Surrey Interface Prescribing Policy
Appendix to Service Level Agreements

1 Introduction

This policy has been produced by Surrey’s Area Medicines Management Steering Group (adapted from the South West London Interface Prescribing Policy) as best practice and is to be agreed by Acute and Primary Care Trusts, Drug and Therapeutics / Prescribing Committees in Surrey.

The aim is to facilitate consistent prescribing policies in Service Level Agreements (SLAs) across Surrey.

It is recommended that Acute and Primary Care Trusts seek the advice of their Chief Pharmacists/Pharmaceutical Adviser during the commissioning process and Local Delivery Plan discussions to ensure that implications for pharmacy and prescribing are taken into account.

CCGs and Trusts should jointly monitor compliance with this policy through regular review at the Area Medicines Management Steering Group.

2 General Principles

The following general principles should be included in all contracts:

2.1 Hospital Trusts should ensure they have a Drug and Therapeutics Committee (or equivalent) in place to co-ordinate medicine use. The Drug and Therapeutics Committee should develop an up-to-date formulary (or equivalent) with the involvement of GPs and the CCG Pharmaceutical Commissioning Team / Medicines Management Team. Hospital prescribing should be from the Hospital Trust formulary (or equivalent) and prescribers should not seek to avoid restrictions by asking GPs to prescribe non-formulary medicines. The trust formulary must comply with the recommendations set out in Innovation Health and Wealth in relation to formularies.

2.2 Hospital Trusts will contribute to the local arrangements for the managed entry of new medicines via the Prescribing Clinical Network. This should consider the clinical and cost-effectiveness of new medicines and the impact on primary as well as secondary care.

2.3 Hospital Trusts will provide a written response quarterly confirming that the decisions made by the Prescribing Clinical Network (PCN) are implemented within 3 months. If there are exceptional circumstances when a recommendation is not implemented this needs to be stated (see implementation of PCN recommendations).

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

2.5 Hospital Trusts should routinely dispense medicines in patient packs, in order to comply with European Community directive 92/27/EEC on pharmaceutical labelling, and the provision of information to patients. Where patient packs are not clinically appropriate, providers should make alternative arrangements to ensure patients receive such information.

2.6 The Hospital Trust should have policies approved by their Drug and Therapeutics Committee for:

- Development and Maintenance of a Formulary
- The use and disposal of patients own medicines in hospital

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2.7 Specifications should reflect principles contained in local, national and professional guidance including the NSFs, NICE Technology Appraisal Guidance and relevant HSC, EL and HSG and Audit Commission reports. In particular prescribing responsibility between primary and secondary care clinicians should be based on EL (91)127.

2.8 Legal responsibility for prescribing lies with the doctor who signs the prescription.

2.9 When a GP takes responsibility for continuing to supply drugs which are not normally available in the community, there should be liaison between the transferring hospital pharmacy and the community pharmacy to ensure a continuity of supply of the drug.

2.10 Hospitals should exercise discretion in purchasing and prescribing to ensure drug prices reflect cost implications in primary care.

2.11 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.

2.12 Evidence of compliance with NICE guidance may be requested e.g. audit

3 Funding

3.1 All medicines are normally included in the SLA unless they are specifically excluded from Tariffs or where separate arrangements have been agreed (see the CCG’s Payment by Results Drug & Device Exclusions Commissioning Intentions Document). CCGs will agree specific funding mechanisms, for excluded drugs, with Acute Trusts. Unless otherwise stated funding for NICE technology appraisals is included in the tariff.

