# South West London Interface Prescribing Policy 2020-2021

**This policy outlines the contractual requirements for licensed providers of NHS services and aims to facilitate consistent prescribing policies in National Standard NHS Contracts across South West London including the organisations listed below.**

| Year | Version | Approved by: | Date of approval: |
|---|---|---|---|
| **2019/20** | **1** | SWL Medicines Optimisation Group | 21 March 2019 |
| **2020/21** | **1** | SWL Medicines Optimisation Group | 23 January 2020 |

**NHS Clinical Commissioning Groups:** Croydon, Kingston, Merton, Richmond, Sutton, Wandsworth
**NHS Trusts:** Croydon Health Services NHS Trust, Epsom & St Helier University Hospitals NHS Trust, Kingston Hospital NHS Foundation Trust, Moorfields Eye Hospital NHS Foundation Trust, The Royal Marsden NHS Foundation Trust, St George's University Hospitals NHS Foundation Trust including Queen Mary's Hospital Roehampton, South West London & St George's Mental Health NHS Trust
**Community Services provided by:** Connect Health, Central London Community Health Services, Hounslow and Richmond Community Healthcare NHS Trust, Croydon Health Services NHS Trust, Epsom & St Helier University Hospitals NHS Trust, St. George's University Hospitals NHS Foundation Trust, Your Healthcare
**Out-of-hours providers:** East Berkshire Primary Care OOH, South London Doctors Urgent Care (SLDUC), Croydon Health Services NHS Trust
**Other Providers:** BMI Healthcare – Croydon site, Nelson Health Centre, Boots UK Ltd (Community Anticoagulation Services), Bromley Healthcare Ltd (Diabetes Intermediate Services), Communitas Clinics Ltd (trading as Croydon Clinics-Dermatology Intermediate Services), St. Raphael's Hospice, Sutton

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Updated and approved by South West London Medicines Optimisation Group: 23 January 2020

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## 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 outlines the contractual requirements for licensed providers of NHS services and aims to facilitate consistent prescribing policies in National Standard NHS Contracts across South West London.

This policy has been developed by the South West London (SWL) Medicines Optimisation Group and has been agreed by Acute, Mental Health, Community Services providers and SWL Clinical Commissioning Groups (CCGs) (known as South West London (SWL) CCG from 1 April 2020), Drugs and Therapeutics/ Prescribing or similar Committees in the SWL sector.

It is recommended that Acute Trusts, Mental Health Trusts, Community Services, other relevant providers and CCG contract managers seek the advice of their respective Chief Pharmacist/Pharmaceutical Adviser during the commissioning process and commissioning strategy/operating plan' or equivalent discussions to ensure that implications for pharmacy and prescribing are taken into account.

Providers are expected to put active systems in place to ensure that the SWL Interface Prescribing Policy and outputs as a result of the SWL Medicines Optimisation Programme are adhered to by all clinicians and other healthcare staff and are required to provide assurances to the CCG. This would include measures to ensure that:

- policies, pathways and guidelines are brought to the attention of new staff
- breaches are followed up as a matter of urgency within clinically appropriate timescales
- medication-related quality incidents are reported, investigated and learning is shared with the SWL Medicines Optimisation Group.

To avoid delays to continuity of care, named contacts for resolution of any breaches must be in place. In the first instance, any breaches should be discussed between the provider's responsible Chief Pharmacist or Medicines Lead and the Chief Pharmacist of the host commissioner and brought to the attention of the provider's Drugs and Therapeutics Committee (or equivalent) as appropriate and if unresolved be addressed through the Clinical Quality Reference Group (CQRG).

The CCG and linked Trusts / Community Services and other providers to which this policy applies should jointly monitor compliance with this policy through regular review at interface prescribing committees (or equivalent) and should report to other commissioners through the SWL Medicines Optimisation Group.

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

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

2.2 The provider should aspire to adhere to "Professional Standards for Hospital Pharmacy Services – For providers of pharmacy services in or to acute hospital, mental health, private, community service, prison, hospice and ambulance settings" published by the Royal Pharmaceutical Society (version 3, December 2017), share an action plan as a result of the baseline audit conducted against these standards with their host commissioner by 30 April 2019 and provide an annual update on implementation of their action plan thereafter.

2.3 Providers should ensure they have a Drugs and Therapeutics Committee (or equivalent) in place to co-ordinate the use of medicines, dressings, appliances, enteral feeds, oral nutritional supplements, glucose monitoring strips and any other items that are issued on prescription in a

similar way as medicines. The Drugs and Therapeutics Committee (or equivalent) should develop an up-to-date formulary (or equivalent) with the involvement of primary care and their CCG pharmacists, acknowledging the primary care impact of such decisions (where applicable). Processes for the Drugs and Therapeutics Committee (or equivalent) and formulary decisions must comply with the recommendations set out in "Innovation Health and Wealth; Accelerating Adoption and Diffusion in the NHS" and NICE Medicines Practice Guidance (MPG1) - "Developing and updating local formularies" (last updated Oct 2015).

