North Central London Integrated Care System

North Central London Medicines Optimisation Network

Interface Prescribing Guidance

This operational guidance has been developed by the NCL Medicines Optimisation Network to facilitate continuity of prescribing and governance across primary, secondary and tertiary care interfaces.

This document is based on a London Framework Pharmacy & Prescribing Guidance and has been ratified by the NCL Medicines Optimisation Board on behalf of the following organisations:

Barnet, Enfield and Haringey Mental Health NHS Trust
Camden and Islington NHS Foundation Trust
Central and North West London NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trusts
Moorfields Eye Hospital NHS Foundation Trust
North Middlesex University Hospital NHS Trust
Royal Free London NHS Foundation Trust Royal National
Orthopaedic Hospital NHS Trust
University College London Hospitals NHS Foundation Trust
Whittington Health
North Central London Integrated Care Board

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1. Introduction

1.1 This guidance has been developed by the North Central London (NCL) Medicines Optimisation Network (MON) and has been ratified by NCL Medicines Optimisation Board (MOB) on behalf of all acute, community and mental health NHS provider trusts and the Integrated Care Board (ICB) in North Central London.

1.2 The aim of this document is to facilitate consistent prescribing practice across NCL and is included in the standard NHS provider contract as a schedule. The appendices may be subject to amendment.

1.3 It is recommended that all provider trusts and the ICB seek the advice of their Chief Pharmacist during the commissioning process to ensure that implications for medicines and prescribing are considered.

1.4 Most medicines are included in the National Tariff, except for nationally defined non-tariff payment system (NTPS) excluded medicines, where commissioners and providers should agree local prices and arrangements for commissioning and monitoring as described in the NCL ICB Commissioned NHS Payment Scheme for Excluded Drugs and Devices Policy.

1.5 The 'red list' is reviewed and updated on quarterly basis. The current version can be found at this link.

2. General Principles

The following general principles apply to all provider trusts and the ICB:

2.1 All provider trusts should ensure they have a Drug and Therapeutics Committee (DTC), or equivalent, in place to coordinate medicines use. Each hospital DTC should regularly liaise with the Joint Formulary Committee (JFC) regarding the most appropriate forum to assess a medicine. It has been agreed that all decisions will need to be ratified by the JFC. The JFC Terms of Reference can be found at this link.

2.2 A joint trust formulary is hosted on the NCL Joint Formulary 'NetFormulary' platform.

The majority of prescribing by hospital clinicians should be in line with their hospital formulary or prescribing guidelines.

2.3 All provider trusts will contribute to the local arrangements for the managed entry of new medicines. This should consider the clinical and cost-effectiveness, and safety of new medicines and the impact on primary as well as secondary care.

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

2.5 All provider trusts should usually 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.

2.6 All provider trusts should have policies approved by their DTC for:

- the use and disposal of patients' own medicines in hospital.
- self-administration of medicines by patients
- use of unlicensed medicines and medicines used for unlicensed indications.
- dealing with the pharmaceutical industry.

2.7 All provider trusts should comply with principles contained in local, national and professional guidance including, NICE Technology Appraisals and Guidance, relevant Health Service Circulars & Guidance, Executive Letters and Audit Commission reports.

2.8 The NCL prescribing guidance should be applied within GMC guidance 'Good practice in prescribing and managing medicines and devices'. The GMC guidance can be found at this link.

2.9 The joint General Practitioner Committee (GPC) and Consultant Committee of the BMA has produced a statement on '*Duty of care when test results and drugs are ordered by secondary care*' which provides updated advice on expectations around responsibilities for test results,

investigations and communication. These should be taken into account and wherever possible adhered to when communicating with GP practices.

2.10 Providers and commissioners in an ICS jointly agree on commissioning policies and formulary recommendations. To operate to the NHS Contract these are classified as host commissioner rules. Therefore, providers will apply these policies and recommendations to all patients undergoing treatment irrespective of the commissioner they are referred from. This includes referring to the Provider Trust's local formulary position on medicines used in the service, red list status and interface prescribing (e.g. shared care) arrangements to ensure continuity of care for patients.

