

Surrey Interface Prescribing Policy

Appendix to Service Level Agreements

1 Introduction

This policy has been adapted from the NHS Surrey Interface Prescribing Policy as best practice and is to be agreed by all providers commissioned to deliver services which include prescribing and drugs.

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

It is recommended that providers seek the advice of their Chief Pharmacist/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 Providers should jointly monitor compliance with this policy through regular review via their routine interface and contracting mechanisms.

2 General Principles

The following general principles should be included in all contracts:

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 including shared care. All medicines will be prescribed, handled, maintained, stored, administered and disposed of in accordance with relevant legislation and best practice.

2.2 Providers will 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. Decisions taken at this committee should be made in line with the recommendations set out in NICE MPG1. The Drugs and Therapeutics Committee will be responsible for the dissemination and implementation of the interface prescribing committee within the provider trust.

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

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

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

*Prescribable items include but are not limited to nutritional supplements, dressings, catheters, stoma items and blood glucose monitoring strips.

2.6 Providers will provide assurance 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. Drugs classified as

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Black on the Surrey traffic light system should be considered as non-formulary in Surrey providers (See Appendix 1. for Surrey traffic light definitions).

2.7 All shared care documents must be approved through the trust Drugs and Therapeutics Committee and returned to the CCG with the trust logo and contact details for the relevant department and clinicians in the back-up advice and support section of the document within 3 months of their approval by the Prescribing Clinical Network.

2.8 Prescribers and pharmacists should prescribe and/or recommend, dispense and label by generic drug name except where this is clinically inappropriate.

2.9 Providers 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.

2.10 Providers should have the following policies in place and approved by their Drug and Therapeutics Committee:

- Medicines Policy
- Safe and secure management and handling of controlled drugs
- Safe and secure management of prescription forms
- Working with the pharmaceutical industry
- Development and Maintenance of a Formulary
- The use and disposal of patients own medicines
- Medicines Reconciliation
- Self-administration of medicines by patients
- Use of unlicensed medicines and medicines used for unlicensed indications
- Non-medical prescribing
- Development and implementation of shared care protocols
- Homecare

2.11 Specifications should reflect principles contained in local, national and professional guidance including 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 the Department of Health Guidance: Responsibility for prescribing between hospitals and GPs EL (91) 127 1991.

Legal responsibility for prescribing lies with the health care professional who signs the prescription. **For further information see the [General Medical Council's Good practice in prescribing and managing medicines and devices \(2013\)](#).**

If a GP agrees to take responsibility for continuing to supply drugs which are not normally available in the community, there should be liaison between the transferring provider pharmacy and the community pharmacy to ensure a continuity of supply of the drug.

2.12 Providers will be expected to prescribe and supply in a manner that minimises the potential for waste

2.13 Providers should exercise discretion in purchasing and prescribing to ensure prices reflect cost implications in primary care.

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- 2.14 Robust, reliable and secure communication mechanisms should exist to ensure information about a patient's medication is available in a timely manner to appropriate professionals responsible for his/her care.
- 2.15 Providers are expected to implement the recommendations of NHS Patient Safety Alerts and other drug alerts within the time frames specified within the alerts and participate in any relevant audits
- 2.16 Providers wishing to prescribe any CCG-commissioned drugs excluded from Payment by Results (PbR) must adhere to the CCG commissioning intentions document for PbR drug and device exclusions (see Section 3 for information on funding).
- 2.17 Evidence of NICE guidance implementation should be publicised on the provider organisation's website and evidence of compliance may be requested

3 Funding

- 3.1 All new and existing drugs and technologies should be provided within the scope of National Tariff guidance unless:
- explicitly excluded from tariffs as described by the Department of Health Payment by Results exclusion list 2015/16 and funding agreed with commissioners, or
 - as part of excluded services or
 - through local arrangements agreed with the commissioners

The 2015/16 Payment by Results excluded drugs Commissioning Intentions document will contain all drugs and indications that are expected to be prescribed in 2015/16 in line with the scoping horizon work undertaken between November 2014 and January 2015. A finalised copy of this document which will be agreed for all Surrey Trusts will be submitted in January 2015.