2.4 Providers should ensure that their local Drugs and Therapeutics Committee (or equivalent) fully engages with the SWL Joint Formulary Committee and should ensure that they have a process in place to implement recommendations from the SWL Joint Formulary Committee in a timely manner. Provider prescribing and recommendations should be from the SWL joint formulary (or equivalent). Providers should have internal processes to ensure clinicians are aware of any updates and ensure that prescribers do not seek to avoid restrictions by asking GPs to prescribe non-formulary items.

2.5 The provider's formulary (including SWL joint formulary) should be published on the provider's website in a timely manner, i.e. within 1 month of any decision.

2.6 Providers should have in place, introduce or strengthen governance arrangements for the managed entry of new devices which are (to be) issued on prescription in a similar way as medicines, using a process which is similar to Drugs and Therapeutics Committees (see item 2.3). This requirement is applicable for devices used by all healthcare professionals including clinicians, nurses, physiotherapists, dieticians and other allied health professionals who prescribe, issue or recommend devices for NHS patients.

2.7 It is the responsibility of the provider, through its governance processes, to ensure that locally agreed / SWL Joint formularies and guidelines (including associated processes) are adhered to by all prescribers and healthcare professionals involved in the care of patients provided by (or on behalf of) the provider.

2.8 Provider prescribing should be from the provider's formulary (or equivalent) and providers should ensure that prescribers do not seek to avoid restrictions by asking GPs/primary care to prescribe non-formulary items.

2.9 Providers are expected to:

- ensure that medicines and devices are used in patients who meet national and local commissioning criteria
- have local processes to manage any demand that falls outside such criteria
- collaborate with commissioners to put systems in place to monitor uptake and compliance of agreed criteria.

2.10 Providers are expected to give due consideration to recommendations from Regional Medicines Optimisation Committees and share any other formulary decisions and documents used to aid the decision making process with SWL Trusts and if possible with the London Medicines Evaluation Network, in order to increase consistency of access to medicines across SWL and reduce duplication of effort in the decision making process.

2.11 Providers are expected to provide assurances through the SWL Medicines Optimisation Group that recommendations of Regional Medicines Optimisation Committees are implemented in their respective organisations, in consultation with commissioners, as appropriate.

2.12 Providers will contribute to the local arrangements for the managed entry of new medicines. This must consider the clinical and cost-effectiveness of new medicines, the impact on primary as well as secondary care and all related issues (e.g. delivery of care and commissioning arrangements). There should be adequate documentation of the decision-making process.

2.13 Any service, resource or financial support offered by a pharmaceutical company, other commercial or external partner either directly or indirectly, needs to be considered through the

provider's governance process to ensure that a full impact assessment has taken account of the implications for the overall health economy.

2.14 Any value added services offered with any medicines, devices, dressings, appliances, enteral feeds, oral nutritional supplements, glucose monitoring strips and any other items that are issued on prescription, in a similar way as medicines, should go though the provider's governance processes and should not be the sole determining factor on which basis one product is chosen over another. Any such decisions should involve commissioners if prescribing is to be continued in primary care or if the cost of the product is charged to commissioners.

2.15 Where there is a change in commissioning arrangements in the future (e.g. if commissioning of chemotherapy is transferred back to CCGs), robust systems and processes must be put in place in the preceding year, to manage the entry of new medicines and relevant prescribing protocols. This will ensure that there is appropriate governance in place and that evidence based, clinically safe, cost effective decisions are made.

2.16 Prescribers and pharmacists should recommend, dispense and label by generic name except where this is clinically inappropriate.

2.17 Providers should routinely dispense medicines in patient packs, in order to comply with the latest European Community directives on pharmaceutical labelling, and the provision of information to patients. Where patient packs are not clinically appropriate (e.g. short-term leave for mental health patients, risk of self harm, continuing dose adjustment), providers should make alternative arrangements to ensure patients receive such information.

2.18 Providers should have the following up-to-date policies approved by their Drugs and Therapeutics Committee (or equivalent):

- Medicines Policy
- Safe and secure management and handling of controlled drugs
- Safe and secure management of prescription forms
- The use and disposal of patients own medicines
- Medicines reconciliation
- Self-administration of medicines by patients
- Development and maintenance of a formulary
- Use of unlicensed medicines and medicines used for unlicensed indications
- Working with the pharmaceutical industry
- Non-medical prescribing
- Patient Group Directions
- Private patient care: NHS patients who wish to pay for additional private care
- Homecare
- Adherence support (in place or in development)

2.19 Adherence to above policies should be monitored and an annual report should be submitted to the SWL Medicines Optimisation Group when requested, which identifies adherence / non-adherence and any remedial action plan where indicated.