Patients managed by an Out of Sector Provider should be treated the same as a patient who is registered with a GP practice within the provider Trusts host ICB i.e., out-of-area patients should be treated in line with NCL ICB approved pathways.

3. Admission Arrangements

3.1 The ICB and all local provider trusts should ensure that processes for patients being admitted into hospital are compliant with NICE guideline NG5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, 2015, particularly the following recommendations:

- Medicines-related communication systems when patients move from one care setting to another
- Medicines reconciliation

3.2 Information on prescribed medicines should be available to the hospital as soon as possible and ideally within 24 hours of admission where possible.

3.3. Patients should be encouraged to bring their own medicines into hospital with them where possible.

3.4 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.

4. In-Patients

4.1 Where possible, patients being admitted into hospital should bring in full packs of their own medicines from home. This will enable accurate medicines reconciliation, support self-administration of medicines, and reduce medicines wastage. Where possible, patients should ensure they have communicated any upcoming admissions to their community pharmacy (this will help the community pharmacist prepare any compliance aids for only the appropriate duration). The provider trust should maximise the use of patients' own medicines and is responsible for the supply of any new medicine started.

5. Discharge Arrangements

5.1 The ICB and all local provider trusts should ensure that processes for patients being admitted into hospital are compliant with NICE guideline NG5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, 2015, particularly the following recommendations:

- Medicines-related communication systems when patients move from one care setting to another
- Medicines reconciliation

5.2 Patients should be discharged from hospital with a minimum of 14 days supply, unless the

full course of treatment is less, a smaller supply is deemed appropriate on mental health grounds, or, if after assessment, it is clear the patient already has appropriate supplies at home.

5.3 Patients should be provided with appropriate written information about the medication prescribed, duration of treatment and obtaining further supplies of medicine.

5.4 Monitored Dosage Systems and other Compliance Aids:

Hospital Trusts should develop discharge planning arrangements for vulnerable patients. Where these include supply of monitored dosage or other similar systems there must be a policy in place for their use, including assessment of need and making appropriate arrangements for continuity after discharge. This arrangement should reflect guidance on support to people with disabilities, compliance with the Disabilities Discrimination Act and include community pharmacies, where appropriate.

5.5 Where appropriate, patients treated in secondary care should be referred to the post-discharge Discharge Medicines Service (DMS) and New Medicine Service (NMS) offered by community pharmacists to ensure that patients can optimise their outcomes from medicines. The DMS has been established to ensure better communication of changes to a patient's medication when they leave the hospital and to reduce incidences of avoidable harm.

5.6 A DMS referral should be considered, where appropriate, when there is a change in the patient's medication by the hospital. Referrals should be made according to the NCL DMS referral criteria (see Appendix 1) or the adapted local trust SOP. Patients who are being discharged on medicines which may require more time to dispense / supply by the community pharmacy, e.g. multi-compartment compliance aid or unlicensed medicines, should be considered for a DMS referral.

6. Out-patients/Day Case

6.1 If immediate treatment is required following an outpatient consultation, a minimum of 14 days of medicines (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.

6.2 If a medicine is required for non-urgent routine care it is appropriate to write to the GP and recommend a medicine, provided it is in the provider trust's formulary and suitable for prescribing by GPs. In this case the patient should be told that the medicine is not urgent and that they should contact their surgery after at least **7 days** when sufficiently complete written information has been received by the GP to enable the GP to make informed decisions.

6.3 The patient should take with them any relevant written information given to them by the hospital to the GP appointment. The Outpatient form must be completed fully and legibly. Where out-patient electronic prescribing exists in the provider trust, it is reasonable to inform the patient that the information to their GP will be enabled within 24 hours, and for the patient to make contact with the GP surgery within 3 working days of their appointment.

6.4 Information provided to the GP must include details of any medicines that have been stopped, the reason why the medicine has been prescribed and the intended duration of the new medicine.