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

A full data set will be submitted for all drug charges and any subsequent challenges. This includes:

- Indication
- NHS number
- Hospital number
- Patient's GP details (Practice code and/or GP name, and postcode)
- Current dose at which prescribed (including daily dose / dose interval)
- Weight of patient if dose is weight based e.g. Infliximab
- Drug name (generic)
- Quantity supplied
- Date of issue
- Acquisition costs of drugs on the invoice (on request but should be same as price charged)

- 3.2 The provider must give confirmation that the patient (or in the case of a minor or vulnerable adult, with the parent/legal guardian/carer) has given appropriate explicit consent for relevant personal, confidential, and sensitive information to be passed to the CCG for processing a funding request and for validating subsequent invoices. This includes the CCG Pharmacy Team who are responsible for approving funding of PbR excluded drugs and IFRs, confirming continuing response to treatments and processing invoices. Consent is only required ONCE at the point of funding request.

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- 3.3 Drug charges must be for the drug only and at acquisition cost or at nationally/locally procured/contracted prices, whichever is lower. There will be no additional charges automatically added to drug prices without prior discussion and explicit agreement with commissioners and in accordance with National Tariff rules.
- 3.4 It is the responsibility of the provider to ensure that all National, Surrey and Sussex wide agreed patient access schemes (PAS) are put in place within the provider and all such drugs will be charged to the commissioners as per the detail of the PAS Challenges to invoices will be responded to by the provider within the prescribed time frame for all challenges as agreed.
- 3.5 Where separate arrangements have been agreed (see the CCG Payment by Results Drug & Device Exclusions Commissioning Intentions Document), CCGs will agree specific funding mechanisms and treatment pathways, for excluded drugs, with providers. Unless otherwise stated funding for positive NICE technology appraisals is included in the tariff.
- 3.6 Pass-through payments are additional payments for use of a particular device, technology or drug and can be made to providers over and above the relevant tariff reimbursement. CCGs and providers must agree 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
 - Where pass-through funding for a more expensive treatment has been agreed on the basis that other costs to the health economy will be reduced, providers should be able to demonstrate that the projected benefits have been realised.
- 3.7 Exclusions to the contract may be subject to specific reporting requirements
- 3.8 Unpredicted in-year cost pressures, excluding NICE technology appraisals, will be managed by discussion between the Provider and the commissioners, and will be clearly communicated to all commissioners in advance. A process is in place for considering funding for individual patients on an exceptional basis.
- 3.9 Cost pressures identified as a result of horizon-scanning, including NICE technology appraisals, will be managed by discussion between the Provider and the commissioners, and will be clearly communicated to all commissioners in advance.

4 Admission arrangements/medicines reconciliation

- 4.1 The GP referral letter 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 or allergies
 - any significant medical history
 - reason for referral / suspected diagnosis
- 4.2 Medicines management arrangements on admission should be in line with national guidance (NICE/NPSA PSG001) on medicines reconciliation and should include:

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- Provision of information to patients before planned admissions about the arrangements in the providers 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 providers 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 Providers. The Provider 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 the Provider with them and they are suitable for use these can be used on the wards in line with local policy.

Providers should encourage the use of "green-bag" and "message in a bottle" schemes.

6 Discharge Arrangements

6.1 Patients should be discharged from Providers 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 an indication of whether the medicine should be continued after initial supply
- 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)
- For any new drugs classified as red on the traffic light system, arrangements for ongoing supply should be communicated on the discharge summary (see Appendix 1. for traffic light system definitions)
- If patients are initiated on nutritional supplements or feeds, dressings or appliances (e.g. stoma appliances, catheters), the provider is expected to provide communication from the initiating clinician to the GP regarding the patient's clinical care plan and quantities required for ongoing prescribing/supply.
- Clear instructions on medications (reasons for taking them, dosage, when to take them, 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

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the GP and copied to the 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**

Providers are encouraged to develop discharge planning arrangements for vulnerable patients. 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. Where the supply of a monitored dosage or other similar system is appropriate there should be a policy in place for its use including making appropriate arrangements for continuity after discharge.

