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## **NORTH CENTRAL LONDON MEDICINES OPTIMISATION NETWORK**

### **PRESCRIBING GUIDANCE**

**This operational guidance has been developed by the NCL Medicines Optimisation Network (NCL MON) 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 North Central London Joint Formulary on behalf of the following organisations:

|   |                   |
|---|-------------------|
| Barnet, Enfield and Haringey Mental Health NHS Trust            | NHS Camden CCG    |
| Camden and Islington NHS Foundation Trust                       | NHS Enfield CCG   |
| Central and North West London NHS Foundation Trust              | NHS Haringey CCG  |
| Great Ormond Street Hospital for Children NHS Foundation Trusts | NHS Islington CCG |
| Moorfields Eye Hospital NHS Foundation Trust                    | NHS Barnet CCG    |
| 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  |                   |

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## Introduction

This guidance has been developed by the North Central London Medicines Optimisation Network and has been ratified by North Central London Joint Formulary on behalf of all acute, community and mental health NHS provider trusts and Clinical Commissioning Groups (CCGs) in North Central London

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

It is recommended that all provider trusts and Clinical Commissioning Groups seek the advice of their Chief Pharmacist/Pharmaceutical Adviser during the commissioning process to ensure that implications for medicines and prescribing are taken into account.

Most medicines are included in the National Tariff, except for nationally defined NTPS excluded medicines, where commissioners and providers should agree local prices and arrangements for commissioning and monitoring as described in the CCG Commissioning of High Cost Drug Policy

The 'red list' and shared care document is reviewed and updated on quarterly basis. The current version can be found at <http://ncl-jfc.org.uk/> or contact your local Chief Pharmacist.

## 2. General Principles

The following general principles apply to all provider trusts and Clinical Commissioning Groups,

2.1 All provider trusts should ensure they have a Drug and Therapeutics Committee (or equivalent) in place to co-ordinate medicine use. Each hospital Drug and Therapeutics Committee 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. Until a joint trust formulary is established, each Trust should maintain an up to date formulary with the involvement of CCG prescribing advisers and CCG prescribing lead, GP or nominated deputy.

The majority of prescribing by hospital clinicians should be in line with their hospital formulary, or prescribing guidelines. Where, exceptionally, a patient's treatment necessitates the prescribing of a non-formulary drug, the hospital clinician should discuss the choice of medicines and reasons for prescribing outside the formulary with the individual GP where relevant.

2.2 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.

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

2.4 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.

2.5 All provider trusts should have policies approved by their Drug and Therapeutics Committee 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.
- 2.6 All provider trusts should comply with principles contained in local, national and professional guidance including National Service Frameworks, NICE Technology Appraisal Guidance and relevant Health Service Circulars & Guidance, Executive Letters and Audit Commission reports.
  - 2.7 The NCL prescribing guidance should be applied within GMC guidance 'Good practice in prescribing and medicines management and devices'. The GMC guidance can be found at [http://www.gmc-uk.org/static/documents/content/Prescribing\\_guidance.pdf](http://www.gmc-uk.org/static/documents/content/Prescribing_guidance.pdf)
  - 2.8 The joint General Practitioner Committee (GPC) and Consultant Committee of the BMA statement on hospital test results has been updated and a statement on *Duty of care regarding medicines recommended from out-patient clinics* now 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 (Appendix 5).

### 3. Admission arrangements

- 3.1 CCGs and all local provider trusts should ensure that written guidance is in place covering information flow on admission or referral as recommended by the Care Quality Commission (CQC).
- 3.2 The recommended minimum dataset for information provided on patient admission to hospital is listed in [Appendix 1](#) and should be agreed locally between CCGs and Hospital Trusts.
- 3.3 CCGs and providers should collaboratively develop a standard template letter that GP practices can use to ensure all information required is readily available.
- 3.4 Information on prescribed medicines should be available to the hospital as soon as possible and ideally within 24 hours of admission where possible.
- 3.5 An agreement should be made between the hospital and CCG to enable audits to be undertaken to monitor the quality and timeliness of information provided on admission and ensure compliance with CQC recommendations.
- 3.6 Health economies should support and encourage patients to bring all their own medicines into hospital with them through a pre-admissions policy.
- 3.7 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.

