South East London Interface Prescribing Policy Introduction

This policy has been developed by the South East London Clinical Commissioning Group (CCG) Medicines Management leads. It has undergone consultation with the Medicines Management/Drug and Therapeutics Committees for Acute and Mental Health Trusts and boroughs forming South East London Clinical Commissioning Group (SEL CCG). The policy has been approved by the SEL Area Prescribing Committee (SEL APC).

The policy clarifies the role of GPs, Acute Hospital clinicians, Mental Health clinicians, community consultants and aims to facilitate consistent prescribing across SEL through better communication between clinicians.

All prescribing decisions must consider patient safety and provide high value care.

Implementation and enforcement of this policy is the responsibility of each Trust and CCG with exceptions reports to be highlighted in contract meetings.

1. General Principles

1.1 Legal responsibility for prescribing lies with the doctor/independent prescriber who signs the prescription.
1.2 All patients should continue to receive the most appropriate drug therapy when necessary and in the most appropriate setting.
1.3 Prescribing responsibility must be based on clinical responsibility. Responsibility for prescribing lies with the clinician who, at the time, has clinical responsibility for a patient and is able to monitor treatment and adjust dose as necessary. This is in the best interest of patients.
1.4 Clinicians must recommend treatment by drug class except where it is clinically inappropriate (see also point 1.12). Pharmacists must dispense and label by generic name unless clinically appropriate to use the brand name.
1.5 The hospital will dispense medicines routinely as patient packs unless there are clinical reasons not to, in order to comply with European Community directive 92/27/EEC on pharmaceutical labelling, and the provision of information to patients.
1.6 The CCG expects providers to adhere to the guidance contained within the following circulars

- Responsibility for Prescribing Between Primary ,Secondary and Tertiary Care, NHS England 29 January 2018
- EL(94)72 ‘ Purchasing and Prescribing’
- EL(95)5 ‘ Purchasing high-tech health care for patients at home’
- Commercial sponsorship in the NHS, Dept of Health Nov 2000.
- National guidance on over-the-counter medicines and items that should not be routinely prescribed

This list is not exhaustive and compliance with all relevant circulars and guidance is required.

1.7 Trusts should have a discharge policy in place that includes arrangements for the transfer of prescribing information to GPs including standards of 6.2 of this policy.
1.8 Trusts should notify within 24 hours of discharge to GPs for ongoing management including any changes in prescribing especially if prescribing was initiated during investigation of unconfirmed condition or awaiting formal diagnosis.
1.9 Trusts to carry out medicines reconciliation as set out in the NICE guideline NG5 Medicines optimisation
1.10 GP prescribing under a shared care arrangement should only be considered when the patient's condition is stable, prior agreement of the GP has been sought, and the GP has sufficient information to safely prescribe for the patient. The CCG may require Trusts to work within locally agreed Shared/Transfer of Care document although this may not be necessary for all drugs and an individual management plan may suffice. (See section 7)
1.11 The South East London Area Prescribing Committee and the South East London Joint Medicines Formulary Committee should develop an up-to-date formulary/prescribing guidelines and treatment pathways for common and high cost drugs with the involvement of GPs and CCG Borough Prescribing Advisers. These pathways should have embedded within them drug choice, RED, AMBER, GREEN, GREY (RAGG) status and signpost to shared care where appropriate.
1.12 The majority of prescribing by hospital clinicians should be in line with the Joint Medicines Formulary, or prescribing guidelines/position statements. Where, exceptionally, a patient's treatment necessitates the prescribing of a non-formulary drug, the hospital clinician should first obtain in-house approval via Trust non-formulary processes and then discuss the choice of drugs and reasons for prescribing outside the formulary with the individual GP.
1.13 When supplying medication to patients on discharge or in clinic or when recommending medications for GPs to supply – to have regard to guidance published by NHS England for GPs on conditions for which over-the-counter items should not routinely be prescribed and items which should not be routinely prescribed.

2. In-patients (person admitted to hospital for the purpose of observation, care, diagnosis and treatment)

2.1 All drugs, enteral nutrition, dressings and appliances prescribed for administration pre-procedure or for while an in-patient are the responsibility of the consultant concerned. All necessary drugs and dressings will be supplied by the Hospital Trust (subject to paragraph 2.2).
2.2 Patients own drugs remain their own property and should be returned to them on discharge from hospital, providing such therapy is still appropriate. Patients own drugs, with the agreement of the patient, may be used while the patient is in hospital until a supply is made by the hospital pharmacy or where a policy exists regarding the use of patient's own drugs. They may be used to fulfil discharge medicine requirements.
2.3 When a patient is discharged from hospital, ensure that patients have a minimum of 14 days of drugs including patients own supply at home (unless trust maintaining responsibility for supply), supplied in the form of a patient pack wherever possible or 7 days in compliance aids where appropriate, or via FP10HP to community pharmacy for compliance aids where appropriate, or 5 days of dressings should be supplied (subject to paragraph 2.2) unless the full course of treatment calls for a shorter supply. The amount

should be sufficient to ensure safe continuation of treatment prior to GPs taking over prescribing responsibility. *Where there is an agreed national tariff charge such that the tariff paid from an inpatient episode includes that the Trust retain responsibility for patients for a period of rehabilitation (which may be less or more than 30 days post discharge), then in accordance with guidance, provision of drug therapy for this period will be part of the Trust responsibility.*

