NHS
Surrey Heartlands

CLIN09

Interface Prescribing Policy

Policy number	CLIN09
Version	2.1
Approved by	Surrey Heartlands Medicines Optimisation Board
Name of originator/ author	Sarah Watkin, Associate Director of Pharmacy
Owner (director)	Linda Honey, Director of Pharmacy
Date of last approval	March 2024
Next approval due	March 2025

Version control sheet

Version	Date	Author/ Committee	Status	Comments / changes since last version
1.0	21/03/2023	Sarah Watkin	Final	i) Policy from the former CCG restored to Version 1.0 for the new ICB and CCG/ICS amended as appropriate to ICB ii) Section 2.4: removed Chief Pharmacists as contact iii) Section 2.11: link to generic/brand prescribing guidance added iv) Section 3.1: removed reference to annex A v) Section 5.4: removed reference to service development plan for discharge medication service vi) Section 6 amended for Royal Surrey supply to 14 days – and exceptions updated vii) Section 6.2: wording amended to confirm expectation for patients own drugs viii) Section 7.2: amended to remove specific example of antibiotics ix) Section 7.3: patient pack changed to original pack x) Section 14.1: Added timeframe for primary care response
2.0	6.3.24	Tejinder Bahra	Final	i) Section 1.6: addition of ‘General Practitioners may also be referred to as Primary Care Prescribers. ii) Section 2.10: addition of 'Where there is evidence for their use, the medicines should be treated as ‘red’ drugs and prescribed and monitored by the provider only'. iii) Addition of point 2.21. iv) Section 4.3: addition of 'sedatives prior to procedures' as an example. v) Section 6.5: information on allergies amended to include 'any other adverse drug reactions'. vi) Section 7.1: addition of 'Prescribing should be in line with the Surrey PAD and the traffic light status should be respected regardless of the type of outpatient appointment' and 'Trusts must have arrangements in place to supply medicines for non-face to face

Version	Date	Author/ Committee	Status	Comments / changes since last version
				consultations e.g., for urgent use, red and amber medicines etc'. vii) Section 9.1: addition of 'Cost-effective product choices are expected to be considered wherever possible'. viii) Addition of point 9.3. ix) Section 9.4: addition of 'The general principle is that all providers will ensure patients will be discharged with access to all their medicines (including pre-admission medicines), in line with local policy'. x) Section 17: change of nomenclature from non-medical to multiprofessional prescribing.
2.0	20/03/2024	Surrey Heartlands Medicines Optimisation Board	Final	Approved
2.1	04/04/2024	Sarah Watkin	Final	QEIA updated after review – no change to policy

Equality statement

Surrey Heartlands Integrated Care Board (ICB) is committed to promoting equality and diversity in all its activities and to promoting inclusive processes, practices and culture.

- We will strive to work to eliminate any unlawful or unfair discrimination including direct or indirect discrimination, discrimination by association, discrimination linked to a perceived characteristic, harassment and victimisation.
- We will remain proactive in taking steps to ensure inclusion and engagement for all the people who work for and with us.
- We will continue to strive towards a culture that is diverse and inclusive that recognises and develops the potential of all staff and service users.
- We recognise the business benefits and opportunities of having a diverse community of staff who value one another and realising the contribution they can make to achieving the ICB's vision.

This includes promoting equality and diversity for all irrespective of:

- age*
- disability*
- ethnic group*
- sex*
- gender reassignment*
- religion or belief*
- sexual orientation*
- marriage and civil partnership*
- pregnancy and maternity*

*Under the Equality Act (2010) these are known as "protected characteristics".

In addition, it includes promoting equality and diversity for carers, people with diverse communication needs and members of the armed forces community.

The ICB aims to meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We take into account the Human Rights Act 1998 and promote equal opportunities for all. We embrace the seven staff pledges in the NHS Constitution that represent a commitment by the NHS to provide high-quality working environments for staff. This policy is consistent with these pledges.

This document has been assessed to ensure that no employee or member of the public receives less favourable treatment based on their protected characteristics.

Members of staff, volunteers or members of the public are invited to request assistance with this policy if they have particular needs. If the member of staff has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

Quality and Equality Impact Assessment

Completed	4/4//2024
Lead Author	Sarah Watkin, Associate Director of Pharmacy
Responsible Director	Linda Honey, Director of Pharmacy
Location of full QEIA	S:\Medicines Management\Medicines Resource Unit\Pharmaceutical Commissioning\Contracting\Interface Prescribing Policy\IPP 2024-25
Outcome	**Outcome 1 -** No major change to the policy required. This QEIA has not identified any potential for discrimination or negative impact, and all opportunities to promote equality have been undertaken.

Contents

Surrey Heartlands Interface Prescribing Policy 2023-24

Appendix to the National Standard NHS Contract

1. Introduction

1.1 The Department of Health requires that NHS providers establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner.

1.2 This policy has been produced for providers of NHS services commissioned to deliver services which include prescribing and drugs.

1.3 The aim is to facilitate consistent prescribing policies in the National Standard NHS Contracts across NHS Surrey Heartlands Integrated Care System (ICS).

1.4 It is recommended that Acute Trusts, Mental Health Trusts, Community Services, other relevant providers and contract managers seek the advice of their Chief Pharmacist/Pharmaceutical Adviser during the commissioning process and discussions to ensure that implications for pharmacy and prescribing are considered.

1.5 Organisations to which this policy applies, will jointly monitor compliance with this policy through regular review via their routine interface and contracting mechanisms.

1.6 General Practitioners (GPs), Hospital Trusts, Mental Health Trusts, Community Services providers, and other relevant providers to which this policy applies are hereafter referred to as “providers”. General Practitioners may also be referred to as Primary Care Prescribers.

2. General Principles

2.1 The provider will adhere to both legal and good practice guidance on prescribing in line with the Medicines Act and any other national/local guidance including shared care. All medicines will be prescribed, handled, maintained, stored, administered and disposed of in accordance with relevant legislation and best practice.