6.5 If medicine is required, patient packs should be dispensed unless the full course of treatment is less or a smaller supply is deemed appropriate on clinical health grounds.

6.6 Medicines and dressings prescribed for administration during a hospital outpatient consultation should be provided by the Trust.

(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 "patient's own medicine" for an in-patient stay: see section 3)

6.7 Provider trusts should discuss with patients their preferences for ongoing supplies of medicines, dressings and appliances in the community. Patients should be informed of the

choices available in the community e.g. Community Pharmacies, appliance contractors etc. It is expected that the ICB will communicate with the provider trusts proactively to ensure this information is up to date.

6.8 Discharge medication for day-case patients are subject to prescription charges as per out-patients. A minimum of 14 days of medicines (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.

7. Transfer of Information

7.1 The GP should be provided with relevant information about the person and their medicines, as per NICE guideline, Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, 2015, which should include, but is not limited, to the following information:

- Contact details of the person and their GP
- Details of other relevant contacts identified by the person and their family members or carers where appropriate – for example, their nominated community pharmacy
- Known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced
- Details of the medicines the person is currently taking (including prescribed, over-the-counter and complementary medicines) – name, strength, form, dose, timing, frequency and duration, how the medicines are taken and what they are being taken for
- Changes to medicines, including medicines started or stopped, dosage changes, and the reason for the change
- For all new medication, the duration of treatment should be provided where appropriate (e.g. steroids and antibiotics)
- 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 ongoing prescribing/supply
- Date and time of the last dose, such as for weekly or monthly medicines, including injections
- What information has been given to the person, and their family members or carers where appropriate
- Any other information needed – for example, when the medicines should be reviewed, ongoing monitoring needs and any support the person needs to carry on taking the medicines. Additional information may be needed for specific groups of people, such as children.

8. Patients attending Accident and Emergency

8.1 If a medicine is necessary, an original pack/ pre-pack should be supplied, unless the full course of treatment is less (in line with paragraph 2.4 and Medicines Act 1968 and the Human Medicines Regulations 2012).

9. Unlicensed Medicines

9.1 The NCL JFC is responsible for assessing the safe prescribing of new unlicensed medicines, including the appropriateness of transferring prescribing to primary care. An unlicensed medicine is a medicine without a UK Marketing Authorisation. Where relevant, unlicensed medications must be initiated by the clinician in the Acute Trust.

9.2 Prescribing by a GP of an unlicensed medicine must be in line with GMC prescribing guidance.

9.3 When prescribing an unlicensed medicine you must:

i. Be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy

ii. Take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring, and any follow up treatment, or ensure that arrangements are made for another suitable doctor to do so

iii. Make a clear, accurate and legible record of all medicines prescribed and, where you are not following common practice, your reasons for prescribing an unlicensed medicine.

iv. Informed consent for the use of unlicensed medicines should be obtained from the patient by the initiating prescriber before the prescription is written. This should be documented in the handover letter to the GP.

v. GPs should not be asked to prescribe unlicensed "specials" when a suitable alternative, more cost effective dosage form/licensed product is available.

vi. If an unlicensed medicine is prescribed for a child in line with information in the Children's BNF and is not on the red list then a GP will be supported to continue prescribing.

vii. Guidance is also available from the Medicines and Healthcare products Regulatory Agency: https://www.gov.uk/drug-safety-update/off-label-or-unlicensed-use-of-medicines-prescribers- responsibilities

10. Medicines Used Outside of Their Licensed Indications (often referred to as 'off-label')

10.1 Informed consent for the use of use of licensed medicines outside their licensed indications should be obtained from the patient by the initiating prescriber before the prescription is written. This should be documented in the handover letter to the GP.

10.2 Where there is a substantial body of evidence to support the use of a licensed medicine outside of its licence (e.g. in paediatrics), the GP may be asked to prescribe. However, the licensed state of the medicine should be brought to the attention of the GP or other prescriber.

