East Surrey CCG, Guildford & Waverley CCG,
North West Surrey CCG, Surrey Downs CCG & Surrey Heath CCG

MEDICINES MANAGEMENT GUIDE TO PRESCRIBING

Section 2 – Prescribing responsibilities

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2.1 INTRODUCTION TO THIS SECTION

Medicines may only be prescribed by registered doctors, dentists or non-medical prescribers. The person issuing the prescription takes **clinically responsibility** for the intervention. This section describes the local structures and mechanisms that are in place to ensure that patients receive prescriptions from the most appropriate person.

2.2 PRIMARY/SECONDARY CARE INTERFACE

The Surrey CCGs interface with a wide range of providers as follows:

CCG	Main Acute Trust
East Surrey CCG	Surrey and Sussex Healthcare NHS Trust
Guildford & Waverley CCG	Royal Surrey County Hospital NHS Foundation Trust
North West Surrey CCG	Ashford and St. Peter's Hospitals NHS Foundation Trust
Surrey Downs CCG (Dorking locality)	Surrey and Sussex Healthcare NHS Trust
Surrey Downs CCG (East Elmbridge locality)	Kingston Hospital NHS Foundation Trust
Surrey Downs CCG (Epsom locality)	Epsom and St Helier University Hospitals NHS Trust
Surrey Heath CCG	Frimley Health NHS Foundation Trust

All Surrey CCGs interface with the same mental health provider, Surrey and Borders Partnership NHS Foundation Trust.

The Medicines Management teams across the CCGs interface with these Trusts on a regular basis and formally at the following forums:

- The Prescribing Clinical Network (PCN)
- Acute Trust Drugs & Therapeutics Committees (D&TC) or equivalent

In addition, the CCGs interface with a number of other providers, including community services providers, Any Qualified Providers (AQP), Out of Hours providers, through various mechanisms.

Individual CCGs have their own Medicines Optimisation Groups (MOG) which support decision making within each organisation.

2.3 MEDICINES COMMISSIONERS GROUP (MCG)

The Surrey CCGs collaborate as a commissioners group to promote a consistent approach to medicines management across Surrey. The group provides oversight, governance and assurance to CCG Governing Bodies on the safe, effective and affordable use of medicines.

Further information about the MCG (including terms of reference) can be found on the PAD at http://pad.res360.net/PAD/Search/DrugCondition/1159

2.4 PRESCRIBING CLINICAL NETWORK (PCN)

The PCN uses a collaborative approach with its constituent CCG and Acute Trust representatives to promote equity and provide rational, safe and transparent recommendations on the use of medicines across the local health economy. Recommendations from the PCN are taken through local governance processes prior to acceptance and implementation within the CCG.

Further information about the PCN can be found on the PAD http://pad.res360.net (search for PCN).

2.5 MEDICINES OPTIMISATION GROUPS (MOGS)

All Surrey CCGs have a Medicines Optimisation Group with a responsibility for advising on medicines optimisation and management of the prescribing budget for each CCG. They support the local governance processes in relation to recommendations from the PCN and MCG.

2.6 PRESCRIBING ADVISORY DATABASE (PAD) – TRAFFIC LIGHT STATUS

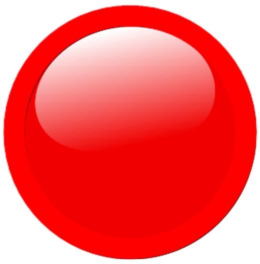
More information about the PAD can be found in Section 1

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.

All providers including NHS organisations, private GPs or specialists or any qualified providers are expected to work within the colour classification framework. Where necessary, clinicians should discuss the appropriate management of individual patients to ensure safe prescribing of medicines when care is transferred across the interface. On occasions both parties may agree to work outside of this guidance. In addition, some CCGs may have a variation to the PCN recommended colour classification.