2.2 Providers will have a Drug and Therapeutics Committee (DTC) (or equivalent) in place to co-ordinate the use of medicines, dressings, appliances, enteral feeds and oral nutritional supplements, glucose monitoring strips and any other items that are issued on prescription in a similar way to medicines, across the primary and secondary care interface. The DTC will develop an up-to-date formulary (or equivalent) with the involvement of primary care prescribers and the ICB Medicines Management Team.

2.3 Processes for the DTC and any local formulary will be in line with the recommendations in NICE MPG1: Developing and updating local formularies Developing and updating local formularies (nice.org.uk), and Innovation Health and Wealth: Accelerating Adoption and Diffusion in the NHS Accelerating adoption of innovation in the NHS - GOV.UK (www.gov.uk).

2.4 Provider prescribing will be from the provider formulary (or equivalent) and prescribers will not seek to avoid formulary restrictions by asking primary care prescribers to prescribe non-formulary medicines. Primary care prescribers should highlight any such

request to their Place Based Medicines Optimisation Team to identify any themes or specific risks.

2.5 Providers will contribute to the local arrangements for the managed entry of new medicines via the Surrey Heartlands Area Prescribing Committee (APC). This will consider the clinical and cost-effectiveness of new medicines and the impact on primary as well as secondary care. The introduction of new medicines or prescribable* items which have an impact on primary care will be agreed via the APC unless an alternative local arrangement is explicitly agreed by the APC.

2.6 The provider will be responsible for the dissemination and implementation of the decisions made by the APC via the DTC (for medicines) or equivalent appropriate committee (for other prescribable items*).

*Prescribable items include but are not limited to enteral feeds and oral nutritional supplements, infant formula, dressings, catheters, stoma items, blood glucose monitoring strips and other items that are issued on a prescription in a similar way to medicines.

2.7 The ICB will not routinely commission for use, a medicine under review by NICE, for which no appraisal or guideline has yet been published, regardless of the existence of a zero-cost scheme unless there is a local written agreement in place. Any provider signing up to such an offer does so at their own risk and should follow advice issued by the Regional Medicines Optimisation Committee (January 2020).

Providers should understand that where the final published guidance does not recommend the therapy, or where the individual patient does not meet the NICE recommended criteria for use, the ICB would in no way be bound to fund on-going treatment.

2.8 Where a medicine receives a positive appraisal and recommendation for use by NICE, local procedures for adoption of NICE recommended medicines will be followed. Evidence of NICE guidance implementation will be publicised on the provider organisation's website and evidence of compliance may be requested.

2.9 Providers will provide assurance that the decisions made by the APC are implemented within 3 months. If there are exceptional circumstances when a decision is not implemented this needs to be stated.

2.10 Acute Trust providers will consider making drugs classified as 'Non-formulary' (formerly Black) on the Surrey Prescribing Advisory Database (PAD) or local formulary, as non-formulary on their provider formulary. Where there is evidence for their use, the medicines should be treated as 'red' drugs and prescribed and monitored by the provider only.

2.11 Prescribers and pharmacists will prescribe and/or recommend, dispense and label by generic drug name except where this is clinically inappropriate or locally agreed. Providers must prescribe by brand when it is recommended by national guidance see Guidelines : Generic prescribing (res-systems.net)

2.12 Providers will routinely dispense medicines in patient packs, to comply with European Community directive 2001/83/EC and Human Medicines Regulations 2012 on pharmaceutical labelling and the provision of information to patients. Where patient

packs are not clinically appropriate, providers will make alternative arrangements to ensure patients receive such information.

2.13 Providers will have policies in place and approved by their DTC (or equivalent) to cover the safe and secure handling of medicines in line with Royal Pharmaceutical Society Professional Standards for Hospital Pharmacy Services Professional Standards for Hospital Pharmacy (rpharms.com) to meet CQC requirements.

2.14 Providers will comply with principles contained in local, national and professional guidance including National Service Frameworks (NSFs), NICE Technology Appraisal Guidance and relevant Health Service Circulars (HSC), NHS Executive Letters (NHS EL) Health and Safety Guidance (HSG) and Audit Commission reports. Prescribing responsibility between primary and secondary care clinicians will be based on the NHS England guidance NHS England » Responsibility for prescribing between primary and secondary/tertiary care.

2.15 Legal responsibility for prescribing lies with the health care professional who signs the prescription, and it is the responsibility of the individual prescriber to prescribe within their own competence. For further information see the General Medical Council's 'Good practice in prescribing and managing medicines and devices (2013)'.

2.16 Providers will comply with guidance on managing conflicts of interest issued by NHS England available at: https://www.england.nhs.uk/ourwork/coi/. Providers will adhere to ICB policies for working with the commercial organisations including pharmaceutical industry. Providers will not start patients on free samples of prescribable items unless approved by APC (or local joint formulary) or local DTC. 'Added value' offers or benefits in kind e.g., company sponsored staffing must be explicitly noted in any new drug application and approved by commissioners.

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

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

2.19 Providers are expected to implement the recommendations of NHS Patient Safety Alerts and other drug alerts within the time frames specified within the alerts and participate in any relevant audits. Providers must supply safety cards and appropriate support materials to all patients in respect to these alerts and to patients treated with a biologic medicine.

2.20 Providers wishing to prescribe any ICB commissioned drugs excluded from National Tariff must adhere to the ICB's 'Arrangements for medicines excluded from the national tariff payment system' document (see Section 3 for information on funding) or a specific locally agreed service.

2.21 Information referred to in this policy which is to be shared with patients must be provided in line with the Accessible Information Standard and language requirements to ensure optimal medicines use.

3. Funding – in-tariff and for medicines not reimbursed by national prices

Note: these medicines were formerly known as Payments by Results (PbR) excluded).

3.1 All new and existing drugs and technologies will be provided within the scope of National Tariff guidance unless:

- explicitly excluded from tariff as described by NHS England in its National tariff workbook **and** funding is agreed with commissioners, or
- as part of excluded services or
- through local arrangements agreed with the commissioners

Drugs and devices excluded from the National Tariff will either be:

- Commissioned by NHS England; or
- Commissioned by an Integrated Care Board (ICB)

The ICB commissioned drugs and devices will be stated in the ICB's 'Arrangements for medicines excluded from national tariff payment system' document.