### 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 appropriate medicines reconciliation, ensure appropriateness of medicines, help with self-administration of medicines, reduce medicines

wastage and therefore provide improved medicines optimisation. 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. Existing primary care-based services such as 'The New Medicines Service' should be made use of where relevant. Patients at risk of experiencing problems managing their medicines should be identified and, if appropriate, a referral made for pharmaceutical support.

## 5. Discharge Arrangements

- 5.1 CCGs and all local provider trusts should ensure that written guidance is in place covering information flow on discharge from inpatient, outpatient, urgent or emergency care as recommended by the Care Quality Commission (CQC).
- 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 after assessment it is clear the patient already has appropriate supplies at home.
- 5.3 The recommended minimum dataset for information provided on patient discharge is listed in [Appendix 2](#) and should be agreed locally between CCGs and provider trusts.
- 5.4 Discharge summaries should be sent to the GP at the time of discharge and ideally received within 24 hours of patient discharge. Consideration should be given to the most convenient form of communication to ensure appropriate information transfer across the interface (for example fax or email).
- 5.5 Hospitals should review templates for electronic discharge systems (where applicable) and adapt where necessary to ensure the fields comply with the required minimum dataset.
- 5.6 An agreement should be made between provider trusts and CCG to enable an audit to be undertaken to monitor the quality and timeliness of information provided on discharge and ensure compliance with CQC recommendations.
- 5.7 Patients should be provided with appropriate written information about the medication prescribed, duration of treatment and obtaining further supplies of medicine.
- 5.8 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.

## 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.

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.

- 6.3 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. It is recommended that hospitals and CCGs agree an outpatient template letter to ensure this information is communicated effectively.
- 6.4 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.
- 6.5 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 "patients 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 CCGs 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 Medication errors occur when information transfer between care settings does not take place satisfactorily. With the advent of electronic prescribing in primary care, as well as secondary / tertiary care, it is reasonable to expect that transfer of medicines-related information will improve significantly thereby reducing the risk of harm to patients.
- 7.2 On referral to a hospital consultant it is the responsibility of the GP to give comprehensive details of a patient's medical history, drug treatment, previous adverse reactions, allergies and any use of compliance aids
- 7.3 On discharge from hospital, clinicians must provide the patients GP with information on diagnosis and reason for admission, patient's medication on discharge, including whether to continue or stop, any medication changes and reasons for the changes. In addition any relevant clinical or biochemical monitoring parameters should be communicated highlighting further monitoring to be undertaken by the GP. This information must be made available to the patient's GP within 7days of discharge to allow ongoing treatment to be maintained. Where provider trusts have implemented electronic prescribing systems, this information will be available to the GP within 24 hours of the patient being discharged. It is expected that this information will be acted upon by the GP to ensure safe clinical management of patients.

## 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.

## 9. Unlicensed Medicines

- 9.1 The safe prescribing of new unlicensed medicines will be assessed when medicines are reviewed by the NCL JFC, including the appropriateness of transferring prescribing to primary care using a shared care arrangement. 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 (see <http://www.gmc-uk.org/guidance/28349.asp> and [http://www.gmc-uk.org/guidance/ethical\\_guidance/14327.asp](http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp))
- 9.3 When prescribing an unlicensed medicine you must:
- be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy
  - 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
  - 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.
- 9.4 Informed consent for the use of unlicensed medicines should be obtained from patients before the prescription is written. This should be documented in the handover letter to the GP.
- 9.5 GPs should not be asked to prescribe unlicensed "specials" when a suitable alternative, more cost effective dosage form/licensed product is available.
- 9.6 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.
- 9.7 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 patients 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. The full agreement of the GP concerned must be obtained before prescribing is transferred.