3.2 Pass-through payments are additional payments for use of a particular device, technology or drug and can be made to providers over and above the relevant tariff reimbursement. CCGs and providers must agree payment is intended primarily for new devices, drugs, treatments or technologies or to new applications of existing technology. For any pass-through payment arrangement the following criteria and conditions apply:
  - The pass-through arrangement should be fixed for a maximum of 3 years
  - CCGs should have regard to the existing cost effectiveness evidence including any NICE guidance or other relevant national guidance
  - The price attached to the pass-through funding should be agreed in advance and the price should only relate to the additional costs associated directly with the device or technology and its use relative to the cost of the alternative treatment

3.3 Exclusions to the contract may be subject to specific reporting requirements

3.4 Unpredicted in-year cost pressures, excluding NICE technology appraisals, will be managed by discussion between the Hospital Trust and the lead commissioners, and will be clearly communicated to all commissioners in advance. A process is in place for considering funding for individual patients on an exceptional basis.
3.5 Cost pressures identified as a result of horizon-scanning, including NICE technology appraisals, will be managed by discussion between the Hospital Trust and the lead commissioners, and will be clearly communicated to all commissioners in advance.

3.6 Inflationary uplifts identified by commissioners for prescribing of NICE TAG implementation should be realised in Trust prescribing budgets.

4 Admission arrangements

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

4.2 Medicines management arrangements on admission should include:
- Provision of information to patients before planned admissions about the arrangements in the hospital for e.g. bringing in own medicines, self-administration, use of patients own medicines, dispensing for discharge.
- Arrangements for medicines history taking and pharmacist review of medication

5 In-patients

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 with them into hospital. The Hospital Trust is responsible for the supply of any new medicines or continuation of existing medicine to in-patients, when the patient’s own supply drops below 14 days. If the patient has brought their own medicines into hospital with them and they are suitable for use these can be used on the wards in line with local policy.

The CCG and Hospital Trusts encourage the use of “green-bag” and “message in a bottle” schemes.

6 Discharge Arrangements (see also the discharge protocol)

6.1 Patients should be discharged from hospital with a supply of medication in line with local policy, minimum 14 days (including Trusts employing dispensing for discharge systems), unless the full course of treatment is less or the patient is palliative when a quantity appropriate to the patient’s needs should be supplied.

6.2 The GP should be provided with the following information about the patient's medicine:
- Notification of diagnosis and reason for admission
- Medicine on discharge and with an indication of whether the medicine should be continued after initial supply (see 6.3 and 6.4)
- Any monitoring required including anticipated increase/decrease in dose
- For all new medication, the duration of treatment should be indicated where appropriate (e.g. clopidogrel, PPIs, antibiotics)
- Clear instructions on medications (reasons for taking them, dosage, when to take them, potential side effects and any other additional instructions)
- Any changes to medication brought in on admission with reason for change
Details of medicines tried in hospital but which proved unsuitable

6.3 For patients admitted for a reason unconnected with their previous medication regimen, e.g. for surgery, the discharge information must list any drugs added and still in use at discharge. If the remaining drugs are unchanged then the discharge notification can say “Other drugs as before”.

6.4 For admissions unrelated to a patient’s pre-existing drug treatment and where there is no change in any medicine at discharge, the discharge information should state “no changes made”.

6.5 Discharge information should be sent to the patient’s GP at the time of discharge. Discharge information should be electronic and sent within 24hrs of patient discharge to the GP and copied to patient (or within 1 working day in cases where the patient has died).

6.6 Patients should be provided with appropriate information about obtaining further supplies of medicine.

6.7 Monitored Dosage Systems and other Compliance Aids
Hospital Trusts are encouraged to develop discharge planning arrangements for vulnerable patients. Where these include supply of monitored dosage or other similar systems there should be a policy in place for their use including making appropriate arrangements for continuity after discharge.

6.8 Dispensing for Discharge (One Stop Dispensing)
Acute trusts are encouraged to employ a dispensing for discharge system in line with the Audit Commission report ‘A Spoonful of Sugar’ 2001.

7 Out-patients/Day Case

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

7.2 In some Trusts this may include writing to the GP and suggesting medicines if not required for immediate treatment i.e. initiation not required within 14 days. When recommending treatment the consultant, where possible, should recommend a therapeutic class of drug, rather than a specified product. Patients should be told that the medicine is not urgent and that they should contact their surgery in approx 14 days time who will inform them when to collect their prescription. Full information must have been received by the GP to enable a prescription to be issued – the interim advice letter should normally be received within 7 days. Where this is not possible, patients should receive supplies from the hospital.