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

A full data set as defined by NHS England Clinical Data Set will be submitted for all drug charges and any subsequent challenges. The NHS Clinical Data Sets define the standard information requirements but as a minimum this will include:

- NHS number
- Drug or device name - both generic and brand (statement of brand name for biosimilar products as recommended as good practice by MHRA)
- Quantity supplied e.g., 4 x 50mg prefilled injection
- Date of issue
- Acquisition cost (or reference price if applicable) of drug (ICB can request invoice for verification)
- Speciality or clinical department
- Indication (preferred but not mandatory if speciality or clinical department already stated)

Any additional pre-agreed charges will be listed on a separate line to the related drug or device within the invoice.

3.2 The provider must give confirmation that the patient (or in the case of a minor or vulnerable adult, with the parent/legal guardian/carer) has given appropriate explicit consent for relevant personal, confidential, and sensitive information to be passed to the ICB for processing any new funding or continuation of funding request and for validating subsequent invoices.

3.3 Drug charges must be for the drug only and at acquisition cost or at nationally/locally procured/contracted prices, whichever is lower. There will be no additional charges automatically added to drug prices without prior discussion and explicit agreement with commissioners and in accordance with National Tariff rules. Commissioners and providers will agree principles for funding drugs at cost above contract price as a priority in 2021/22.

3.4 It is the responsibility of the provider to ensure that all national and locally agreed Patient Access Schemes (PAS) or commercial agreements are put in place within the provider and all such drugs will be charged to the commissioners as per the detail of the PAS or commercial agreement.

3.5 The provider will respond to invoice challenges within the contractual time frame for all challenges as agreed.

3.6 Where separate arrangements have been agreed (see the ICB's 'Drugs and Devices excluded from the National Tariff' document), the ICB will agree specific funding mechanisms and treatment pathways for excluded drugs, with providers. Unless otherwise stated, funding for positive NICE technology appraisals is included in the tariff.

3.7 Locally agreed (previously known as pass-through) payments are additional payments for use of a particular device, technology or drug and can be made to providers over and above the relevant tariff reimbursement. The ICB and providers must agree that payment is intended primarily for new devices, drugs, treatments or technologies or to new applications of existing technology. For any locally agreed payment arrangement the following criteria and conditions apply:

- The arrangement will be fixed for a maximum of 3 years.
- The ICB will have regard to the existing cost effectiveness evidence including any NICE guidance or other relevant national guidance.
- The price attached to the additional funding will be agreed in advance and the price will only relate to the additional costs associated directly with the device or technology and its use relative to the cost of the alternative treatment.
- Where additional funding for a more expensive treatment has been agreed on the basis that other costs to the health economy will be reduced, providers will be able to demonstrate that the projected benefits have been realised. Data collection criteria for this will be agreed in advance.

3.8 Exclusions to the contract may be subject to specific reporting requirements which will be agreed in advance.

3.9 Unpredicted in-year cost pressures, excluding NICE technology appraisals, will be managed by discussion between the provider and the commissioners, and will be clearly communicated to all commissioners in advance.

3.10 A process is in place for considering funding for individual patients on an exceptional basis**.** Please refer to the ICB policy 'CLIN01 Clinical Commissioning Policy: Individual Funding Requests'.

3.11 Cost pressures identified as a result of horizon-scanning, including NICE technology appraisals, will be managed by discussion between the provider and the commissioners, and will be clearly communicated to all commissioners in advance.

4. Referrals and admissions

4.1 The referral for specialist assessment must include as per Professional Records Standards Body, available at https://theprsb.org/ :

- Medication names, form, strength, dose, frequency and indication for:
  - Acute prescriptions in the last 12 months
  - Repeat prescriptions
  - Discontinued medicines related to referral condition
  - Medicines prescribed elsewhere
- Any adverse reactions or allergies with details of causative agent

Any special supply arrangements must also be included in referral information.

Electronic record sharing systems will be used to facilitate the transfer of information on medicines where available.

4.2 All providers will have medicines management arrangements in line with national guidance (NICE NG5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes) on medicines reconciliation on admission which will include:

- Provision of information to patients before planned admissions about the arrangements in the providers e.g., for bringing in own medicines, self-administration, use of patients own medicines, dispensing for discharge.
- Arrangements for medicines history taking and pharmacist review of medication.
- Exclusions for day cases

4.3 Primary care prescribers will not be asked to prescribe medicines and other items which are intended to be used/administered in hospital out-patient clinics, day-care surgery (e.g.: intra-uterine levonorgestrel implants, topical anaesthetic creams, sedatives prior to procedures) or in a patient's home, if provided as part of a package of care or if the medicines are required as part of a planned procedure (e.g., anticoagulation bridging).

It is the provider's responsibility to ensure that arrangements are in place to ensure any treatments are available as appropriate.

Note: this does not apply to those medicines which have been prescribed by the GP for patient's use at home and which the patient has brought into the provider as a "patients own medicine" for an inpatient, day case stay, or during outpatient appointments.

4.4 The requestor of any test is responsible for ensuring any action required as a result of that test. Providers will ensure that any treatment required as a result of pre-operation

assessment clinics e.g., MSU and MRSA testing is supplied to the patient by the requestor in a timely manner and for the whole treatment period.

5. Inpatients

5.1 The ICB encourages the use of patients own medicines in hospital in line with the Audit Commission report 'A Spoonful of Sugar' (2001). GPs and other primary care professionals should encourage patients to take their own medicines with them into hospital. If the patient has brought their own medicines into hospital with them and they are suitable for use, these can be used on the wards in line with the provider's local policy.

5.2 The ICB and providers encourage the use of "green bag" and "message in a bottle" schemes.

5.3 The provider is responsible for the supply of any new medicine or continuation of existing medicines to inpatients when the patient's own supply drops below 7 or 14 days (as agreed locally) days (see section 6). This may exclude specified continuing care units.

5.4 Providers will support safe discharge by using digital referral to community pharmacies for identified patients (as agreed with the operational group for the Discharge Medicines Service (DMS), If not yet available, the provider will work towards implementation according to an agreed plan for 2024-25.