2.4 Providers should have in place a policy for use of Patients' Own Drugs, Self-Administration of Medication, Dispensing Medicines for Discharge, and the use of Compliance aids (including monitored dosage systems), this should include liaison between primary and secondary care and appropriate arrangements for continuity of care after discharge, supply of amber/red medicines supplied by the provider and work towards a sector approach.

3. Accident and Emergency, Urgent Care Centres

3.1 A minimum 5 days' supply of drugs and/or dressings needed should be given unless the full course of treatment requires for a shorter supply. Self-care should be encouraged for example with OTC analgesia. Full course of antibiotics and steroids should be given if duration known and is less than 2 weeks.

3.2 Patients own drugs should remain with the patient during the time of their assessment (unless unsafe to do so when e.g. safe storage of medicines is unavailable) and transferred with them if they are admitted or sent home, unless clinically inappropriate.

4. Outpatients (A person who is not an inpatient, not hospitalised)

4.1 Drugs and dressings and appliances prescribed for administration during a hospital outpatient consultation should be provided by the Trust.

4.2 If immediate treatment is required following an outpatient consultation, a minimum of 14 days of drugs (supplied in the form of a patient pack wherever possible) and a minimum of 5 days of dressings should be supplied by the hospital, unless the full course of treatment requires a shorter supply. Patients to be advised on the importance of a hospital supply for urgent treatment rather than a delayed supply from their GP. A separate policy exists for the supply of medicines for end of life care.

4.3 When the patient does not require an immediate supply, the patient should be informed that their treatment is not urgent. The clinician must fill out all relevant sections (including diagnosis, allergies, prescribing information and contact details of prescriber) of the Out-Patient Referral form and tick the 'Non-Urgent' box. Patients should be advised that it can take up to 3 working days for a GP to process requests for new medication and to issue an FP10. All relevant information enabling the GP to prescribe, should reach the practice as soon as possible but no longer than 10 working days.

4.4 There may be instances where the patient may not require an immediate supply of medication but the drug being recommended requires specialist initiation. *Either all* prescribing of the treatment is hospital only (i.e. RED drugs,) or initial supplies are from the hospital (i.e Amber 2) where the hospital supplies an initial portion of treatment, and Amber 3, where the initial supplies are by the hospital and SE London shared care arrangements are followed. In these instances the initial supply should be made by the

hospital and the shared care process outlined in section 7 of this document should be implemented.

5. Day Case Patients (a person that requires an intervention to be performed in hospital but doesn't need to stay overnight)

5.1 Drugs and dressings prescribed for administration during day case treatments are the responsibility of the consultant concerned (subject to paragraph 2.2). All necessary drugs and dressings for administration pre-procedure or for a day case will be supplied by the Trust (subject to paragraph 2.2).

5.2 Discharge medication for day case patients are subject to prescription charges as per out-patients. A minimum of 14 days of drugs (supplied in the form of a patient pack wherever possible) and a minimum of 5 days of dressings should be supplied, unless the full course of treatment requires a shorter supply.

6. Transfer of Information

6.1 On referral to a hospital consultant for a planned attendance, it is the responsibility of the GP to give comprehensive details of a patient's relevant medical history, drug treatment, previous adverse reactions, allergies and any use of compliance aids

6.2 On discharge from hospital or the community, clinicians must provide the patients GP with information on diagnosis and reason for admission, patient's medication on discharge including hospital supply medications, including whether to continue or stop, any medication changes and reasons for the changes. In addition any relevant clinical or biochemical monitoring parameters should be communicated highlighting further monitoring to be undertaken by the GP. The information provided should include the recommended core content of records for medicines when patients transfer care providers as outlines in the RPS guidance "keeping patients safe when they transfer between care providers- getting the medicines right" and NICE guideline NG5 Medicines optimisation. This information must be made available to the patient's GP ideally within 24 hours but no longer than 72 hours of discharge to allow ongoing treatment to be maintained. If this cannot be guaranteed, then the hospital should prescribe for as long a period as necessary.