6.8 **Dispensing for Discharge (One Stop Dispensing)**

Providers are encouraged to employ a dispensing for discharge system in line with the Audit Commission report 'A Spoonful of Sugar' 2001.

7 Out-patients/Day Case

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

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

- 7.2 The following categories must be prescribed by the Providers:

- Medicines required for immediate treatment (i.e. initiation required within 14 days) e.g. antibiotics
- Drugs agreed with the CCG as provider/specialist only (Red drugs)
- Drugs requiring continued monitoring or where an agreement to shared care is pending (Amber or Amber-star Drugs)
- Provider based clinical trials
- Compassionate supply medicines

- 7.3 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 (e.g. antibiotics, short-term analgesia or short-course corticosteroids). A longer supply may be indicated e.g. where the dispensed pack cannot be easily divided; for diabetics receiving insulin, or when the consultant feels there are clear medical reasons why they should supply the whole course (monitoring requirements) or when ongoing treatment is part of a commissioned service.

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

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8 Homecare

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

9 Nutritional supplements, dressings, glucose monitoring strips and appliances

- 9.1 The provider will work with the commissioner when contracts are negotiated for the procurement or supply of items such as continence or stoma devices, glucose monitoring devices or feeds which may require ongoing prescription in primary care.
- 9.2 In the case of Oral Nutritional Supplements (ONS) providers should only supply feeds on discharge if accompanied with a nutritional management plan including a MUST score.
- 9.3 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. See also section 6.2 regarding communication with the GP.
- 9.4 Providers should not be requesting GPs to prescribe dressings outside of the CCG’s dressing formulary.
- 9.5 No arrangements should be made by the providers with appliance contractors for ongoing supplies of dressings or appliances in the community without involving patients in the decision about where their prescriptions are dispensed.

10 Patients attending Accident and Emergency

- 10.1 If a medicine is necessary, a minimum of 14 days should be supplied, unless the full course of treatment is shorter. This is to allow the GP sufficient time to receive the information about the patient’s A&E attendance and arrange a continuing supply.
- 10.2 Information should be sent to the GP within 3 working days and should include a minimum data set for medicines reconciliation as per local policy.

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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 or medicines used outside their licensed indications 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 Provider Pharmacy Department. In these cases, information must be given to patients explaining that they must obtain continuing supplies of their medicine only from the provider, not their GP.
- 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.
- 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 paediatrics), 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 Providers (drugs that are classified as RED on the Surrey traffic light system)

(See Appendix 1: Prescribing Advisory Database for traffic light definitions)

Note: this applies to CCG commissioned drugs only, not those commissioned by NHS England Specialised Commissioning.

- 12.1 The Provider Trust is expected to retain prescribing responsibility for medicines where:
- Medicine has been commenced in the Provider and needs specialist ongoing intervention and monitoring
 - Patients receive the majority of on-going care, including monitoring, in the Provider and the only benefit to transferring care would be to Provider costs
 - 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 the Provider i.e. are not available on FP10 including certain 'borderline' products when used outside approved indications.
 - Medicines are part of a Provider initiated clinical trial or the continuance of a Provider initiated clinical trial or compassionate use, where no arrangement has been made in advance with the purchaser to meet the extra cost of the treatment.
 - No shared care exists or the GP does not feel confident in taking on clinical responsibility for the prescribing of a drug
 - Medicines and dressings which are intended to be used/administered in outpatient clinics or day surgery
 - The individual GP is unable to monitor therapy sufficiently to oversee treatment and / or adjust the dose where necessary to ensure safety
 - GPs have insufficient information to participate in a shared care arrangement
 - Where NICE or PbR have ruled that the intervention should be excluded (unless specified in the CCG's commissioning intentions document)

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- 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 at the 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
 - 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.