6. Discharge Arrangements

6.1 The general principle is that all providers will ensure patients will be discharged with access to all their medicines (including pre-admission medicines), in line with local policy.

As agreed, as per the NHS Standard Contract (NHS Standard 22/23 contract wording 'for the period required by local practice… (but at least 7 days)', the minimum supply agreed locally is as follows:

Trust	Minimum no. days' supply
Ashford and St Peter's NHS Foundation Trust	14
Epsom and St Helier University Hospitals NHS Trust	14
Royal Surrey NHS Foundation Trust	14
Surrey and Borders Partnership NHS Foundation Trust	14
Surrey and Sussex Healthcare NHS Trust	14

6.2 The provider must supply that quantity of medication to the patient, except to the extent that they are assured that the patient already has an adequate quantity and/or will receive an adequate supply via an existing repeat prescription from the patient's primary care prescriber.

6.3 Patients will normally be discharged from providers **in line with local policy**, with a **minimum supply of** 14 days (as agreed locally) or an original pack, whichever is the higher (including trusts employing dispensing for discharge systems) unless:

- The full course or duration of treatment is less than 14 days e.g., electrolyte supplements or
- If continued supply requires a clinical review to ensure safe prescribing a supply less than 14 days may be given e.g., opioids for acute pain or
- The patient is palliative when a quantity appropriate to the patient's need will be supplied; or
- When responsibility for prescribing remains with the hospital (section 13), an adequate supply will be given to ensure continuity until next clinical review; or
- The patient was admitted on a non-formulary drug that cannot be fully replenished to 14 days by the trust or
- Local arrangements are in place for other prescribable items e.g., enteral feeds supplied according to contract.

In all these exceptional cases, the patient must be informed of the reasoning for not supplying 14 days (of some or all of their medication) and given advice on whether they need further supply, how to obtain it and what the urgency is.

This also applies to existing pre-admission medicines when the patient's own drug supply is less than 14 days on discharge unless the provider is assured that the patient will have direct access to their pre-admission medicine for at least 14 days on discharge.

6.4 The requirement to supply a minimum of 14 days (as agreed locally) of medication on discharge also applies to patients requiring adherence support, including patients requiring multi-compartment compliance aids (see section 6.11 for further details).

6.5 The GP will be provided with the following information about the patient's medicine:

- Diagnosis and reason for admission
- Medicines on discharge (including dose and frequency) with clear instructions as to whether or not the medicine should be continued after the initial supply.
- Any monitoring required including anticipated increase/decrease in dose.
- For all new medication, the specific reason for starting the new medication will be stated and the duration of treatment will be indicated where appropriate (e.g., clopidogrel, PPIs, antibiotics, opiates)
- For any existing medication which is stopped, the specific reason for stopping will be stated.
- For any pre-admission medicine which is changed, the specific reason for the change will be stated.
- For any medicines requiring ongoing prescribing by hospital, and initiated on the current admission, arrangements for ongoing supply must be in place and this will be communicated on the discharge summary.

- If patients are initiated on enteral feeds or oral nutritional supplements, dressings or appliances (e.g., stoma appliances, catheters), the provider is expected to provide communication from the initiating clinician to the GP regarding the patient's clinical care plan and quantities required for ongoing prescribing/supply.
- Clear instructions on medications (reasons for taking them, dosage, when to take them, and any other additional instructions)
- Details of medicines tried in hospital but which proved unsuitable
- Details of any compliance aids issued e.g., reminder charts.
- Any information on allergies in line with NICE CG 183 Drug allergy: diagnosis and management from September 2014 and any other adverse drug reactions.

6.6 For patients admitted for a reason unconnected with their previous medication regimen, e.g., for surgery, the discharge information must list any drugs added with a clear indication of expected duration of use and any still in use at discharge. If the remaining drugs are unchanged then the discharge notification can state "Other drugs as at pre-admission".

6.7 For patients admitted for a reason unconnected with their previous medication regimen, e.g., for surgery **and** where there is no change in any medicine at discharge, the discharge information can state "no changes made".

6.8 Discharge information will be sent to the patient's GP at the time of discharge. Discharge information will be electronic and sent within 24 hours of patient discharge to the GP and copied to the patient (or sent to the GP within 1 working day in cases where the patient has died).

6.9 Patients will be provided with appropriate information about obtaining further supplies of medicine.

6.10 Patients at risk of experiencing problems managing their medicines should be identified and, if appropriate, a referral made for pharmaceutical support. Any issues identified as a risk to safe discharge will be mitigated by the provider.

6.11 Monitored Dosage Systems and other Compliance Aids

Providers are encouraged to develop discharge planning arrangements for vulnerable patients. The use of monitored dosage systems and other compliance aids are not routinely supported unless clinically required - an assessment for appropriateness will be undertaken in line with the Royal Pharmaceutical Society's 2013 guidance on better use of multi-compartment compliance aids before a monitored dosage system is initiated. Where the supply of a monitored dosage or other similar system is appropriate there will be a policy in place for its use including making appropriate arrangements for continuity after discharge.

6.12 Dispensing for Discharge (One Stop Dispensing)

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

7. Outpatients/Day Case

7.1 Medication will be provided for outpatients in line with local policy and this includes, but is not limited to, prescribing from all outpatient-type appointments such as:

- Advice and Guidance (A&G)
- Patient Initiated Follow Up (PIFU)
- Health Care Prescriber (HCP) led clinics
- Remote consultations
- Triage

Prescribing should be in line with the Surrey PAD and the traffic light status should be respected regardless of the type of outpatient appointment.

Trusts must have arrangements in place to supply medicines for non-face to face consultations e.g., for urgent use, red and amber medicines etc.

7.2 Provision of medicines following an out-patient appointment may include writing to the primary care prescriber and suggesting medicines if **not** required for immediate treatment i.e., initiation not required within 14 days. When recommending treatment, the prescriber where possible, will recommend a therapeutic class of drug, rather than a specified product.

Patients will be provided with written information telling them that the medicine is not urgent and that they should contact their surgery in approximately 14 days when the surgery will inform them when to collect their prescription.