7.3 The following categories must be prescribed by the hospital:
- Medicines required for immediate treatment (i.e. initiation required within 14 days)
- Hospital only drugs
- Drugs agreed with the CCG as hospital only (Red drugs)
- Drugs requiring continued monitoring or where an agreement to shared care is pending (Amber or Amber-star Drugs)
- Hospital based clinical trials

7.4 Where a prescription is issued the quantity provided should be in line with local policy. 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 treatments (these should be provided free to patients from the Hospital Trust); when the consultant feels there are clear medical reasons why he should supply the whole course (monitoring requirements).

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7.5 GPs should not be asked to prescribe medicines and dressings which are intended to be used/administered in hospital out-patient clinics or day-care surgery. (e.g. intrauterine levonorgesteral, implants). (note: this does not apply to those medicines which have been prescribed by the GP for patient's use at home and which the patient has brought into hospital as a “patients own medicine” for an in-patient stay).

8 Homecare

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

The Trust should have a strategy for homecare medicines developed with the local drugs and therapeutics committee and an annual homecare plan which the Trust Chief Pharmacist needs to deliver in line with the recommendations of the Hackett Report – Homecare Medicines ‘Towards a Vision for the Future’.

9 Dressing and Appliances

9.1 Suitable local arrangements should be in place for the supply of dressings and appliances. A minimum of five days supply should be provided. Sufficient information about a patient's dressing and appliance treatment should be provided to ensure continuity of care in the community.

9.2 The Hospital Trust should not be requesting GPs to prescribe dressings outside of the CCG’s dressing formulary.

9.3 No arrangements should be made by the Hospital Trust with appliance contractors for ongoing supplies of dressings or appliances in the community without involving patients in the decision about where their prescriptions are dispensed.

10 Patients attending Accident and Emergency

10.1 If a medicine is necessary, a minimum of 7 days should be supplied, unless the full course of treatment is shorter.

10.2 Information should reach the GP at least 3 working days before the treatment runs out and should include a minimum data set for medicines reconciliation as per local policy

11 Unlicensed Medicines (see also Prescribing Clinical Network’s Recommendations to Prescribers on the Use of Unlicensed Medicines and Licensed Medicines for Unlicensed Indications)

11.1 Prescribing of unlicensed medicines should usually remain the responsibility of the clinician initiating treatment. The Hospital Trust will accept full responsibility for the continued sourcing, quality and supply, which should be under the control of the Hospital Trust Pharmacy Department.

11.2 Informed consent for the use of unlicensed medicines or the use of licensed medicines outside their licensed indications should be obtained from patients before the prescription is written.

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11.3 Where there is a substantial body of evidence to support the use of an unlicensed medicine or a licensed medicine outside of its licence (e.g. in pediatrics), the GP may be asked to prescribe. However the GP must be fully informed and made aware of the licensing status. The GP should refer to the BNF / Children’s BNF as a guide for prescribing of unlicensed medicines / licensed medicines outside of licence. The full agreement of the GP concerned must be obtained before prescribing is transferred.

12 When Responsibility for Prescribing Remains with Hospital Trust Consultants

(See Appendix 2: Prescribing Advisory Database - updated website to be launched shortly)

12.1 The Hospital Trust is expected to retain prescribing responsibility for medicines where:

- Medicine has been commenced in the Hospital Trust and needs specialist ongoing intervention and monitoring
- Medicines are unlicensed or are being used for an unlicensed indication or at an unlicensed dose (see section 11 for clarification)
- Medicines are only available through Hospital Trusts i.e. are not available on FP10 including certain ‘borderline’ products when used outside approved indications.
- Medicines are part of a Hospital Trust initiated clinical trial or the continuance of a hospital initiated clinical trial or compassionate use, where no arrangement has been made in advance with the purchaser to meet the extra cost of the treatment.
- No shared care exists or the GP does not feel confident in taking on clinical responsibility for the prescribing of a drug

12.2 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 Pharmaceutical Commissioning or Interface Pharmacist who will seek resolution between parties concerned. Disagreements over the principles of prescribing responsibility, not individual disagreements that are resolved case by case, are probably best resolved at the Prescribing Clinical Network. Care 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 situations.

