the individual service user.
- 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 taking certain medicines such as valproate.
- Patients receiving biologic medicines should be issued with a biologic alert card by the provider and patients advised to this card when accessing healthcare services.

7. Dressings, Appliances, Enteral Feeds and Glucose Monitoring Strips

- Suitable local arrangements should be in place for the supply of dressings, appliances and enteral feeds.
- A minimum of 7 days' supply should be provided following discharge from secondary care.
- Sufficient information about a patient's dressing, appliance and enteral feed treatment, preferably in the form of a care plan as part of the discharge summary, should be provided to ensure continuity of care in the community.
- Providers should only supply oral nutritional supplements (ONS) on discharge if accompanied by a nutritional management plan, including MUST score.
- Providers should not request GPs to prescribe dressings/ appliances and enteral feeds outside of the CCG agreed formulary/guidance where available.
- No arrangements should be made by the provider with appliance contractors for ongoing supplies of dressings or appliances in the community without involving patients in the decision about where and how their further supplies are obtained.

8. Patients Attending Accident and Emergency

- If a medicine is necessary a minimum of 7 days should be supplied, or shorter if the medicines are not required for that length of time, and take account of the NHS England guidance on prescribing over the counter medicines.
- Information should reach the GP at least 3 days before treatment runs out and should include the minimum data set for medicines reconciliation as specified above.
- Principles of antibiotic stewardship should be followed to ensure appropriate use and selection of antibiotics.

9. Unlicensed Medicines or Medicines Used Outside of their Licensed Indication(s)

- Prescribing of unlicensed medicines or medicines used outside their licensed indication, including 'specials', should usually remain the responsibility of the clinician initiating treatment.
- 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.
- Where there is a substantial body of evidence to support the use of an unlicensed medicine or licensed medicine outside of its licence, the GP may be asked to prescribe. Any decision must have gone through a process for due consideration with all benefits and risks clearly identified and the decision made jointly with affected CCGs.
- The GP must be fully informed and made aware of the licensing status and the full agreement of the GP concerned should not be assumed but obtained before prescribing is transferred.
- Informed consent for the use of unlicensed medicines or the use of medicines outside their licensed indications should be obtained from the patient before the prescription is written.

10. When Responsibility for Prescribing Normally Remains with Providers

- The provider is expected to retain responsibility for prescribing in the following circumstances:
  - Medicines requiring on-going specialist intervention and specialist monitoring
  - Patients receiving the majority of on-going care, including monitoring, from the provider
  - Unlicensed medicines or those used outside of product licence
  - Medicines only available through the provider, including 'borderline' products used outside approved indications

- Medicines used as part of a provider-initiated clinical trial or the continuation of a provider-initiated clinical trial or compassionate use, where no arrangement has been made in advance with the commissioner to meet the extra cost of treatment
- The GP has insufficient information to agree a shared care arrangement where applicable
- No shared care prescribing agreement exists and the GP does not feel competent to prescribe
- Medicines and other items which are intended to be used/administered in the provider's out-patient clinic or during day-case surgery
- Medicines and other items (e.g. dressings) intended to be used/administered in the provider's out-patient clinic or during day-case surgery
- Medicines and other prescribable products not approved for addition to the provider's formulary
- PbR-excluded drugs and devices where shared care prescribing is not agreed
- All anti-cancer medicines except where shared care prescribing or other agreements exist
- Drugs subject to High-tech Hospital at Home guidance
- Specified packages of care
- All other treatments funded by NHS England unless specifically agreed to be provided through a shared care prescribing agreement or other agreed process.

- Repeat prescriptions for hospital/specialist only drugs should not incur an attendance Tariff charge unless the patient receives a clinical review by a nurse or clinical specialist. The provider should make arrangements for issuing medication in between clinical reviews as appropriate
- GPs should be informed of any drugs that continue to be supplied by the provider. Discharge and outpatient letters should clearly state that these drugs are to be supplied by the provider. GP practices should include this information on clinical systems to ensure that they have a full medication history for their patients.

The SWL Hospital-only list can be accessed via http://www.swlmcg.nhs.uk/Policies/Pages/Hospital-Only-Spcialist-Drug-List.aspx

11. Shared Care Prescribing

- 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 is shared between the GP and consultant.
- It is the responsibility of the consultant to ensure that the GP is willing to prescribe before mentioning shared care to the patient and before the GP is expected to continue prescribing.
  Under no circumstance should the patient be used as the vehicle for informing the GP that prescribing could be continued by the GP.