10.3 GMC prescribing guidance should also be referred to: see

<http://www.gmc-uk.org/guidance/28349.asp>

[http://www.gmc-uk.org/guidance/ethical\\_guidance/14327.asp](http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp) .

10.4 When prescribing an off-label medicine you must:

- a. be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy
- b. 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
- c. 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.

10.5 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 (see [Appendix 3](#))**

11.1 The provider trust is expected to retain prescribing responsibility where:

- Medicine has been commenced in the provider trust and specialist ongoing intervention and monitoring is needed.
- Medicines are only available through Hospital Trusts.
- Medicines are part of a provider trust-initiated clinical trial.
- Medicines listed in Part XVIII A of the Drug Tariff (the 'Blacklist') cannot be prescribed on an FP10
- Medicines have not been approved by the Drugs & Therapeutics Committee (or equivalent), excluding individual authorisation under Chair's Action.

11.2 Where a mutually agreed resolution cannot be reached, about where prescribing of a patient's treatment should best take place, the Provider Trust's, host CCG should 'facilitate collaborative discussions with the associate to the contract', in seeking a resolution.

## **12. Transfer of Prescribing Medicines Requiring Specialist Monitoring (see [Appendix 4](#))**

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.

12.2 Hospital consultants should communicate with GPs to enable continuation of prescribing in primary care prior to care being transferred. 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.

12.3 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.



- 12.4 The following conditions should be met before the shared care takes place:
- the patient's condition is stable;
  - the agreement of the patient's GP is sought prior to the transfer of prescribing and
  - the GP is sufficiently informed and able to monitor treatment, identify medicine interactions and adjust the dose of any medicines as necessary.
  - 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.
- 12.5 All prescribers should be aware of their responsibilities to develop their expertise and the expertise of others in the managed introduction of new medicines.
- 12.6 A framework for the production and use of shared care guidelines for medicines in North Central London is detailed in [Appendix 4](#).
- 12.7 A list of shared care guidelines and the organisations which approve their use is detailed in [Appendix 4](#).
- 12.8 It is essential that a copy of the NCL MON 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.

### **14. Clinical Trials & Ethics Committees**

- 14.1 All clinical trials must have been subject to Ethical Committee approval and research governance approval, where the arrangements for consulting and informing patients should be considered. 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.
- 14.2 Prescribing and supply of clinical trial medicine is the responsibility of the provider 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.
- 14.3 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 and this should be clearly stated in the information for patients. The trial documentation must include a clear exit strategy for any trial medication detailing any post trial funding implications that must be agreed by the CCG prior to entry to the trial.



## Appendix 1

### ***Standard dataset for information on medicines required on admission to hospital***

#### **Introduction**

In October 2009 the Care Quality Commission (CQC) published a report on a national study which raised concerns about the quality and timeliness of information on patients' medicines transferred between acute trusts and general practitioners and vice versa when patients are admitted to and discharged from hospitals. This paper lists the minimum dataset for information which should be provided on admission to hospital, adapted from the CQC self-assessment tool.<sup>1</sup> The CQC recommends that written guidance be in place covering information flow at admission.

#### **Minimum dataset for information provided on admission**

- Complete patient details (full name, date of birth, NHS number, GP, date of admission)
- Presenting condition plus co-morbidities
- A list of all medicines currently prescribed for patient (furthermore, it is good practice for this to additionally include those bought over the counter)
- Dose, frequency, formulation and route of all medicines listed
- An indication of medicines not intended to be continued
- Known allergies
- Major side effects / sensitivities / adverse reactions to previously taken medicines (if relevant)

#### **Other recommendations**

- This information should be available to hospital when a patient is admitted for planned admissions and as soon as possible (ideally within 24 hours of admission) for unplanned admissions.
- Guidance may set out schemes / systems for ensuring that a patient's medicine is brought with them into hospital – this could apply to either elective or emergency admissions (or both). An example of this would be the 'Green Bag' scheme. This will assist the reconciliation process. This recommendation is considered good practice and not an expectation.