13 Transfer of prescribing Medicines Requiring Specialist Monitoring

(See Appendix 2: Prescribing Advisory Database - updated website to be launched shortly)

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.

13.1 It is the responsibility of the consultant to request shared care with a GP. The key principle is that the GP is provided with information and given the opportunity to accept prescribing responsibility before the transfer takes place.

13.2 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 hospital then prescribing must remain with the hospital and must not be transferred solely on the basis of cost.
13.3 The following conditions should be met before the shared care takes places:

- The patient’s condition is stable on the initiated medicine.
- Treatment is in accordance with a patient-specific shared care protocol / information leaflet which clearly defines the responsibilities of all parties, and which has been approved by the Trust DTC with GP involvement and by the CCG Medicines Management Committee (or equivalent).
- The written agreement of the patient’s GP is given prior to the transfer of prescribing.
- The GP is sufficiently informed and able to monitor treatment and identify medicines interactions.

13.4 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 Tertiary Care Referrals

It is expected that the care and treatment of patients referred to tertiary care will remain the responsibility of the tertiary centre while they continue to require specialist care.

14.1 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 using FP10(HP)s).

14.2 In some circumstances it may be appropriate to transfer prescribing to a more local Hospital trust or more rarely a GP. In all situations there should be robust processes in place between the tertiary centre, Hospital Trust and GP to ensure timely and accurate transfer of a patient's medication details to appropriate professionals responsible for his/her care.

15 Clinical Trials & Ethics Committees

15.1 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 Trust’s 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 continued supply of medicines at the end of the trial. In order to respond appropriately to any suspected adverse events that occur outside hospital, the GP should be adequately informed if a patient is participating in a clinical trial.

15.2 Prescribing and supply of clinical trial medicine is the responsibility of the Hospital Trust. Standard out-patient or in-patient treatment costs will be met for patients on a trial as required by HSG(97)32; this will not include the cost of the trial medicines either during or after the trial.

15.3 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 considered for funding by CCGs where exceptional circumstances exist.
APPENDIX 1

Following the reorganisation of the NHS, drugs will either be:
- commissioned by the specialised commissioning group (SCG) which are part of the NHS England
  OR
- commissioned by the Clinical Commissioning Groups (CCGs)

FOR CCG COMMISSIONED DRUGS NORMALLY FOR HOSPITAL PRESCRIBING ONLY

Products which meet any of the following criteria are not normally suitable for shared care arrangements and as such prescribing responsibility remains with secondary / tertiary care:

- Patients receive the majority of on-going care, including monitoring, in hospital and the only benefit to transferring care would be to hospital costs
- Drugs being used outside licensed indications that are not in common usage and / or doses
- Unlicensed drugs only in certain cases
- The product is being used as part of a hospital-based clinical trial
- The product is only available through hospitals: drugs, dressings or appliances which are not available or prescribable in general practice
- The individual GP is unable to monitor therapy sufficiently to oversee treatment and / or adjust the dose where necessary to ensure safety
- Complex monitoring & specialist drugs: patients attending the hospital frequently for complicated treatments and specialist investigations with the consultant monitoring progress
- GPs have insufficient information to participate in a shared care arrangement
- Where NICE or PbR has ruled that the intervention be excluded (unless specified in the CCG’s commissioning intentions document)
- New classes of drugs and new indications for older drugs: where clinical experience is limited in general practice
- Drugs that have not gone through due consideration processes in each Trust and CCG
- Packages of care:
  - CCG commissioned injectable antibiotics, antifungals and antivirals (unless special local arrangements exist)
  - Drugs for IVF (see local CCG policy)
  - All orphan drugs commissioned by CCGs e.g. Agalsidase (Fabrazyme)
  - Insulin pumps (package of care)

*Orphan drugs are those designated by the EMEA to promote development of drugs to treat rare diseases or conditions. They have marketing exclusivity for 10 years with assistance from the EMEA in optimising drug development and applications for marketing approval.
APPENDIX 2

PRESCRIBING ADVISORY DATABASE (PAD)

The Prescribing Advisory Database (PAD) will provide guidance on the use of medicines across the interface between primary and secondary care.