Full information will be received by the primary care prescriber to enable a prescription to be issued – the advice letter from the provider will normally be received within 7 days. Where this is not possible, patients will receive supplies from the provider. Providers will ensure that outpatient letters are completed so that professionals, patients and carers receive timely, consistent, reliable, high-quality information between clinicians and patients.

For safety and clarity, any changes in medication or route of supply will be highlighted and a clear statement given to indicate if a primary care prescriber is being asked to initiate or change medication, or to highlight any regular medicines that will be supplied from the provider.

7.3 The following categories must be prescribed by the providers:

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

7.4 Where a prescription is issued the quantity provided will be in line with local policy. Original packs will normally be dispensed unless the full course of treatment is shorter (e.g., antibiotics, short-term analgesia or short-course corticosteroids). A longer supply may be indicated e.g., where the dispensed pack cannot be easily divided; for diabetics receiving insulin, or when the consultant feels there are clear medical reasons why they will supply the whole course (monitoring requirements) or when ongoing drug treatment is part of a commissioned service (in which case the drug will be included within tariff).

7.5 Providers will ensure that their outpatient prescription form clearly states that the prescription can only be dispensed at the provider's own pharmacy and cannot be taken to any other pharmacy or to the patient's primary care prescriber to request a prescription. Providers must ensure that patients are made aware of this and make provision for supply even if out of stock.

7.6 Primary care prescribers should not be asked to initiate products specified in the NHS England document '*Items which should not routinely be prescribed in primary care: Guidance for CCGs'* unless the patient has exceptional circumstances as identified by the guidance. Similarly, for patients newly initiated on such treatment by the Provider, GPs should not be asked to continue this treatment unless exceptional circumstances apply as per guidance.

For a full list of items and exceptional circumstances, the guidance can be accessed via: https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/

7.7 Primary care prescribers should not be asked to initiate products specified in the NHS England document *'Conditions for which over the counter items should not routinely be prescribed in primary care: Guidance for CCGs'* unless the patient has exceptional circumstances as identified by the guidance. Similarly, for patients newly initiated on such treatment by the provider, GPs should not be asked to continue this treatment unless exceptional circumstances apply as per guidance.

For a full list of items and exceptional circumstances, the guidance can be accessed via: https://www.england.nhs.uk/medicines/conditions-for-which-over-the-counter-items-should-not- routinely-be-prescribed/

7.8 Providers will communicate any ongoing treatment plan for medicines administered by providers on a one-off/infrequent basis e.g., annual dose of intravenous zoledronic acid. Primary care prescribers will ensure that patient medication records include and accurately record these medicines and treatment plan to be alert to potential side-effects and interactions with other medicines prescribed in primary care. This will ensure that primary care records, which are accessed by other healthcare providers, are a true and accurate reflection of the patient's medication.

8. Homecare

8.1 Providers and commissioners will fully implement their responsibilities as described in Royal Pharmaceutical Society Professional Standards for Homecare Services. Suitable arrangements for setting up homecare services, including the responsibilities

of providers and the ICB with funding arrangements clearly identified prior to setting up the service.

9. Other prescribable items

9.1 The provider will work with the commissioner when contracts are negotiated for the procurement or supply of items such as continence or stoma devices, glucose monitoring devices or enteral feeds and oral nutritional supplements which may require ongoing prescription in primary care. Cost-effective product choices are expected to be considered wherever possible.

9.2 In the case of Oral Nutritional Supplements (ONS), providers will only supply feeds on discharge if accompanied with a nutritional management plan including a Malnutrition Universal Screening Tool (MUST) score completed by a dietician and goals of treatment. Oral nutritional supplements requested on discharge will be reviewed for ongoing need and swapped to cost effective products in line with primary care prescribing guidance unless it is clearly stated in the dietician's letter that the ONS requested is unsuitable for swapping.

9.3 In the case of wound dressings, prescribing should be in line with the wound dressing formulary and associated documents on the Surrey PAD, available at: Guidelines : Wound management (res-systems.net)

9.4 Suitable local arrangements will be in place for the supply of dressings and appliances. The general principle is that all providers will ensure patients will be discharged with access to all their medicines (including pre-admission medicines), in line with local policy. A minimum of five days' supply will be provided. Sufficient information about a patient's dressing and appliance treatment will be provided to ensure continuity of care in the community. See also section 6.4 regarding communication with the GP.

9.5 Providers will not request primary care prescribers to prescribe dressings outside of the ICB's dressing formulary.

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

10. Patients attending Accident and Emergency departments.

10.1 If a prescribed medicine is necessary and the required treatment course is ≤ 14 days, the full course will be supplied. Where longer term medication is required, a minimum of 14 days treatment will be supplied. This is to allow the primary care prescriber sufficient time to receive the information about the patient's A&E attendance and arrange a continuing supply. In all other circumstances, 7 days treatment should be supplied (unless the treatment course is shorter).

10.2 Information will be sent to the GP within 3 working days and will include a minimum data set as specified in section 6.4.

11. People at risk of harm

11.1 When making arrangements for the prescribing of medicines for someone who may be at risk of self-harm or have the potential to misuse the medication, the arrangements should fit within the overall care plan for the individual service user. In addition, the safe use of some medicines requires specific information resources, such as the patient guide, prescriber checklist and patient card for girls and women of childbearing age who may be taking or considering taking certain medicines such as valproate.

12. Unlicensed medicines or medicines used outside of their licensed indication(s)

See also the APC's document Recommendations for the use of unlicenced meds and licensed meds for unlicensed indications (generic PAD version) - Apr 2018.pdf (res-systems.net).

12.1 Prescribing of unlicensed medicines or medicines used outside their licensed indications will usually remain the responsibility of the clinician initiating treatment. The provider will accept full responsibility for the continued sourcing, quality and supply, which will be under the control of the provider pharmacy department. In these cases, information must be given to patients explaining that they must obtain continuing supplies of their medicine only from the provider, not their primary care prescriber.

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

12.3 Informed consent for the use of unlicensed medicines or the use of licensed medicines outside their licensed indications will be obtained from patients/carers before the prescription is written.