2.20 Specifications should reflect principles contained in local, national and professional guidance including the NSFs (National Service Frameworks), NICE Technology Appraisal Guidance and relevant HSC (Health Service Circulars), NHS EL (NHS Executive Letters) and HSG (Health and Safety Guidance) and Audit Commission reports. In particular prescribing responsibility between primary and secondary care clinicians should be based on "Responsibility for prescribing between primary & secondary/tertiary care" (version 1, January 2018; publications gateway reference: 07573).

2.21 Legal responsibility for prescribing lies with the healthcare professional who signs the prescription and it is the responsibility of the individual prescriber to prescribe within their own level of competence. For further information see the General Medical Council's 'Good practice in prescribing and managing medicines and devices' (2013) (http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp).

2.22 When a primary care professional takes responsibility for continuing to prescribe items which are not normally available in the community, there should be liaison between the transferring provider pharmacy and the community pharmacy to ensure continuity of supply.

2.23 Providers should exercise discretion in purchasing to ensure the most cost-effective medicine for primary care is used if prescribing is to be continued in primary care.

2.24 Providers wishing to prescribe any CCG-commissioned drugs excluded from National Tariff must adhere to the 'SWL Commissioning Principles for PbR Excluded Drugs/Devices 2020/21 (see section 3).

2.25 Providers are expected to prescribe and supply in a manner that minimises the potential for waste.

2.26 Providers are expected to support the principles of antibiotic stewardship in ensuring appropriate use and selection of antibiotics. This includes addressing patient beliefs about the clinically appropriate use of antibiotics and ensuring consistency in the messages given to patients in primary and secondary care. This particularly applies to patients attending urgent and emergency care settings who may already have seen a healthcare professional in primary care.

2.27 Robust, reliable and secure communication mechanisms should exist to ensure information about a patient's medication is available to appropriate professionals responsible for his/her care.

2.28 Providers should ensure that patients have easy access to a pharmacy team member for medicines advice during a care episode or, where appropriate, after transfer to another care setting.

2.29 Evidence of relevant NICE guidance implementation should be publicised on the provider organisation's website and evidence of compliance may be requested (e.g. audit).

2.30 Providers are expected to implement the recommendations of NHS Patient Safety Alerts and other drug alerts within the specified time frames and participate in any relevant audits.

2.31 If applicable, the provider is expected to continue work on implementing the recommendations from the Carter report as reflected in NHS improvement model hospital toolkit. Where there is overlap the provider should link their Hospital Pharmacy Transformation Programme (HPTP) with the SWL Medicines Optimisation Programme in order to achieve a joined up programme to optimise the use of Medicines across SWL (ref: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf). The provider should provide regular updates on progress (including any issues) against these programmes and ensure this is reported to their organisation's executive committee.

2.32 The provider is expected to continue work with SWL commissioners and support implementation of the SWL Medicines Optimisation Programme. The provider should update local/joint formularies and guidelines as appropriate, in order to drive optimal value and outcomes for medicines. This programme currently includes the following work streams which are likely to be refined further over time in consultation with the SWL Medicines Optimisation Group:

- **Optimising secondary care drug pathways**, which are evidence based, cost-effective, safe and of high quality and meet the QIPP (quality, innovation, productivity and prevention) agenda in the context of the local health economy
- **DROP-list / de-prescribing drugs review-** stopping or switching medicines or products which are considered to be a low priority, poor value for money or where safer alternatives exist
- **Reduction of pharmaceutical waste**- general and in care homes
- **New models of care and formulary review**, including wound care, oral nutritional supplements, stoma and incontinence
- **Promoting self care and prevention**

- **Other transformation approaches**- also in view of organisational changes the provider is expected to work with commissioners to explore system wide working and new models of care

2.33 The provider will work with commissioners to implement agreed recommendations as part of the SWL Medicines Optimisation work stream on "Secondary Care drug pathways" for rheumatology, gastroenterology, dermatology, ophthalmology and other clinical areas which may be prioritised in the future in a timely manner.

2.34 In line with national guidance to promote self-care and NHS England guidance on prescribing over the counter medicines, all providers are expected to implement the SWL position statements on prescribing for self-care and over the counter medicines by ensuring all formularies and guidelines mention the need to sign post patients to local pharmacies for advice and to buy such products where applicable. This particularly applies to urgent care centres, out-patient clinics and accident and emergency departments (see https://www.swlmcg.nhs.uk/Policies/Pages/Self-Care.aspx).

## 3. Funding

Following the re-organisation of the NHS, drugs/devices excluded from the Tariff will either be:

- Commissioned by the Specialised Commissioning Group (SCG) which is part of NHS England OR
- Commissioned by Clinical Commissioning Groups (CCGs).