In the table below, shared care agreements are mentioned under Amber status. These arrangements aim to facilitate the seamless transfer of individual patient care from secondary / specialist care to general practice. They are intended for use when medicines, often prescribed for potentially serious conditions and complex by their very nature, are initiated in secondary / specialist care and then prescribed by a prescriber in primary care. These medicines will often have a relatively high adverse effect profile and may require specific monitoring.

The PCN has agreed the following traffic light definitions:

	**Black - Not recommended** Not recommended for use in any health setting across Surrey due to one or more of the following: • Lack of evidence of benefit compared with standard • Lack of evidence of safety compared with standard • Less cost-effective than standard therapy • NICE guidance does not recommend
	**RED - Specialist ONLY drugs** Treatment initiated and continued by specialist clinicians on the grounds of one or more of the following: • Specialist assessment to enable patient selection, initiation and continuation of treatment • Long term specialist monitoring of efficacy and not suitable for shared care • Long-term, on-going specialist monitoring of toxicity (because the side-effect profile necessitates rigorous supervision by the hospital consultant or, the full range of possible side-effects, particularly long-term effects needs to be established; or problematic investigations to identify toxicity). • Specifically designated as being “specialist” or “hospital only” by product license, Department of Health, NICE or BNF • Unlicensed or off-label treatment without acceptance of authoritative body of recommended opinion e.g. BNF, cBNF or Palliative Care Formulary • Primary Care is unable to monitor therapy sufficiently to oversee treatment or adjust the dose where necessary to ensure safety. • Administration requirements of formulation make it unsuitable for use in primary care (some of these can appropriately be waived in certain situations e.g. palliative care) • Medicines for which the funding is levied outside of tariff e.g. PBR excluded drugs • Only available through or require preparation by hospital pharmacy • Hospital initiated clinical trial materials.

<table>
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<u>Amber - Specialist Initiation WITH Shared Care Agreement</u>
Prescribing initiated and stabilised by specialist but has potential to transfer to primary care under a formal shared care agreement on the ground of one of the following:

Specialist assessment to enable patient selection and initiation of treatment
Short or medium term specialist monitoring of efficacy until patient is stable
Short or medium term specialist monitoring of toxicity
Infrequently used such that individual prescribers are unlikely to see sufficient patients and acquire a working knowledge of the medicine, thus requiring ongoing specialist support
Long-term monitoring of toxicity needing on-going specialist support

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<tr><td></td><td>
<u>Blue (formerly Amber*) Specialist Input WITHOUT Formal Shared Care Agreement</u>
Prescribing initiated and stabilised by specialist but has potential to transfer to primary care WITHOUT a formal shared care agreement on the grounds of the following:

Specialist assessment or recommendation to enable patient selection and initiation of treatment
Monitoring of efficacy can be undertaken in primary care without specialist support
Monitoring of toxicity can be undertaken in primary care without specialist support
May require specific monitoring and possibly dose titration before transfer
No ongoing requirement for specialist support but opportunity for advice

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<u>Green Non-Specialist Drugs</u>

Prescribers are able to take full responsibility for initiation and continuation of prescribing. Local prescribing guidelines or NICE guidance may apply

These are drugs that can be initiated and/or continued in primary, secondary or tertiary care.
</td></tr>
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2.7 MEDICINES NOT ON THE PAD / HOLDING STATEMENTS

The PAD only provides a traffic light status for medicines that have been considered by the PCN since its inception in 2009. For established medicines, new to market pre-2009, that are not on PAD, prescribers should consider that they have the confidence, and knowledge/experience to accept clinical responsibility to prescribe. The BNF and Summary of Product Characteristics are valid sources of information to use.

The CCG Medicines Management teams undertake regular “horizon scanning” and may identify new medicines or products that might be of interest for prescribers. An assessment of their potential impact is made and one of the following holding statements may be assigned and will appear on the PAD. The aim of the entry will be to advise that the drug has not yet been considered locally and an estimate of the timescale for consideration.

Standard entry:
This drug / device has not yet been evaluated by NICE or the Surrey and Sussex Prescribing Clinical Network (PCN). As such, advice regarding safety, effectiveness (including cost-effective) and its place in therapy is yet to be determined. It is recommended that clinicians contact their medicines management team for further information and advice before prescribing this drug / device.