#### **References**

1. Care Quality Commission. Managing patients' medicines after discharge from hospital - A Self Assessment Tool. October 2009. Accessed at [http://www.cqc.org.uk/db/documents/Managing\\_patients%E2%80%99\\_medicine\\_after\\_discharge\\_%E2%80%93\\_A\\_self-assessment\\_tool.doc](http://www.cqc.org.uk/db/documents/Managing_patients%E2%80%99_medicine_after_discharge_%E2%80%93_A_self-assessment_tool.doc)

Acknowledgement with thanks: Imperial College Healthcare NHS Trust

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April 2010

## Appendix 2

### **Standard dataset for information on medicines required on discharge from hospital**

#### **Introduction**

In October 2009 the Care Quality Commission (CQC) published a report on a national study which raised concerns about the quality and timeliness of information on patients' medicines transferred between acute trusts and general practitioners and vice versa when patients are admitted to and discharged from hospitals. This paper lists the minimum dataset for information on medicines which should be provided on discharge from hospital, adapted from the CQC self-assessment tool<sup>1</sup> and National Prescribing Centre recommendations.

#### **Minimum dataset for information on medicines provided on discharge**

*This information is also included in the NHS standard contract.<sup>2</sup>*

- complete patient details (full name, date of birth, NHS and hospital number, GP, date of discharge)
- key diagnosis made during the patient's admission, plus co-morbidities, and any procedures carried out
- medication prescribed at the time of discharge, including any medication not dispensed
- dose, route, frequency, formulation (where relevant) and length of course for all medications, with details of any variable prescriptions
- the reasons for any medications started or stopped
- any adverse reactions or allergies to medications or treatments observed in the patient during admission, and any previous reactions
- the name of the responsible Consultant at the time of the patient's discharge
- any immediate post-discharge requirement from the primary healthcare team
- any planned follow-up arrangements
- whether the patient has any relevant infection, for example MRSA
- who should be contacted in the event of a query (e.g. responsible doctor and their contact details)

#### **Other recommendations**

- Discharge summaries must be received by the GP within 24 hours<sup>2</sup>
- The patient should be given a copy of the discharge letter
- The CCG should have considered how community pharmacists can be included in the flow of discharge information.

#### **References**

1. Care Quality Commission. Managing patients' medicines after discharge from hospital - A Self Assessment Tool. October 2009. Accessed at [http://www.cqc.org.uk/db/documents/Managing\\_patients%E2%80%99\\_medicine\\_after\\_discharge\\_%E2%80%93\\_A\\_self-assessment\\_tool.doc](http://www.cqc.org.uk/db/documents/Managing_patients%E2%80%99_medicine_after_discharge_%E2%80%93_A_self-assessment_tool.doc)
2. Department of Health. Guidance on the NHS Standard Contract for Acute Services 2010/11. 16 January 2010. Accessed at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalassets/dh\\_111267.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalassets/dh_111267.pdf)

Acknowledgment with thanks: Imperial College Healthcare NHS Trust  
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## Appendix 3

### ***Management of the North Central London 'Red List' of Medicines that hospital/NHS Trust doctors should not ask GPs to prescribe***

North Central London Joint Formulary Committee (NCL JFC) or NHS Trust Drug and Therapeutics Committees (D&TC) consider published evidence on the effectiveness of a new medicine and its cost-effectiveness and safety before deciding whether to add it to the hospital's formulary. All such committees in NCL have representation from local CCGs. When a medicine is added to a provider formulary, the committee must also consider whether it is reasonable for a GP to prescribe the medicine, or whether it should be added to the red list (see Appendix 4 for criteria for shared care, and Appendix 3 for the Red list).

When NCL JFC or D&TC decide a new medicine should be added to the red list or that a fact sheet or shared care agreement be developed, the NCL Medicines Optimisation Network (MON) will be informed. 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.