This section relates to drugs/devices commissioned by CCGs only.

3.1 See latest version of "SWL Commissioning Principles for PbR Excluded Drugs/Devices 2020/21" for details. All drugs/devices are normally included in the National Standard Contracts unless they are specifically excluded from the National Tariff or where separate arrangements have been agreed. The CCG will agree specific funding mechanisms for Payment by Results (PbR) excluded drugs/devices assigned to CCGs with providers. Unless otherwise stated funding for NICE Technology Appraisals is included in the Tariff.

3.2 Exclusions to the contract may be subject to specific reporting requirements.

3.3 Unpredicted in-year cost pressures, excluding NICE Technology Appraisals, will be managed by discussion between the provider and the lead commissioner, and will be clearly communicated to all commissioners in advance.

3.4 A process is in place for considering funding for patients on the basis of an Individual Funding Request (IFR). See current IFR guidance and associated documents.

3.5 Cost pressures identified as a result of horizon-scanning, including NICE Technology Appraisals, will be managed by discussion between the provider and the lead commissioner, and will be clearly communicated to all commissioners in advance.

3.6 Providers should submit any business cases, business proposals and service developments relating to medicines, devices and other items used at the interface or issued on discharge with significant financial or service implications via the established contracting process. Although it is encouraged that any proposals relating to medicines are shared with the lead pharmacist of the host commissioner and the SWL Medicines Optimisation Group for consultation as appropriate, the contractual process will have to be used before any proposals can be considered and agreed.

3.7 Inflationary uplifts identified by commissioners for prescribing or NICE Technology Appraisal implementation should be realised in providers' prescribing budgets.

## 4. Admission arrangements / Medicines Reconciliation

4.1 The GP referral letter should be sent at or before admission and must include relevant information about the person and their medicines, as per NICE guideline 5 [NG5, March 2015]. This should include but is not limited to the following information:

- Medicine history
- Current medicines - name, form, strength, dose, timing, frequency and indication (also 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 medicine allergies and reactions to medicines or their ingredients, and the type of reaction experienced (see NICE clinical guideline 183)
- 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, including details of any compliance aids issued e.g. reminder charts)
- 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) or alternative system should be used to facilitate the transfer of information on medicines.

4.2 Medicines management arrangements on admission should be in line with national guidance (NICE Guideline 5, March 2015) on medicines reconciliation and should include:

- Provision of information to patients before planned admissions about the arrangements in the provider e.g. for bringing in own medicines, self-administration, use of patients own medicines, dispensing for discharge.
- Arrangements for medicines history taking, pharmacist review of medication and medicines reconciliation
- Exclusions for day cases

4.3 Primary care 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. It is the provider's responsibility to ensure that arrangements are in place to ensure any elements of treatments are available as appropriate. This will be subject to on-gong monitoring.

## 5 In-patients

5.1 The CCG encourages 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 into hospital. If the patient has brought their own medicines into hospital and they are suitable for use these can be used on the wards in line with the provider's local policy.

5.2 The CCG 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

6.1 Patients should normally be discharged from providers with a **minimum** supply of 14 days or an original pack, whichever is higher (including providers employing dispensing for discharge

systems), unless the full course of treatment is less, 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). This applies to new and existing medicines when the patient's own medicine supply is less than 14 days on discharge (but not if there is a minimum of 14 days of patient's own medicine supply left, or the patient will receive such a supply through an existing repeat prescription). However please see 2.34; providers should ensure that national and local guidance to promote self-care and NHS England guidance on prescribing over the counter medicines is implemented at discharge.

6.2 The requirement to supply a minimum of 14 days of medication on discharge also applies to patients requiring adherence support or multi-compartment compliance aids (see 6.9 for further details).

6.3 Discharge information should be available on the day of discharge to ensure there is ample time to set up on-going supplies 14 days following discharge.

6.4 The GP should be provided with relevant information about the person and their medicines, as per NICE guideline 5 [NG5, March 2015], which should include but is not limited to 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 (see sections 6.5 and 6.6)
- Medicines advised for self care
- For all new medication, the duration of treatment should be provided where appropriate (e.g. clopidogrel, proton pump inhibitors, antibiotics)
- 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" (see section 13), arrangements for on-going supply should be communicated on the discharge summary
- If patients are initiated on oral nutritional supplements, enteral 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 on-going prescribing/supply
- Any review and/or (ongoing) 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 medicine allergies and reactions to medicines or their ingredients, and the type of reaction experienced (see the NICE Clinical Guideline 183 "Drug allergy: diagnosis and management", Sept 2014)
- Any other information needed – for example 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

6.5 For patients admitted for a reason unconnected with their previous medication regimen, e.g. for surgery, the discharge information must list any medicines added and still in use at discharge.