One of the following statements will also apply:

	Statement	Rationale
1)	NICE are due to publish guidance on this drug in …… and will be considered by the PCN within 90 days of publication	Refers to NICE timetable
2)	It is expected that an evaluation of this drug will be completed by mm/yyyy	If on PCN work plan and some certainty that the evaluation will be completed within a reasonable timeframe – this would apply to drugs where a need to have a position is clear
3)	This drug is on the PCN workplan, but it has not yet been evaluated by NICE or the Prescribing Clinical Network (PCN). As such, advice regarding safety, effectiveness (including cost-effectiveness) and its place in therapy is yet to be determined	If on PCN work plan but uncertainty that the evaluation will be completed within a reasonable timeframe
4)	This drug is currently not on the PCN workplan. The PCN will consider recommending prescribing of this treatment upon submission of a formal request with its associated evidence. Please contact your local CCG Medicines Management team formulary pharmacist or chief pharmacist at your acute trust, if you wish to make a submission.	If not on PCN work plan
5)	This drug / device falls under the responsibility of NHS England Specialised Commissioning and should therefore not be prescribed in Primary Care.	NHS England funded

Prescribers are encouraged to follow local prescribing recommendations where possible. In circumstances where the PCN has not yet considered a medicine and existing, assessed medicines are not suitable, prescribers are recommended to seek appropriate information on safety, clinical effectiveness and value to the NHS prior to prescribing. The BNF and the Summary of Product Characteristics (SPC) are valid sources of information (SPCs may be accessed at https://www.medicines.org.uk/emc/). If in doubt, contact the local CCG medicines management teams for advice.

2.8 INTERFACE PRESCRIBING

The interface prescribing policy is included in contracts with all providers commissioned to deliver NHS services which include prescribing and drugs. The aim is to facilitate consistent, cost-effective, safe prescribing practice across Surrey

Providers will have a Drug and Therapeutics Committee in place which should reflect recommendations made at the PCN. Prescribing will be from the Provider formulary (or in line with the PAD) and hospital clinicians should not seek to avoid restrictions by asking primary care prescribers to prescribe non-formulary medicines.

The policy includes information on:

- Admission arrangements / medicines reconciliation
- In-patient arrangements, including the use of patients' own drugs
- Discharge Arrangements, including requirements of supply and information to be provided to the patient's GP
- Out-patients/Day Case, including information regarding non-urgent medicines
- Patients attending Accident and Emergency
- Unlicensed Medicines
- When Responsibility for Prescribing Remains with Providers
- Transfer of Prescribing – Shared Care
- Tertiary Care Referrals

For each situation, duration of supply and expectations of information to be provided to patients and clinicians are articulated within the policy

The most recent policy is available on the PAD at
http://pad.res360.net/PAD/Search/DrugCondition/749

Template letters to support primary care prescribers when asked to prescribe drugs outside of this policy are available on the Interface Prescribing Policy page on the PAD. These cover black drugs, red drugs, request for shared care information and unlicensed drugs.

In situations where requests are made by providers outside of local interface arrangements the following general points should be considered:

The GMC's Good Medical Practice guidelines state that you must:

- Make the care of your patient your first concern
- Recognise and work within the limits of your professional competence

The doctor who has clinical responsibility for the patient should undertake the prescribing (EL(91)127)

Prescribing at the primary/secondary care interface presents a number of potential difficulties:

- The medicine may be outside of the GP's current experience
- The prescriber may have been given inadequate information about the medication and its management
- The prescriber may not be in control of the monitoring and/or does not receive results of such
- The treatment may be outside of the licensed indications
- The dosage may be outside of the licensed range
- Local Policy and/or the BNF recommends specialist supervision
- The treatment may not be obtainable from community pharmacy

Formal "Shared Care" arrangements may be an appropriate way of overcoming some of these issues.