10.3 GMC prescribing guidance should also be referred to: see https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines https://www.gmc-uk.org/-/media/documents/updated-decision-making-and-consent-guidance_pdf-84160128.pdf .

10.4 When prescribing an off-label medicine you must:

i. Be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy in line with local formulary approval processes.

ii. Take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring, and any follow up treatment, or ensure that arrangements are made for another suitable doctor to do so

iii. Make a clear, accurate and legible record of all medicines prescribed and, where you are not following common practice, your reasons for prescribing an licensed medicine in an off-label capacity.

iv. Guidance is also available from the Medicines and Healthcare products Regulatory Agency: https://www.gov.uk/drug-safety-update/off-label-or-unlicensed-use-of-medicines-prescribers- responsibilities .

11. 'Red List' When Responsibility for Prescribing Remains with Hospital Trust Consultants

11.1 The NCL Shared Care Group is responsible for maintaining the NCL red list. The NCL Red List is updated regularly and available at this link.

11.2 The provider trust is expected to retain prescribing responsibility where the:

i. Medicine has been commenced in the provider trust and specialist ongoing intervention and monitoring is needed.

ii. Medicines are only available through Hospital Trusts.

iii. Medicines are part of a provider trust-initiated clinical trial.

iv. Medicines listed in Part XVIIIA of the Drug Tariff (the 'Blacklist') cannot be prescribed on an FP10

v. Medicines have not been approved by the DTC (or equivalent), excluding individual authorisation under Chair's Action.

11.3 Where a mutually agreed resolution cannot be reached about where prescribing of a patient's treatment should best take place, the ICB should facilitate collaborative discussions to seek a resolution.

12. Transfer of Prescribing Medicines Requiring Specialist Monitoring (see Appendix 2)

12.1 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. The NCL Shared Care Group (SCG) is responsible for the development of interface prescribing support documents, including shared care agreements.

12.2 Shared care is a particular form of the transfer of clinical responsibility from a hospital or specialist service to general practice in which prescribing by the GP, or other primary care prescriber, is supported by a shared care agreement.

12.3 The NCL SCG may agree that some medicines would benefit from a transfer of prescribing responsibilities (not full shared care). This is different from shared care prescribing because the patient will not require ongoing specialist monitoring or follow-up.

12.4 Hospital consultants should communicate with GPs to enable continuation of prescribing in primary care prior to care being transferred. For shared care agreements, it is expected that the GP's agreement will be sought and confirmed, and that the GP has sufficient information to safely prescribe for the patient. The consultant should then write to the GP and copy the patient in the letter (where appropriate) to confirm transfer of care and prescribing to GP.

12.5 A GP should not decline to prescribe a medicine solely on the basis of cost. Where a patient is to receive the majority of their ongoing care through the hospital (e.g. for ongoing chemotherapy) then prescribing should remain with the hospital. The following conditions should be met before the shared care takes place:

i. the patient's condition is stable;

ii. the agreement of the patient's GP is sought prior to the transfer of prescribing and

iii. the GP is sufficiently informed and able to monitor treatment, identify medicine interactions and adjust the dose of any medicines as necessary.

iv. Resources are available to ensure (where required) the safe administration of any specialist medication in the community, e.g. IV therapy. This would usually be agreed with the community nursing services.

12.6 A framework for the production and use of interface prescribing support documents for medicines in North Central London is available at this link. A fact sheet will be developed when additional information needs to be provided to the GP to support safe and effective prescribing but no specific additional monitoring is required.

12.7 It is essential that a copy of the NCL SCG approved shared care guideline / prescribing monitoring document including the baseline monitoring information is provided to the GP in order to facilitate the shared care transfer.

13. Tertiary Care Referrals and Prescribing Medicines Requiring Specialist Monitoring

13.1 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).

13.2 In some circumstances it may be appropriate to transfer prescribing to a more local Hospital Trust or more rarely to 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.