6.6 Discharge information should be sent to the patient's GP in line with NHS Standard Contract 2020/21 and 2020/21 Technical Guidance.

6.7 Patients should be provided with written information about obtaining further supplies of medicines including hospital /specialist only medicines.

6.8 Patients at risk of experiencing problems managing their medicines should be identified, and if appropriate, a referral made for pharmaceutical support.

6.9 **Adherence Support**
Providers are encouraged to develop discharge planning arrangements for vulnerable patients where a need for adherence support is identified. Adherence support may include, but is not limited to: large labels, easy-to-open tops, reminder charts, or monitored dosage systems. Where these include the supply of monitored dosage or similar systems, an assessment for appropriateness should 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 (see *https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Support/toolkit/rps-mca-july-2013.pdf*). Providers should have a policy in place for their use including appropriate arrangements for continuity after discharge. The requirement to supply a minimum of 14 days of medication on discharge applies to patients requiring adherence support, including patients requiring multi-compartment compliance aids. If the latter is not possible, the provider should provide a multi-compartment compliance aid containing a minimum of 7 days supply and ensure that arrangements are in place for on-going supply following discharge, including availability of discharge information on the day of discharge. This is subject to change pending further work between commissioners and providers to explore more integrated assessment of patients on discharge as well as alternative adherence support options.

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 Primary healthcare teams should advise patients to take a list of all current medicines they are taking to all outpatient consultations to allow a comprehensive assessment by the specialist. In most cases this can be obtained as an FP10 list from the GP practice.

7.2 Medication should be provided for outpatients in line with national and local policy and take account of national and local guidance to promote self-care and NHS England guidance on prescribing over the counter medicines is implemented in outpatients/ day case settings (see also 2.32).

7.3 This may include writing to the primary care prescriber and suggesting the required medicines if not needed for immediate treatment i.e. initiation not required within 14 days. When recommending treatment, the consultant should recommend a therapeutic class of medicine, rather than a specified product where possible. Patients should be informed that the medicine is not urgent and that they should make a routine appointment with their GP after 14 days. Patients should also be provided with written information explaining that their medicine is not urgent and that the provider will be writing to their GP to recommend the medication required. Full information must have been received by the GP to enable a prescription to be issued - the interim advice letter/outpatient medication referral form should normally be received within 7 days. Where this is not possible/appropriate (see 13.1), patients should (continue to) receive supplies from the provider (see appendix 9 and 10 for exclusions/exceptions).

7.4 Length of outpatient prescription supplies for any hospital outpatient service provided in the community must be agreed with the relevant commissioner, but must be sufficient supply for a patient's immediate needs, at least up to the point where the clinic letter has reached the GP and the GP can then prescribe on an ongoing basis.

7.5 The following categories must be prescribed by the provider (see also sections 12 and 13):
- Medicines required for immediate treatment (i.e. initiation required within 14 days)
- Hospital / specialist only drugs included in appendix 1
- Medicines agreed with the CCG as hospital/specialist only

- Medicines requiring continued monitoring or where an agreement to shared care is pending (appendix 2)
- Provider based clinical trials

7.6 Where a prescription is issued, the quantity provided should be a minimum of 14 days supply. Patient packs should normally be dispensed unless the full course of treatment is shorter. A longer supply may be indicated e.g. where the dispensed pack cannot be easily divided; for diabetics receiving insulin, for tuberculosis treatment (these should be provided free of charge to patients from providers); when the consultant feels there are clear medical reasons for supplying the whole course (monitoring requirements) or when on-going treatment is part of a commissioned service (e.g. IVF).

7.7 Primary care should not be asked to prescribe medicines and other items which are intended to be used/administered in provider's out-patient clinics, day-care surgery (e.g.: intra-uterine levonorgestrol implants, topical anaesthetic creams) or in patient's home if provided as part of a package of care or medicines required as part of a planned procedure. It is the provider's responsibility to ensure that arrangements are in place to ensure any elements of the treatments are available as appropriate. This will be subject to on-going monitoring.

Note: This does not apply to those medicines which have been prescribed by the primary care prescriber for patient's use at home and which the patient has brought into hospital as a "patients own medicine" for an in-patient stay (see sections 4.2 and 5.1).

7.8 Patients should be copied into correspondence with their primary care prescriber wherever possible. Provider clinicians should follow best practice national guidelines regarding copying of correspondence to patients.

## 8 People at risk of harm

8.1 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.

8.2 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 taking certain medicines such as valproate.

8.3 Providers should ensure that patients receiving biologic medicines are issued with a biologic alert card and emphasise to patients the importance of showing this card when accessing healthcare services.