Each drug entry on the PAD has been assigned a Traffic Light Status which is a locally agreed colour-coded guidance system on the use of medicines across the interface between primary and secondary care. It provides a framework for defining where clinical and therefore prescribing responsibility should lie. The system is only advisory but is intended to clarify expectations of prescribing responsibility.

The PAD is an innovative resource which can be accessed by healthcare professionals in primary and secondary care and by patients. The website is currently being updated and a new web address will be sent shortly.

The PAD provides guidance and key information on medicines use within Surrey. You can search by medicine, condition or NICE technology appraisal. Information available on the PAD includes:

- Recommendations, decisions, policy statements and submission papers from our Prescribing Clinical Network and Medicines Commissioning Group
- Links to associated NICE Technology Appraisals
- Relevant drug / safety alerts issued by the NPSA, EMEA and the MHRA
- Local Policies, procedures, protocols and guidelines relating to the use of medicines
- Materials used in the course of optimising medicines use e.g. audit tools, letter templates

It is also intended that key decisions made by the local Acute Trust Drugs and Therapeutic Committees (Frimley Park Hospital NHS Foundation Trust, Ashford and St Peter's Hospitals NHS Foundation Trust, Epsom & St Helier University Hospitals NHS Trust, Royal Surrey County Hospital NHS Trust, Surrey & Sussex Healthcare NHS Trust, Surrey & Borders Partnership NHS Foundation Trust) will be made available on the PAD.

Surrey Traffic Light System

Red

For specialist use in secondary / tertiary care – prescribing to be initiated and continued by the specialist.

Amber

Prescribing to be initiated by a hospital specialist (or if appropriate by a GP with specialist interest) but with the potential to transfer to primary care when:

- an individual GP has agreed to accept clinical responsibility for an individual patient
- agreed shared care arrangements have been established and the GP is willing to take over shared care
- the patient’s condition and/or treatment has been stabilised

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In one off situations, a specific GP can agree to enter into a 'shared care arrangement' without a formal shared care guideline providing a letter is sent to the GP giving appropriate advice and guidance.

the request is accompanied by a written proposal that the GP is happy to accept. This may take the form of a shared care guideline or other written communication. For a drug that is regularly transferred from secondary to primary care then a formal shared care protocol should be set up, however for a one off arrangement with one GP then a letter containing appropriate advice and guidance should be sufficient. The key principle is that the GP is provided with the information and given the opportunity to accept prescribing responsibility before transfer takes place. These drugs should be initiated and prescribed by a secondary care specialist until the patient is stabilised on treatment in order to monitor their response, adjust dosage and treat side effects. Once the patient is stabilised (usually within 3 months but see individual shared care protocols) the GP can be asked to agree shared care.

Amber*

Drugs that in principle are in the amber category but due to more widespread experience in primary care GPs are generally happy to prescribe on specialist advice without the need for a formal shared care protocol. These drugs will have information sheets available on the Prescribing Advisory Database (PAD). It is therefore not necessary for the specialist to send a copy to the GP for individual patients with the clinic letter (work is currently ongoing to produce these information sheets and in the interim a more detailed clinic letter will suffice). A minimum of one month’s supply of medication will be provided by the initiating consultant.

Green

These are drugs that can be initiated and/or continued in primary, secondary or tertiary care. By default any drugs not listed under red or amber should be considered green.

Black

These are drugs that have been reviewed by the Prescribing Clinical Network and have been considered as not suitable for routine prescribing within Surrey. They are therefore not routinely recommended for prescribing in Primary or Secondary Care. This may be due to a lack of good clinical evidence, cost effectiveness, concerns over safety or due to the availability of more suitable alternatives.

As such drugs classified as Black should be considered as non-formulary in Surrey Acute Trusts (Frimley Park Hospital, Ashford & St Peter’s Hospitals, Epsom & St Helier Hospitals, Royal Surrey County Hospital, Surrey & Sussex Healthcare NHS Trust).