- 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 Medicines Management team 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.
- 12.3 Repeat prescriptions for specialist drugs should not incur an attendance tariff charge unless the patient receives a clinical review. The provider should make arrangements for issuing medication in between clinical reviews as appropriate.
- 12.4. GPs should be informed of any drugs which continue to be prescribed by the specialist. Discharge and outpatient letters should clearly state that these drugs are to be supplied by the provider and that the GP is not expected to prescribe.

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

(See Appendix 1: Prescribing Advisory Database for traffic light definitions)

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

- 13.1 It is the responsibility of the specialist to request shared care with a GP. The key principle is that the GP is provided with information and given the opportunity to accept prescribing responsibility **before** informing the patient and before the transfer takes place. Under no circumstance should the patient be used as the mechanism for informing the GP that prescribing will be transferred to them.
- 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 Provider then prescribing must remain with the Provider and must not be transferred solely on the basis of cost.

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- 13.3 The following conditions should be met before shared care takes place:
- The initial specialist responsibilities set out in the shared care guideline have been fulfilled
 - Treatment is in accordance with a patient-specific shared care protocol / information leaflet which clearly defines the responsibilities of all parties. This document must have been approved by the Trust DTC and by the CCG Medicines Management Committee (or equivalent) and contain the trust logo and contact details for the relevant department and clinicians in the back-up advice and support section of the document.
 - The written agreement of the patient's GP is given prior to the transfer of prescribing.
 - The GP is sufficiently informed and able to monitor treatment and identify medicines interactions.

All prescribers 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.

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).

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

15 Patient Group Directions

Providers wishing to use Patient Group Directions (PGDs) to deliver any part of the service are required to develop and use PGDs within the appropriate clinical governance framework as outlined in national guidelines (e.g. NICE good practice guidance) 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.

16 Non-Medical Prescribing

Nurses, pharmacists and other allied health professionals who become qualified prescribers are expected to work within the policies and guidelines of their employing organisation and the established agreed local prescribing guidelines.

The Provider must ensure that non-medical prescribers should:

- be accountable for, and prescribe within, their own level of competence and expertise
- Seek advice and make appropriate referrals to other professionals with different expertise, when required
- Adhere to the Code of Conduct and Ethics of their regulatory body, ensuring they have sufficient professional indemnity insurance, by means of membership of a professional organisation or trade union which provides this cover
- Ensure competencies are maintained through continuous professional development and clinical supervision.

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18 Clinical Trials & Ethics Committees

- 18.1 All clinical trials must have been subject to Research Ethics Committee approval, when the arrangements for consulting and informing should be considered. Trials should also have been through the Provider 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 Providers, the GP should be adequately informed if a patient is participating in a clinical trial.
- 18.2 Prescribing and supply of clinical trial medicine is the responsibility of the Provider. Standard out-patient or in-patient treatment costs will be met for patients on a trial as required by HSG(97)32; this will not include the cost of the trial medicines either during or after the trial.
- 18.3 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.

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APPENDIX 1

PRESCRIBING ADVISORY DATABASE (PAD)

[The Surrey Prescribing Advisory Database \('PAD'\)](#) is an innovative resource which can be accessed by healthcare professionals in primary and secondary care and by patients. 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 ToRs)
- 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.

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.

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

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Acute Trusts: Ashford & St Peter's NHS Trust, Royal Surrey County Hospital NHS Trust, Surrey & Sussex Healthcare NHS Trust, Frimley Park Hospital NHS Foundation Trust, Epsom & St Helier NHS Trust, Kingston Hospital NHS Trust

- the patient's condition and/or treatment has been stabilised
- 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).

Adapted from the NHS Surrey interface prescribing policy.

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