## 9 Homecare

9.1 Providers that issue medicines through the homecare route should adhere to all national policy or guidance published as a result of the Hackett Report, "Homecare Medicine –towards a vision for the future (http://media.dh.gov.uk/network/121/files/2011/12/111201-Homecare-Medicines-Towards-a-Vision-for-the-Future2.pdf) "including the Royal Pharmaceutical Society's – *Professional Standards for Homecare Services***.**

9.2 Providers should have a strategy for homecare medicines developed with the local Drugs and Therapeutics Committee (or equivalent) and an annual homecare plan which the provider's Chief Pharmacist needs to deliver in line with section 9.1.

9.3 Suitable arrangements for setting up homecare services, including the responsibilities of providers and CCGs and funding arrangements should be clearly identified and agreed prior to setting up the service.

## 10. Dressings, Appliances, Feeds and Glucose Monitoring Strips

10.1 The provider will work with the commissioner when contracts are negotiated for the procurement or supply of items which may require on-going prescribing in primary care. This includes procurement of incontinence and stoma products, glucose monitoring devices, dressings and feeds (including oral nutritional supplements).

10.2 Suitable local arrangements should be in place for the supply of dressings, appliances, enteral feeds and oral nutritional supplements. A minimum of 7 days supply should be provided. 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 (see also section 6.4 regarding communication with GPs).

10.3 Providers should only supply oral nutritional supplements (ONS) on discharge if accompanied by a nutritional management plan, including MUST score. For clarification, providers should ensure all patients have:

- been properly assessed as needing ONS during any episode of care and on discharge
- clear communication sent to the GP and other relevant healthcare professionals / carers including the information below and whether any further supplies are needed once hospital supply runs out:
    - Anthropomorphic measurements (weight, BMI and MUST score)
    - Goals of ONS treatment and dietetic intervention
    - Dietetic treatment summary including education provided to the patient/carer
    - Assessment of SWL ONS prescribing criteria for the ONS to continue in primary care
    - Underlying cause(s) of compromised nutritional status and support provided
- a review and monitoring plan including targets, review dates and responsibilities (e.g. action required by the GP, referral to community dietetics)
- where possible, the ONS should be changed to the most cost-effective product for primary care on discharge. The letter should inform the patient that their ONS prescription may be changed following discharge to primary care in line with primary care prescribing guidelines. Refer to SWL Adult ONS Guidelines for further information on appropriate ONS prescribing on secondary care discharge (see *http://www.swlmcg.nhs.uk/Clinical/Pages/Oral-Nutritional-Supplements.aspx*).

10.4 Providers should not request primary care to prescribe dressings/ appliances, enteral feeds, oral nutritional supplements outside of the CCG agreed formulary/guidance where available.

10.5 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.

## 11 Patients Attending Urgent and Emergency Care Settings

11.1 Although there are no specific requirements within the NHS Standard Contract, patients attending an urgent and emergency care setting should receive a supply of prescription medicines for a minimum of 7 days, or shorter if the medicines are not required for that length of time. However please see 2.32; providers should ensure that national and local guidance to promote self-care and NHS England guidance on prescribing over the counter medicines is implemented in urgent and emergency care settings.

11.2 Information should reach the GP at least 3 days before the treatment runs out and should include the minimum data set for medicines reconciliation as specified in section 6.4.

11.3 Principles of antibiotic stewardship should be followed to ensure appropriate use and selection of antibiotics. This includes addressing patient beliefs about the clinically appropriate use of antibiotics and ensuring consistency in the messages given to patients in primary and secondary care especially if the patient has already seen a healthcare professional in primary care.

## 12 Unlicensed Medicines or Medicines Used Outside of their Licensed Indication(s)

12.1 Prescribing of unlicensed medicines or medicines used outside their licensed indication, including 'specials', should usually remain the responsibility of the clinician initiating treatment. The provider will accept full responsibility for the continued sourcing, quality and supply, which should be under the control of the initiating provider. 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 licensed medicine used outside of its licence (e.g. supported by 'BNF for Children'), 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 should be documented in the provider's policy for use of unlicensed medicines and medicines used for unlicensed indications. 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 must be obtained before prescribing responsibility is transferred.

12.3 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.

## 13 When Responsibility for Prescribing Normally Remains with Providers

See Appendix 1 - Hospital / Specialist Only Drugs List

13.1 The provider is expected to retain responsibility for prescribing in the following circumstances:

- Medicines requiring on-going specialist intervention and specialist monitoring
- Patients receive the majority of on-going care, including monitoring, from the provider and the only benefit of transferring care would be to provider costs
- Medicines which are unlicensed or are being used outside of product license (e.g. licensed medicine used for 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 sections 12.1 and 12.2
- Medicines which are only available through the provider i.e. are not available on FP10, including any "borderline" products when 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 participate in a shared care prescribing arrangement where applicable
- No shared care prescribing agreement exists and the GP does not feel competent in taking on clinical responsibility for the prescribing of a specialist medicine
- Medicines and other items (e.g. dressings) which are intended to be used/administered in the provider's out-patient clinic or during day-case surgery (e.g. intrauterine levonorgestrel implants, local anaesthetic creams)
- Medicines and other prescribable products which have not been 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 (EL(95)5)
- 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
- Without collaboration and agreement with the patient and/or carer.