12.4 Prescribing of products classified as Borderline Substances outside of circumstances approved by the Advisory Committee on Borderline Substances (ACBS) remain the responsibility of the clinician initiating treatment. The provider will accept full responsibility for the continued sourcing, quality and supply, which will be under the control of the provider pharmacy department. In these cases, information must be given to patients explaining that they must obtain continuing supplies of their medicine only from the provider, not their primary care prescriber.

13. When Responsibility for Prescribing Remains with Providers

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

13.1 The provider trust is expected to retain prescribing responsibility for the following:

- Medicines requiring ongoing specialist intervention and specialist monitoring including those classified as RED and those subject to transfer of care arrangements (AMBER or BLUE medicines with minimum supply criteria)
- Patients receive the majority of ongoing care, including monitoring, from the provider and the only benefit of transferring care would be to provider costs.
- Medicines that are unlicensed or are being used outside of the product license e.g., for an unlicensed indication or at an unlicensed dose unless there is a recognised evidence base and/or it is standard treatment. In terms of paediatric medicines, inclusion of dosage guidance in the children's BNF provides a suitable evidence base (see section 11.2 for clarification)
- Medicines that are only available through the provider i.e., are not available on FP10 including certain 'borderline' products when used outside approved indications.
- Medicines that are part of a provider initiated clinical trial or the continuance of a provider initiated clinical trial or compassionate use, where no arrangement has been made in advance with the purchaser to meet the extra cost of the treatment.
- The primary care prescriber does not feel confident in taking on clinical responsibility for the prescribing of a drug and there is no shared care guideline for that drug.
- Medicines and other items e.g., dressings which are intended to be used/administered in the provider's outpatient clinics or day-case surgery e.g., intrauterine levonorgestrel implants, local anaesthetic creams.
- Medicines and other prescribable products, which have not been approved for addition to the provider's formulary.
- A medicine under review by NICE, for which no appraisal or guideline has yet been published.
- Drugs that have not gone through due consideration processes at the ICB
- All anti-cancer medicines except where shared care prescribing or other arrangements exist.
- All other treatments funded by NHS England unless specifically agreed to be provided through a shared care prescribing agreement or other agreed process.
- Where there has been no collaboration or agreement with the patient and/or carer
- Packages of care:
    - ICB commissioned injectable antibiotics, antifungals and antivirals (unless special local arrangements exist)
    - Drugs for IVF (see local ICB policy)
    - All orphan drugs* commissioned by ICBs

- Insulin pumps (package of care)

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

13.2 If there is disagreement about where prescribing of an individual patient's treatment should best take place the case should be referred to the ICB, via the Place Chief Pharmacist/Deputy Chief Pharmacist (Out of Hospital) who will seek resolution between the parties concerned. Disagreements over the principles of prescribing responsibility, not individual disagreements that are resolved case by case, are probably best resolved at the Area Prescribing Committee. Care will be taken to ensure that the patient does not suffer as a consequence of the NHS decision-making process and co-operation on both sides is sought in achieving resolution in difficult situations.

13.3 Repeat prescriptions for specialist drugs will not incur an attendance tariff charge unless the patient receives a clinical review. The provider will make arrangements for issuing medication in between clinical reviews as appropriate.

13.4 Primary care prescribers will be informed of any drugs which continue to be prescribed by the specialist. Discharge and outpatient letters will clearly state that these drugs are to be supplied by the provider and that the primary care prescriber is not expected to prescribe.

13.5 Primary care prescribers will ensure that patient medication records include and accurately record any medicines for which prescribing remains the responsibility of secondary or tertiary care providers in order to be alert to potential side-effects and interactions with other medicines prescribed in primary care. This will ensure that primary care records, which are accessed by other healthcare providers, are a true and accurate reflection of the patient's medication.

14. Transfer of Prescribing - medicines requiring specialist monitoring (drugs that are classified as Amber or Amber*/Blue on the APC traffic light system)

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 primary care prescribers if sufficient support, review and information are shared between the primary care prescriber and consultant.

14.1 It is the responsibility of the specialist to request shared care with a primary care prescriber. Primary care should respond to any request with 14 days.

The key principle is that the primary care prescriber is provided with information and given the opportunity to accept prescribing responsibility before informing the patient and before the transfer takes place.

Under no circumstance will the patient be used as the mechanism for informing the GP that prescribing will be transferred to them.

14.2 It would not normally be expected that a primary care prescriber would decline to prescribe on the basis of cost unless there is a clinically suitable cost-effective alternative available. Likewise, if the patient is to receive the majority of their on-going care through the provider, then prescribing must remain with the provider and must not be transferred solely on the basis of cost or practical considerations of supply.

14.3 The following conditions will be met before shared care takes place:

- The initial specialist responsibilities set out in the shared care guideline have been fulfilled.
- Treatment is in accordance with a patient-specific shared care protocol/information leaflet which clearly defines the responsibilities of all parties. This document must have been approved by the Trust DTC and by the APC and must contain the trust logo and contact details for the relevant department and clinician in the back-up advice and support section of the document.
- The written agreement of the patient's GP is given prior to the transfer of prescribing.
- The primary care prescriber is sufficiently informed and able to monitor treatment and identify medicines interactions.
- Specialists will ensure that patients are aware of and understand their responsibilities to attend appointments and undertake appropriate monitoring arrangements. They will advise patients that their medicine may be stopped if they do not fulfil these responsibilities.

All prescribers will be aware of their responsibilities to develop their own and the expertise of others in the managed introduction of new medicines.

15. Tertiary Care Referrals

15.1 It is expected that the care and treatment of patients referred to tertiary care will remain the responsibility of the tertiary centre while they continue to require specialist care or as indicated within NHS England service specification.

If NHS England are providing an advisory service for the assessment and development of a treatment plan only, the referrer is responsible for making prescribing decisions in relation to the referral.

Primary care prescribers will only be asked to prescribe drugs initiated by tertiary care referrals if the referral is compliant with the requirements of the Interface Prescribing Policy.

15.2 Where it is clinically appropriate for the patient to be cared for at home, under the supervision of the tertiary centre, the centre will make appropriate arrangements for prescribing and supply of specialist medicines (e.g., 'Purchasing high-tech healthcare at home' EL95/5 or using FP10(HP)s).