13.3 The principles outlined in Section 12 should be applied.

Appendix 1: NCL Discharge Medicines Service Referral Criteria (based on NHSE DMS Toolkit)

Eligibility Criteria
1. Patient must give consent. *(If lacks capacity (as per Mental Capacity Act), liaise with Next of Kin/ carers.)*
2. Patient should fulfil the Referral Criteria agreed by the trust before considering referral to the DMS.

Patient and Medication Referral Criteria
(from NHSE DMS Toolkit)
When developing eligibility criteria, NHS trusts should take into consideration local population needs (e.g. care homes and areas of deprivation). The table below lists situations where medicines or patients could be considered high risk. This list is not exhaustive. The table is intended to be used as a guide.

High risk patients
• Changes to medicines
• New medicines (e.g. inhalers)
• More than 5 medicines (resulting in increased risk or interactions)
• Concerns regarding medicines use (e.g. confused, LD, require additional support)
• Patients who have help at home
High risk medicines
• Medicines requiring follow-up (e.g. blood monitoring*, dose titration)
• Medicines that have potential to cause dependence
• Medicines which doses change/ vary over time
• High risk medicines including (but not limited to):
○ anticoagulants
○ antiepileptics
○ antipsychotics
○ aspirin
○ cardiovascular drugs (e.g. beta-blockers, diuretics, digoxin, amiodarone)
○ controlled drugs
○ insulin
○ lithium
○ methotrexate
○ NSAIDs
○ opioids
○ valproate

*Trusts may find the NCL Drugs which require monitoring signposting document useful

Appendix 2: Framework for the Production and Use of Shared Care Agreement for Medicines in North Central London

1. Background

Safe shared care and transfers of prescribing should be undertaken with regard to the General Medical Council's [GMC's] Good Practice in Prescribing and Managing Medicines and Devices Guidance.

Shared care is where one clinician shares responsibility for a patient's care with a colleague. In proposing a shared care arrangement, specialists may advise the patient's GP which medicine to prescribe. If a treatment requires specialist initiation, is rarely prescribed in primary care or is a medicine or clinical condition that requires monitoring by a specialist, this will require a formal shared care agreement. Shared care requires the agreement of all parties, including the patient, defining respective roles and responsibilities. Effective communication and continuing liaison between all parties to a shared care agreement are essential.

Treatments can be assigned the following features:

- Treatment meets the agreed local criteria for inclusion on the Red List, therefore prescribing should remain in secondary / tertiary care. These treatments, with their respective indication, are documented in the Red List, and are usually accessed directly at the hospital or via Homecare arrangements.
- Where shared responsibility is required between the specialist and primary care due to the treatment or the condition, a shared care agreement would be required.
- Prescribing is initiated and stabilised by the specialist, who can then request a primary care clinician to continue prescribing and monitoring of the patient. The primary care clinician will need to be supported with additional prescribing and monitoring guidance and the roles and responsibilities of all parties should be well defined and clearly documented.
- Transfer of prescribing to the primary care clinician which is supported by a NCL SCG approved fact sheet.

2. Essential features of effective shared care agreements

- **Best interests of the patient**

  Any shared care arrangement should be focused on providing the best standard of care for the patient.

- **Individual, patient by patient arrangements**

  Shared care documents should be accompanied by information about the patient in question, outlining all relevant aspects of that patient's care. The hospital doctor and GP must agree which elements of the patient's care each will undertake. If the GP agrees to undertake a specific element of care subject to receiving appropriate support the onus is on the hospital to provide this support.

- **The GP should never be asked to initiate prescribing for shared care medicines**

- **Reasonably predictable clinical situation**

  Sharing care with primary care should only be considered where a patient's clinical condition is stable or predictable.

- **Willing and informed consent of all parties, including patients and carers**

  All parties must have sufficient accurate and up-to-date information in a form they can understand. Consent must be given voluntarily.

  Consultants and GPs are encouraged to communicate directly when questions arise around shared care for a particular patient. If issues about prescribing remain after these discussions, a Pharmacist at the ICB or Hospital Trust should be contacted for advice.

- **Clear definition of responsibility**

  The areas of care for which each party has responsibility must be clearly defined and should be patient specific. The documentation should include details of any specialist resources that may be available.