13.2 Any proposed changes to the SWL list of "Hospital/Specialist Only Drug" list including proposals for new shared care prescribing guidelines (see section 14) or transfer of care arrangements (see section 15), will require consideration of impact on the total care pathway, including any financial implications. As such providers and the CCG will be expected to present relevant data as part of any new proposals before these can be considered. Anything with significant financial implications cannot be implemented unless considered and approved as part of the prioritisation round for the following year. The CCG and providers will endeavour to ensure that any prescribing is in the most appropriate setting and that financial implications will be considered but should not normally be a barrier to achieving this.

13.3 Care should 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 cases. If there is disagreement about where prescribing of an individual patient's treatment should best take place, the case should be referred to the CCG, via the Chief Pharmacist who will seek resolution. Disagreements over the principles of prescribing responsibility are probably best resolved at the local interface prescribing committee or equivalent.

13.4 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; e.g. by extending the length of prescriptions to last until the next clinical review, use of FP10HP prescriptions which can be posted to the patient, arrange for the patient to collect repeat medication from the provider's pharmacy at agreed intervals.

13.5 Primary care should be informed of any medicines that continue to be supplied by the provider. Discharge and outpatient letters should clearly state that these medicines are to be supplied by the provider and that primary care is not expected to prescribe. GP practices should include this information on clinical systems to ensure that they have a full medication history for their patients.

## 14 Shared Care Prescribing: Sharing care including prescribing for medicines requiring on-going specialist monitoring

See:
**Appendix 2:** SWL Shared Care Prescribing Guidelines and Transfer of Care Agreements in place
**Appendix 5A:** SWL Principles of Shared Care
**Appendix 5B:** Shared care prescribing guideline template

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. See also GMC guidance on shared care (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/shared-care)

14.1 It is the responsibility of the consultant to ensure that the GP is willing to prescribe **before** confirming shared care arrangements with 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.**

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 ongoing 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 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/ information leaflet, which clearly defines the responsibilities of all parties, and which has been approved by the provider's Drugs and Therapeutics Committee (or equivalent) with GP involvement, and by the CCG Medicines Management or similar committee
- 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.

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

14.5 A framework for the production and use of shared care prescribing guidelines in SWL is detailed in Appendix 2A (Principles of Shared Care).

14.6 Providers are expected to continue to support the CCG/CSU with updates of existing and development of new shared care prescribing guidelines in a timely manner in order to secure participation in any such agreements and ensure implementation across their organisation. Any proposals for new or changes to existing shared care prescribing guidelines require consideration of impact on the total care pathway, including any financial implications (see also 13.2).

14.7 A list of shared care prescribing guidelines and the organisations approving their use is detailed in Appendix 2.

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

See:
- **Appendix 2:** SWL Shared Care Prescribing Agreements and Transfer of Care Agreements in place and
- **Appendix 6:** Transfer of care document template

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 (see section 14) because the patient will not require ongoing specialist monitoring or follow up. See also GMC guidance on sharing information with colleagues (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/sharing-information-with-colleagues).

15.1 'Transfer of Care' forms contain additional standardised information, the content and format of which are agreed through the SWL Medicines Optimisation Group. They ensure that the transfer of prescribing responsibilities to the GP is considered and safe. It can be used for medicines that are relatively new or medicines which were not previously routinely prescribed in primary care (e.g. on hospital / specialist only list) or used infrequently. They provide an opportunity for the GP to seek further advice where needed when receiving a request to accept transfer of care.

15.2 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.**

15.3 It would not normally be expected that a GP would decline to prescribe on the basis of cost. However due to the nature of the medicines for which a transfer of care is requested, the GP needs to ensure that they have all the required information and knowledge to safely take on

prescribing responsibility and seek additional information / clarification from the provider if required.

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

15.5 Providers are expected to continue to support the CCG/CSU with updates of existing and development of new 'Transfer of Care' forms in a timely manner in order to secure participation in any such agreements, and ensure implementation across their organisation. Any proposals for new or changes to existing transfer of care arrangements require consideration of impact on the total care pathway; including any financial implications (see also 13.2).

15.6 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.

15.7 A list of Transfer of Care forms agreed for use in SWL is detailed in Appendix 2.

## 16. Patient Group Directions (PGDs)

16.1 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.

## 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:

- 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.

## 18 Tertiary Care Referrals

18.1 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 medicines

initiated by tertiary care referrals if this is compliant with all criteria listed above, in particular section 13, 14 and 15.