15.3 In some circumstances it may be appropriate to transfer prescribing to a more local provider trust or more rarely a primary care prescriber. In all situations there will be robust processes in place between the tertiary centre, provider trust and primary care

prescriber to ensure timely and accurate transfer of a patient's medication details to appropriate professionals responsible for the patient's care.

16. Patient Group Directions

16.1 Providers wishing to use Patient Group Directions (PGDs) to deliver any part of the service are required to develop and use PGDs within the appropriate clinical governance framework as outlined in national guidelines (e.g., NICE Good Practice Guidance MPG2) and obtain appropriate medical and pharmaceutical advice in drawing up the documents. Where the legal framework does not allow this, the provider may seek advice from the Commissioner. Providers are reminded that PGDs will not be used to supply unlicensed medicines and in the case of antimicrobial medicines, should comply with national guidelines.

17. Multiprofessional Prescribing (formerly Non-Medical Prescribing)

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

17.2 The provider must ensure that multiprofessional prescribers will:

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

18. Clinical Trials & Ethics Committees

18.1 All clinical trials must have been subject to Research Ethics Committee approval when the arrangements for consulting and informing will be considered. Trials should also have been through the provider trust's Research Governance process. This will take account of whether the trial is in line with strategic objectives of the organisation (for research and clinical care) and continued supply of medicines at the end of the trial.

From 31 March 2016, Health Research Authority (HRA) Approval is the process for applying for approvals for all project-based research in the NHS. Therefore, all project-based research is subject to approval from HRA Approval.

18.2 In order to respond appropriately to any suspected adverse events that occur outside the provider setting, following patient consent, the primary care prescriber will be adequately informed if a patient is participating in a clinical trial.

18.3 Prescribing and supply of clinical trial medicine is the responsibility of the provider. Costs (including Excess Treatment Costs) will be attributed in line with latest national guidance (AcoRD). Standard outpatient or inpatient 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 unless specifically agreed with the relevant commissioner.

18.4 Patients participating in a clinical trial must be made aware that there is no guarantee that the medicine will be continued at the end of the trial, irrespective of the results. Where trial results indicate that treatment will continue, post-trial costs will only be considered for funding by the ICB where exceptional circumstances exist.

18.5 Primary care prescribers should be aware that their patient is receiving a “hospital only clinical trial medicine” and ensure that this is recorded in the patient’s notes in order to be alert to potential side-effects and interactions with other medicines prescribed in primary care. This will ensure that primary care records, which are accessed by other healthcare providers, are a true and accurate reflection of the patient’s medication.

19. Appendix A – Procedural Document Checklist for Approval

Title of document being reviewed:		Yes/No/ Unsure	Comments/ Details
1.	**Sponsoring Director**		
	Is there a sponsoring director?	Y	
	Have they approved **this version** of the policy?	Y	
2.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
3.	**Rationale**		
	Are reasons for development of the document stated?	Y	
4.	**Development Process**		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	Old policy
	Is there evidence of consultation with stakeholders and users?	Y	Document sent for review by primary & secondary care
5.	**New or review**		
	Is this a new document?	N	
	Is the ratification date stated on the front cover?	Y	
	Is the ratification Committee stated on the front cover?	Y	
	Is the review date stated on the front cover?	Y	
	Is the version control detailing the version history of the document?	Y	
	If this is a review document, has the version number been amended throughout?	Y	
6.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target group clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
7.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	

Title of document being reviewed:		Yes/No/ Unsure	Comments/ Details
8.	**Quality and Equality Impact Assessment**		
	Has a QEIA been completed?	Y	
	Is the QEIA attached?	Y	Summary includes filepath
9.	**Style and Format**		
	Is the style and format in line with the *Framework for the Production of Procedural Documents*?	Y	
	Does the footer include the title, date of ratification and version number?	Y	
	Are definitions provided for the key terms used in the document?	Y	Within the document
	If applicable, are abbreviations written according to the guidance in *Framework for the Production of Procedural Documents*?	Y	
10.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	Medicines Optimisation Board
11.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how the document will be disseminated and implemented amongst the target group? Please provide details.	Y	For publication on SyH policies page as well as PAD. Included in NHS standard contract
12.	**Process for Monitoring Compliance**		
	Have specific, measurable, achievable, realistic and time-specific standards been detailed to monitor compliance with the document? Complete Compliance & Audit Table.	N/A	This is an over-arching policy and will not have SMART objectives. Compliance to be assessed through complaints & queries
13.	**Review Date**		
	Is the review date identified?	Y	
14.	**Overall Responsibility for the Document**		

Title of document being reviewed:		Yes/No/ Unsure	Comments/ Details
	Is it clear who will be responsible for implementing and reviewing the documentation i.e. who is the document owner?	Y	
15.	**Archive arrangements**		
	If this is a reviewed document, has the superseded document been archived, and if so where?	Y	\\SHeartlands.XSWHealth.nhs.uk\ccg\Directorate\Medicines Management\Medicines Resource Unit\Pharmaceutical Commissioning\Contracting\Interface Prescribing Policy\IPP 2023-24

20. Appendix B – Compliance and Audit Table

Compliance measurement	Reporting to
This is an over-arching policy. Compliance will be assessed through complaints and queries raised through our meeting structure: • Place-Based Medicines Optimisation Groups • Area Prescribing Committee • Medicines Optimisation Operational Group • Medicines Safety Committee • Provider contract monitoring groups	**Medicines Optimisation Board**

21. Appendix C: Quality and Equality Impact Assessment (QEIA) template

Scheme/policy name: Interface Prescribing Policy

Date commenced QEIA: 12/03/2024

Indicate below whether this scheme or policy will affect stakeholders at place (select which one(s)) or system level:

East Surrey ☐ Guildford & Waverley ☐ North West Surrey ☐ Surrey Downs ☐ Surrey Heartlands ☒ Surrey ☐