Any North Central London CCG or NHS Trust can request that a medicine is added to or removed from the red list. The trigger for consideration for the red list is normally following the review of a new medicine at NCL JFC or NHS Trust D&TC. The Trust's Chief Pharmacist (or equivalent) should make the case for the change at a NCL MON meeting. The NCL MON will normally take a view on red list decisions at the first meeting to which the decision is presented.

The red list will include recommendations for medicines commissioned by NHS England.

The following criteria are used by D&TCs and the NCL MON in deciding whether a change to the red list should be made:

The Hospital Trust is expected to retain prescribing responsibility where:

- Medicine has been commenced in the hospital and specialist ongoing intervention and monitoring is needed.
- Medicines are only available through Hospital Trusts.
- Medicines are part of a Hospital Trust initiated clinical trial.
- Medicines listed in Part XVIII A of the Drug Tariff (the 'Blacklist') cannot be prescribed on an FP10.
- Medicines have not been approved by the Drugs & Therapeutics Committee (or equivalent), excluding individual authorisation under Chair's Action.

If there is disagreement about where prescribing of a patient's treatment should best take place the case should be referred to the CCG, via the Chief Pharmacist who will seek resolution.

#### **Criteria for adding a medicine to the red list:**

- Safe or effective use of the medicine, throughout its use, requires expertise or facilities that a GP will not normally have.
- Medicines added to the red list will normally be 'specialist medicines' that a GP will see infrequently, medicines used in the treatment of rare conditions, or medicines only available from a hospital or requiring a special 'package of care'
- Relevant changes to a medicine's licensing or to national policy (e.g. Summary of Product Characteristics, NICE guidance, BNF monographs, MHRA alerts, Patient Safety alerts).

#### **Criteria for removing a medicine from the red list:**

- Relevant changes to a medicine's licensing or to national policy (e.g. from NICE or other sources as above) now states that it is reasonable for GPs to prescribe the medicine, perhaps in the context of a shared care agreement.

- New trial evidence or a change in licence has made the medicine easier to use than at the time it was added to the red list (e.g. by demonstrating that less monitoring is needed than previously or appropriate support or packages of care are now provided in primary care).

**A medicine will not be added to the red list:**

- If, although the medicine should only be initiated by a hospital specialist, it is reasonable for a GP to continue to prescribe it once the patient and treatment are stable (e.g. monitoring, dose changes and stopping treatment require no specialist expertise or facilities).
- On grounds of cost.

There should be a quarterly review of the red list and regular review of shared care agreements to incorporate any change in national policy or if a significant incident occurs in clinical practice.

If a NDP or D&TC decision appears inconsistent with these criteria, the NCL MON will review the decision against the above criteria and may recommend referral to the JFC for final decision.

The NCL Acute Medicines Management team will be responsible for updating the red list using the documentation and process approved by MON in Dec 2016.

**Appendix 3**  
***Red list***  
**North Central London Red List**

This document is updated quarterly at the NCL Medicines Management Pharmacy Network meeting following discussions held at local Hospital Drugs and Therapeutics or New Drug Panel meetings. It is published on the North Central London Joint Formulary Committee website add link. It contains medicines that are on hospital formularies but owing to their speciality, safety or monitoring requirements, GPs should not be asked to continue the prescribing. The responsibility for prescribing these medicines should remain with the hospital trust consultant unless shared care has been agreed or in exceptional cases where transfer of treatment for an individual patient has been agreed with both the consultant and GP.

Further information on the background of the Red list and Shared Care can be found in Appendix 1 and 2 of the NCL Prescribing Guidance. If you have any queries on any of the information contained in this document, please contact your local NCL Medicines Management representative.

**Please refer to JFC website:**

<http://ncl-jfc.org.uk/prescribing-guidelines.html>

**Red list**

GPs should not be asked to take on the prescribing of any of the following medicines. It relates to all formulations unless a specific formulation is given.