18.2 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 (e.g. High tech home health care schemes EL(95)5 or use FP10HPs).

18.3 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 in section 13, 14 and 15 should be applied.

18.4 GPs should be informed of any medicines that continue to be supplied by the provider. Discharge and outpatient letters should clearly state that these medicines are to be supplied by the provider and that the GP is not expected to prescribe.

## 19. Subcontracting to a Third-Party Provider

19.1 Commissioners recognise that providers may wish to explore alternative methods of service delivery and medication supply e.g. outsourcing of outpatient dispensing, provision of a hospital service by an out of area provider. However, for all services and medicines supply provided to the populations of the SWL CCG, the provider and subcontractor must ensure that they meet the medicines standards and follow governance processes of the CCG. Commissioners must be included in any such discussions and finally agree any subcontractor arrangements.

## 20 Clinical Trials & Ethics Committees

20.1 All clinical trials must have been subject to Research Ethics Committee approval, when the arrangements for consulting and informing should be considered. Trials should also have been through the local or regional NHS Research Governance process. This should take account of whether or not the trial is in line with strategic objectives of the organisation (for research and clinical care) and any continued supply of medicines at the end of the trial if required. In order to respond appropriately to any suspected adverse events that occur outside the provider setting, the GP should be adequately informed if a patient is participating in a clinical trial following patient consent and record this in the patient's notes.

20.2 Prescribing and supply of clinical trial medicines 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 normally include the cost of the trial medicines either during or after the trial unless specifically agreed with the relevant commissioner. Any excess treatment costs need to be agreed with the host commissioner and will be considered in line with the latest national guidance on funding Excess Treatment Costs related to non-commercial research studies.

20.3 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 should continue, post-trial costs will only be funded where prior agreement has been reached with the relevant commissioner(s).

This document was originally based on a London Framework Prescribing Policy and has subsequently been amended annually and approved by the SWL Medicines Optimisation Group which represents the organisations listed in the footer of this document.

**Document updated by:** Brigitte van der Zanden, SWL Lead Commissioning Pharmacist (January 2020)

# APPENDICES

This policy document is accompanied by the following appendices. Appendix 1, 2, 3, 4, 5A, 5B and 6 are available from www.swlmcg.nhs.uk. Appendix 1 and 2 are subject to regular review by the SWL Medicines Optimisation Group.

**Appendix 1: SWL Hospital / Specialist only drug list** (available from www.swlmcg.nhs.uk; updated periodically-presentation is subject to change)
**Appendix 2: SWL Shared Care Prescribing Guidelines and Transfer of Care Agreements in place** (available from www.swlmcg.nhs.uk; updated periodically-presentation is subject to change)
**Appendix 3: Decision Support Tool to determine place of prescribing** (available from www.swlmcg.nhs.uk)
**Appendix 4: Proforma for suggesting changes to SWL Hospital/Specialist only drug list** (available from www.swlmcg.nhs.uk)
**Appendix 5A: SWL Principles of Shared Care** (available from www.swlmcg.nhs.uk)
**Appendix 5B: Shared care prescribing / Transfer of prescribing and monitoring guideline template** (available from www.swlmcg.nhs.uk)
**Appendix 6: Transfer of care document template** (available from www.swlmcg.nhs.uk)

## Appendix 7: Exclusions/Exceptions to the Policy applicable to Mental Health

The following exclusions/exceptions to the policy have been agreed with South West London & St George's Mental Health Trust; however, it is implicit that the general principles would normally apply to all Mental Health providers. For numbering please refer to main document.

**2 & 7 General Principles & Outpatients/Day case**

2.8 and 7.6 Patient packs

For reasons of compliance monitoring, patient safety, etc., original packs may not be appropriate for out-patients and those going on incremental leave prior to discharge and occasionally, at the point of discharge from hospital or home treatment team.

## Appendix 8: Exclusions/Exceptions to the Policy applicable to Community Services providers

The following exclusions/exceptions to the policy have been agreed with Community Services providers. For numbering please refer to main document.

**2.9 Policies**

Homecare – Not applicable to community services providers.

## Appendix 9: Exclusions/Exceptions to the Policy applicable to Acute Trusts

The following exclusions/exceptions to the policy have been agreed with the following Trusts. For numbering please refer to main document.

**7. Outpatients/Day Case**

7.3 Not applicable to Epsom and St. Helier University Hospitals NHS Trust.

## Appendix 10: Exclusions/Exceptions to the Policy applicable to other providers

The following exclusions/exceptions to the policy have been agreed with the other providers. For numbering please refer to main document.

**7. Out-patients/Day Case**

7.3 Not applicable to patients attending the Nelson Health Centre: in these situations, a minimum of 4 weeks supply of any new medication must be supplied at each consultation, unless specifically agreed otherwise with the relevant commissioner.