- **Communication network and emergency support**

  A telephone contact number, and/or email address must be provided so that the GP can access advice and information if problems arise. Out-of-hours contact numbers must be provided so that the GP can contact an appropriate healthcare professional out-of-hours.

  The documentation should state how often the patient will be reviewed and must detail a 'route of return' should the patient's condition become less predictable (e.g. return of symptoms, development of adverse effects). Progress reports should be produced to an agreed timescale.

- **Clinical information**

  Shared care documentation should not duplicate information that is available in the British National Formulary (BNF) or Summary of Product Characteristics (SPCs); it should direct the reader to the BNF/SPC when appropriate. It may however be appropriate to include the following:

  - A brief overview of the disease
  - A note of relevant NICE or other guidance and weblink to the full guidance
  - Intended duration of treatment
  - Common and important adverse effects (incidence, identification, importance and management)
  - Clear information regarding monitoring requirements (e.g. liver or renal function), who is responsible for obtaining and interpreting samples, frequency of testing and what to do when adverse test results occur.

  It is envisaged that all prescribers will want to keep reasonably up-to-date with important developments in therapeutics. Practitioners have a duty to keep themselves informed of the medicines that are recommended for their patients.

- **Review**

  Shared care documentation must be reviewed by the authors, every 3 years or sooner if indicated (e.g. when NICE guidance is reviewed or updated).

3. Circumstances in which prescribing and monitoring responsibility is retained by the specialist

Hospitals must normally retain responsibility for prescribing in the following instances:

- When the GP does not feel competent to take over responsibility for prescribing.

- Delegation of responsibility for prescribing from hospital to GP can only take place with the explicit consent of the GP concerned.
- Where patients receive the majority of care, including monitoring, in hospital and the only benefit achieved by sharing care would be a reduction in hospital expenditure.
- Where the medicine is unlicensed, only available through hospital or being used as part of a hospital-initiated clinical trial.
- Where the medicine is included on the NCL Red List of medicines that hospital doctors should not ask GPs to prescribe

4. Checklist for GPs when considering sharing care

GPs should only agree to prescribe if, after reading the shared care document, they can answer YES to the following questions:

- Is the patient's condition predictable or stable?
- Do you have the relevant knowledge, skills and access to equipment to allow you to monitor treatment as indicated in this shared care document?
- Have you been provided with, or have access to, relevant clinical details including monitoring data to manage the patient?
- Are you confident in accepting clinical and legal responsibility for prescribing?

If the answer is NO to any of these questions the GP should write to the consultant, within 14 days, outlining their concerns. Refusal to prescribe must ONLY be on the grounds of clinical responsibility. The cost of the medicine should not be a barrier to sharing care nor should a hospital seek to transfer prescribing on the grounds of cost alone, unless the commissioning arrangements stipulate that the hospital must make all supplies and retain all responsibility.

5. Involving the patient

The consultant should only obtain the consent of the patient (and his or her carers if appropriate) after the GP has agreed in principle to share care.

Under no circumstance should the patient be asked to convey information between the hospital clinician and GP regarding decisions to take on prescribing. Care should be taken to ensure that the patient does not suffer due to the NHS decision-making process and collaboration on both sides is sought in achieving resolution in difficult cases.

6. Process for development and approval of shared care arrangements

- The need to have an NCL shared care agreement, prescribing and monitoring document or a fact sheet will be addressed at the time when a treatment is considered by the Joint Formulary Committee (JFC) or by the NCL Shared Care Group (SCG).
- The NCL SCG will identify a lead Trust who will draft a shared care arrangement using the relevant standard template, gain agreement with other NCL Trusts, and share the final draft with ICB colleagues, who will seek primary care clinician input.
- The final draft will be approved by NCL SCG, and made available on the NCL ICS website.
- Each shared care document should be reviewed every 3 years or sooner if indicated (e.g. if new NICE guidance or MHRA/NPSA medicine safety alerts are issued).