NCL Red List v18 NF  
13.03.17.pdf

## Appendix 4 Shared Care

### **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 Guidance ([http://www.gmc-uk.org/guidance/ethical\\_guidance/14321.asp](http://www.gmc-uk.org/guidance/ethical_guidance/14321.asp)). 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 general practitioner 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 stabilized 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.
- Have previously been considered specialist and now deemed appropriate to be initiated by a primary care clinician. This would be supported by a more simplified treatment 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 CCG 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, fax 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 (see [Appendix 3](#)).

### **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.

Patients should never be used as a conduit for informing the GP that prescribing is to be transferred. Nor should they ever be placed in a position where they are unable to obtain the medicines they need because of lack of communication between primary and secondary/tertiary care.

### **6. Process for development and approval of shared care arrangements**

- 6.1 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 local Drug and Therapeutics Committee (DTC).
- 6.3 NCL MON 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 CCG colleagues.
- 6.4 CCGs will obtain comments from their local clinicians through their Medicines Management Committee structures.
- 6.5 The final draft will be approved by NCL MON, endorsed at NCL JFC and made available on the JFC website.
- 6.6 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).

Adapted by the North Central London Medicines Management Pharmacy Network from NWL Prescribing policy, that was adapted from 'Effective Shared Care Arrangements' issued by the Midlands Therapeutic Review & Advisory Committee.

### **For current and up to date Shared Care and Fact Sheets**

**Please refer to JFC website:**

<http://ncl-jfc.org.uk/gp-shared-care-guidelines.html>

<http://ncl-jfc.org.uk/gp-fact-sheets.html>

### **Process for Agreeing Shared Care**

**See link below via JFC website**

<http://ncl-jfc.org.uk/gp-shared-care-guidelines.html>

## **Appendix 5**

### ***Duty of Care***

The joint GPC and Consultant Committee statement on hospital test results has been updated and a statement on *Duty of care regarding medicines recommended from out-patient clinics* has also been published – as per below and on the [BMA website](#).

#### **Duty of care regarding communication of investigation results**

We are aware that in some areas, some hospital doctors have been instructing GPs to find out the test results which the hospital had ordered.

Both the General Practitioner Committee and the Consultants Committee of the BMA agree this practice is potentially unsafe, and that the ultimate responsibility for ensuring that results are acted upon, rests with the person requesting the test.

That responsibility can only be delegated to someone else if they accept by prior agreement. Handover of responsibility has to be a joint consensual decision between hospital team and GP. If the GP hasn't accepted that role, the person requesting the test must retain responsibility.

This advice is in line with both National Patient Safety Agency guidance and the Ionising Radiation (Medical Exposure) Regulations

#### **Duty of care regarding medicines recommended from outpatients**

Communication of prescribing recommendations from out-patient clinics to patients and their GPs is a complex area where patient safety can be compromised. We would strongly recommend that LMCs and Hospital Trusts agree policies that are publicised and adhered to by all parties. These policies should include the following general principles:

- Medicines required for urgent administration should be prescribed by the hospital doctor, and if appropriate dispensed by the hospital.
- Responsibility for the provision of a prescription for non-urgent medications should be determined and agreed locally, but must recognise that delegation of responsibility for prescribing from hospital to GP can only take place with the explicit agreement of the GP concerned.
- All communications should be in writing with the responsible doctor identified.
- Where communications are sent via the patient, there should be clear instructions to the patient regarding the time scale for completion of the prescription, and this should be in addition to and not instead of a formal communication.
- The doctor recommending a prescription should ensure that the prescription is appropriate, including carrying out any tests required to ensure safety.
- The doctor recommending a prescription should provide counselling for the patient about important side effects and precautions, including any need for ongoing monitoring, which if needed should be agreed between primary and secondary care clinicians.
- Recommendations should be in line with any agreed local formularies. Individual judgements should be made about the desirability of recommending a particular drug as opposed to a therapeutic class.
- Where a GP feels that a prescription recommendation is inappropriate, the secondary care clinician should be informed.
- Notwithstanding any of the above, all prescribers must be aware that the ultimate responsibility for the prescription lies with the prescribing doctor and cannot be delegated.