2.9 REQUESTS FOR PRESCRIBERS TO PRESCRIBE RED/ HOSPITAL ONLY DRUGS

Prescribers should not be asked to accept prescribing responsibility for Red or Black drugs from our local acute Trusts or other specialists. The Interface prescribing Policy states that for specialist drugs, the provider will make arrangements for issuing medication in between clinical reviews as appropriate e.g. implementation of a trust repeat dispensing scheme.

If after contacting the acute Trust / specialist the issue cannot be resolved, the prescriber should contact their CCG by the relevant route outlined below:

North West Surrey CCG	Initially contact their practice Medicines Optimisation Team pharmacist or technician directly or go via North West Surrey CCG main switchboard 01372 232400 asking to be put through to the Medicines Optimisation Team
East Surrey CCG Guildford & Waverley CCG Surrey Downs CCG Surrey Heath CCG	Through the local medicines management teams or through the relevant lead commissioning pharmacist Contact through Surrey Downs CCG main switchboard (01372 201700) or the medicines management team administrator (01372 201805)

There may be some occasions where requests from tertiary centres are in conflict with the local Traffic Light System. In these instances the prescriber should:

- Consider whether they have the confidence and knowledge/experience to accept the clinical responsibility associated with prescribing the drug
- Decide whether they have been given sufficient information from the tertiary centre or if there is a shared care protocol available from the tertiary centre
- Contact a member of the CCG Medicines Management team for further advice if necessary – drugs funded by NHS England that are for specialised services should not be prescribed by in primary care.

If a prescriber is unwilling to accept responsibility, it should be possible for prescriptions to be issued by a hospital doctor and posted to a patient who lives at a distance from the hospital.

NB: Where a Red drug is prescribed by a practice the financial impact should be considered. An adjustment to the practice prescribing allocation is highly unlikely to be made to cover the cost of prescribing.

2.10 PAYMENT BY RESULTS (PBR) EXCLUDED DRUGS AND DEVICES , FUNDING REQUESTS TO THE CCG FROM ACUTE TRUSTS FOR HIGH COST DRUGS

A number of high cost drugs, devices, procedures and products have been excluded from the scope of the national tariff of PbR. PbR excluded drugs are not included within the national tariff prices that are paid for routine packages of care. Some of the PbR excluded drugs are funded by NHS England for specialised services and some are funded by the CCG.

The Surrey CCGs have agreed specific commissioning arrangements for PbR excluded drugs (which fall under the remit of CCGs) with the providers from which it commissions services. An annual commissioning intentions document details the CCGs' criteria and specific funding arrangements for each of the PbR excluded drugs; it cannot be assumed that the Surrey CCGs will automatically fund these drugs.

A series of standard forms have been developed ('tick box' or individual funding request form) in line with the CCGs' PbR excluded drug commissioning intentions. Acute trusts must use these forms for either prior approval or notification as applicable. Forms **must** be submitted electronically via the web-based database https://www-blueteq-secure.co.uk/trust. The patient must meet ALL pre-determined criteria for funding to be approved.

An individual funding request (IFR) should be submitted where a request for a PbRe drug is made for use outside of the commissioning intentions or when the commissioning intentions specify that an IFR must be submitted for that particular drug and indication. If the IFR clinical triage panel agrees that the case is eligible for consideration as an IFR, it will be discussed at the next available IFR panel. IFR panels are held on the 4th Wednesday of each calendar month.

Although the majority of the PbR excluded drugs are Red drugs on the traffic light system (prescribing to be retained in secondary / tertiary care) detailed guidance on the use / prescribing of these drugs across the interface can be found in the Prescribing Advisory Database (see section 1.7)

Most of these drugs and devices are specialist in nature and should not be prescribed in primary care. Due to the complexities of funding streams, if primary care prescribe a drug that is usually funded through NHS England, the CCG will pick up the costs of a drug for which they do not have allocated funds; this will then impact on the resources available to support other local services. In addition, if a patient does not meet the defined criteria for access to the drug, this will lead to inequity.