The following conditions should be met before shared care prescribing takes place:

- The initial specialist responsibilities set out in the shared care prescribing guideline have been fulfilled
- The patient's condition is stable or predictable for the initiated medicine
- Treatment is in accordance with a patient-specific shared care prescribing guideline
- The written agreement of the patient's GP is obtained, using an agreed form or equivalent, prior to the transfer of prescribing
- The GP is sufficiently informed and able to monitor treatment, identify medicine interactions and adjust the dose of any medicines as necessary.

The list of SWL shared care prescribing guidelines in place is available via
http://www.swlmcg.nhs.uk/Policies/Pages/Shared-Care.aspx
Appendix 5a of the Interface Prescribing Policy provides details on the principles of shared care and can be accessed via http://www.swlmcg.nhs.uk/Policies/Pages/Interface-Prescribing-Policy.aspx

12. Transfer of Care: Transfer of care and prescribing responsibilities for medicines requiring additional information to ensure the transfer is considered and safe

- The introduction of (relatively) new (classes of) medicines, medicines which were previously not routinely prescribed in primary care (e.g on hospital / specialist only list) or used infrequently, some of which require ongoing monitoring (which is similar in nature to other medicines prescribed in primary care that require monitoring), demands for additional and standardised information to be provided by the provider to the GP when the care (including prescribing) responsibilities are transferred. This is different from shared care prescribing because the patient is discharged from hospital and no ongoing specialist monitoring or follow up is required.
- 'Transfer of Care' forms contain additional standardised information, the content and format of which are agreed through the SWL Medicines Optimisation Group, to ensure that the transfer of prescribing responsibilities to the GP is considered and safe.
- It is the responsibility of the consultant to request a transfer of care with the patient's GP. Under no circumstance should the patient be used as the vehicle for informing the GP that prescribing could be transferred to the GP.

- Patients who are being treated on advice of the secondary/tertiary care team, but are no longer seen in that setting, may still need review should problems arise. The appropriate level of care and advice should be available from the secondary/tertiary care team in a timely manner without necessarily requiring a new referral.

The list of SWL transfer of care agreements in place is available via http://www.swlmcg.nhs.uk/Policies/Pages/Shared-Care.aspx

13. Patient Group Directions (PGDs)

- The preferred way for patients to receive the medicines they need is for a prescriber to provide care for an individual patient on a one-to-one basis and the majority of clinical care should be provided on an individual, patient-specific basis.
- PGDs should not be used if the current care pathway can include the issue of a prescription or a written Patient Specific Direction by a doctor or non-medical prescriber so that the patient receives the medicine in a timely manner.
- Providers wishing to use 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 should not be used to supply unlicensed medicines.

14. Non-Medical Prescribing

- 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.
- The provider must ensure that non–medical prescribers:
  - are 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.

15. Tertiary Care

- It is normally 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 specifications. If NHS England Commissioned Services are providing an advisory service for the assessment and development of a treatment plan only before transferring back to the referrer, the original referrer is responsible for making prescribing decisions in relation to the referral.
- Primary care should only be asked to prescribe drugs initiated by tertiary care referrals if this is compliant with all criteria listed above – see 'When Responsibility for Prescribing Normally Remains with Providers', 'Shared care Prescribing' and 'Transfer of Care' above.
- Where it is clinically appropriate for the patient to be cared for at home, under the supervision of the tertiary centre, the centre should make appropriate arrangements for prescribing and supply of specialist medicines.
- In some circumstances it may be appropriate to transfer prescribing to a more local provider or more rarely to a GP. In all situations there should be robust processes in place between the tertiary centre, the local provider and GP to ensure timely and accurate transfer of a patient's medication details to appropriate professionals responsible for the patient's care. The principles outlined above in 'When Responsibility for Prescribing Normally Remains with Providers', 'Shared care Prescribing' and 'Transfer of Care' should be applied.
- GPs should be informed of any drugs that continue to be supplied by the provider. Discharge and outpatient letters should clearly state that these drugs are to be supplied by the provider and that the GP is not expected to prescribe.

Information sources

- The latest South West London Interface Prescribing Policy is available via http://www.swlmcg.nhs.uk/Policies/Pages/Interface-Prescribing-Policy.aspx
- The latest South West London Hospital / Specialist Only list is available via http://www.swlmcg.nhs.uk/Policies/Pages/Hospital-Only-Spcialist-Drug-List.aspx
- The latest South West London Shared Care Prescribing Guidelines and Transfer of Care Agreements is available via http://www.swlmcg.nhs.uk/Policies/Pages/Shared-Care.aspx