7. Shared Care

7.1 The process for agreeing and implementing shared care guidelines in SEL and shared care guidelines approved by the SEL APC can be found at the Committee's website.

8. Special considerations

8.1 Responsibility for prescribing will remain with the hospital consultant where;

- Drugs are undergoing or included in a hospital based clinical trial or for compassionate use
- The consultant considers that only they are able to monitor the patient's response to medication because, for example, of the need for specialised investigations
- A drug or appliance is not available on a FP10 or is only available through the hospital

- Drugs subject to High-tech Hospital at Home guidance, EL(95)5
- GP does not feel confident taking on clinical responsibility for prescribing of specialist drugs. Where agreements have been made at medicines management/DTC meetings, GPs should be encouraged to prescribe in line with these.(Disagreements should be resolved at the local Interface meetings)
- Red drug from RAGG list of drugs. Exceptional circumstances to be discussed between consultant and GP as per RAGG list definitions

8.2 GPs are encouraged to continue to prescribe medicines for off-label indications where such use is approved in evidence based guidelines or is established practice. Unlicensed drugs remain the responsibility of the hospital consultant except where evidence exists to support the use of an unlicensed medicine (e.g APC amber recommendation).

8.3 Where a treatment that is not listed in 8.1 is wished to be used but is not licensed for a particular indication, the GP must be informed and the consultant should give full justification for the use of the drug to the GP. Consultant to ascertain the GP has agreed to be responsible for prescribing before handed over to primary care.

9. New Drugs and Clinical Trials

9.1 The process for managing the entry of new drugs must consider clinical and cost-effectiveness and the impact on Primary Care prescribing. In South East London, the process for managing the entry of new drugs that will impact on primary care or are CCG commissioned is through the SELAPC after review by the triage panel. Submissions will be considered through the Medicines Pathway Review Group, which is the working group of the SELAPC. Submissions for hospital only, in tariff drugs will be considered through the Joint Formulary Committee.

9.2 Clinicians should refer to the Terms of Reference for the SEL APC for detail on how New Drug applications should be submitted; these can be accessed via the Committee's website.

9.3 Individual SEL CCG Broughs will need to ensure that a process is in place by which GPs are informed of decisions for new drugs, approved or rejected, by the SEL APC.

9.4 All clinical trials must have been subject to Ethical Committee approval. The hospital clinician is responsible for informing the GP if a patient is participating in a clinical trial.

9.5 Prescribing and supply of clinical trial, compassionate or patient access scheme material is the responsibility of the Hospital Trust. The CCG will not automatically continue compassionate or clinical trial medicine funding once the compassionate funding or clinical trial ends. Trusts must discuss on-going treatment with appropriate commissioners.

9.6 Patients should be made aware that funding for clinical trial medication may not be available once the trial comes to an end.

10. Commissioning of NICE technology appraisals

SEL CCG will fund treatments that fall within local commissioning responsibilities which are recommended by a NICE Technology Appraisal. Funding will be within the time frame stipulated in the NICE guidance (usually within 3 months of the final NICE publication).

Providers supplying such treatments prior to the formal commissioning date stipulated in the NICE Technology Appraisal (e.g. under an early access scheme) are required to ensure that separate arrangements for funding are in place up to the stipulated date for formal commissioning.

11. National shortage of medicines

Where a medication is initiated in a Trust and continued in Primary Care and there is a national shortage, Trusts and Commissioners will work together to ensure patients' care is not adversely affected and will provide advice on alternative options during the shortage. In these scenarios it may be necessary to temporarily amend formulary restrictions, or make non-formulary products available if this is the most appropriate clinical course of action.

12. National medicines value programme

Commissioners and providers will work collaboratively to promote and implement the national Medicines Value Programme (MVP), which aims to improve health outcomes and ensure the best value from medicines. Initiatives covered by the MVP include:
- Decreasing or stopping the use of medicines which are neither clinically- or cost-effective
- Promoting the self-care agenda, including associated SEL APC resources
- Increasing the use of best value biological and generic medicines, including biosimilar medicines where appropriate
- Supporting antimicrobial stewardship
- Supporting implementation of guidance from the NHSE Regional Medicines Optimisation Committee (RMOC)

SEL CCG Borough Medicines Management Team Contact Details

Bexley	020 8298 6000 (switchboard)	bexley.mmt@nhs.net
Bromley	01689 866228	BROCCG.Medicinesmanagement@nhs.net
Greenwich	020 3049 9000 (switchboard)	GRECCG.Pharmacy@nhs.net
Lambeth	020 3049 4197	lamccg.medicinesoptimisation@nhs.net
Lewisham	020 7206 3200 (switchboard)	LEWCCG.medicinesoptimisationteam@nhs.net
Southwark	020 7525 3253	souccg.medicines-optimisation@nhs.net