Brief summary of the proposal

This policy has been produced for providers of NHS commissioned services to deliver services which include prescribing and drugs to support the safe and secure handling of medicines. This is not a new policy but small changes have been made as follows and QEIA reviewed accordingly:

i) Section 1.6: addition of 'General Practitioners may also be referred to as Primary Care Prescribers.
ii) Section 2.10: addition of 'Where there is evidence for their use, the medicines should be treated as 'red' drugs and prescribed and monitored by the provider only'.
iii) Addition of point 2.21.
iv) Section 4.3: addition of 'sedatives prior to procedures' as an example.
v) Section 6.5: information on allergies amended to include 'any other adverse drug reactions'.
vi) Section 7.1: addition of 'Prescribing should be in line with the Surrey PAD and the traffic light status should be respected regardless of the type of outpatient appointment' and 'Trusts must have arrangements in place to supply medicines for non-face to face consultations e.g., for urgent use, red and amber medicines etc'.
vii) Section 9.1: addition of 'Cost-effective product choices are expected to be considered wherever possible'.
viii) Addition of point 9.3.
ix) Section 9.4: addition of 'The general principle is that all providers will ensure patients will be discharged with access to all their medicines (including pre-admission medicines), in line with local policy'.
x) Section 17: change of nomenclature from non-medical to multiprofessional prescribing.

These have been agreed by stakeholders and are unlikely to have impact on patients.

Engagement and Involvement (Duty to Involve)

Who has been or needs to be involved with developing this QEIA? A key principle for completing impact assessments is that **they should not be done in isolation.** Consultation and engagement with affected groups and stakeholders is vital and needs to be built in from the start, to enrich the assessment and develop relevant mitigations/actions. Detail here who is supporting the completion of this QEIA.

List any groups / forums you have approached, such as service users, carers, protected characteristic groups etc.	Activity undertaken e.g., meeting; workshop; focus group
Provider organisations via Pharmacy Departments	**Virtual circulation for comment**
Area Prescribing Committee consultation distribution list	**Virtual circulation for comment**
Area Prescribing Committee members present at the meeting on 6th March 2024	**Item as part of TEAMs meeting**

List any individuals you have consulted with, either from your own organisation or partner agencies:	
Job Title	**Organisation**
As above	

Equality and Health Inequalities Impact Assessment

Protected characteristics under the Equality Act 2010 must all be considered, and information included for each characteristic.

Duties as to reducing health inequalities: Where relevant to your proposal, please also provide details on how the proposal impacts on the following:

(a) Reducing inequalities between persons with respect to their ability to access health services; and
(b) Reducing inequalities between persons with respect to the outcomes achieved for them by the provision of health services.

Protected equality characteristic	**Summary explanation of the main potential positive or adverse impact of your proposal. Describe concerns regarding the proposal/policy for these groups.**	**Main recommendations from your proposal to reduce any key identified adverse impact or to increase the identified positive impact**
Age older people; middle years; early years; children and young people	The policy covers all age groups – there is no impact on any one specific age group. Age is accounted for in the policy where consent is required Discharge planning for vulnerable patients is noted in the policy Inclusion of requirement to provide specific patient resources to reduce risk of harm to unborn children	N/A
Disability Physical, sensory, and learning impairment, long-term conditions, mental health condition)	The policy covers medicines for all people within Surrey Heartlands who need them. The policy considers arrangements for people at risk of self-harm or potential for drug misuse	Information referred to in this policy which is to be shared with patients must be provided in line with the Accessible Information Standard and language requirements to ensure optimal medicines use.

Protected equality characteristic	Summary explanation of the main potential positive or adverse impact of your proposal. Describe concerns regarding the proposal/policy for these groups.	Main recommendations from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
		Discharge planning for vulnerable patients is noted in the policy.
Gender reassignment and/or people who identify as Transgender	There is no to reference gender identity in the policy that would result in any positive or negative impact on trans people.	N/A
Marriage & civil partnership People married or in a civil partnership	This policy does not impact adversely on this group.	N/A
Pregnancy & maternity Women before and up to one year after childbirth	Being pregnant and taking particular medication can present a risk to the unborn child.	Inclusion of requirement to provide specific patient resources to reduce risk of harm to unborn children in women and girls of child-bearing age
Race[1]	People belonging to different races may not speak or understand English as a first language	Information referred to in this policy which is to be shared with patients must be provided in line with the Accessible Information Standard and language

[1] Addressing racial inequalities is about identifying any ethnic group that experiences inequalities. Race and ethnicity include people from any ethnic group including Black and Minority Ethnic communities, non-English speakers, Gypsies, Roma and Travelers, migrants etc. who experience inequalities so includes addressing the needs of BME communities but is not limited to addressing their needs; it is equally important to recognise the needs of White groups that experience inequalities. The Equality Act 2010 also prohibits discrimination on the basis of nationality and ethnic or national origins, issues related to national origin and nationality.

Protected equality characteristic	Summary explanation of the main potential positive or adverse impact of your proposal. Describe concerns regarding the proposal/policy for these groups.	Main recommendations from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
		requirements to ensure optimal medicines use
Religion & beliefs People with different religions/faiths or beliefs or none.	This policy does not impact on religion and beliefs	N/A
Sex Men; women	There is no reference to sex in the policy that would result in any positive or negative impact on males or females.	Inclusion of requirement to provide specific patient resources to reduce risk of harm to unborn children in women and girls of child-bearing age
Sexual orientation Lesbian; Gay; Bisexual; Heterosexual.	The policy covers medicines for all people within Surrey Heartlands who need them irrespective of their sexual orientation	N/A

Briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below).

Groups who face health inequalities[2]	Summary explanation of the main potential positive or adverse impact of your proposal. Describe concerns regarding the proposal/policy for these groups.	Main recommendations from your proposal to reduce any key identified adverse impact or to increase the identified positive impact.
Armed forces	Nothing specific in our policy. NHSE makes separate provision for specialised services but our policy would not impact either positively or negatively on this group.	N/A

[2] Please note many groups who share protected characteristics have also been identified as facing health inequalities.

Groups who face health inequalities[2]	Summary explanation of the main potential positive or adverse impact of your proposal. Describe concerns regarding the proposal/policy for these groups.	Main recommendations from your proposal to reduce any key identified adverse impact or to increase the identified positive impact.
Carers of patients Unpaid, family members.	N/A	N/A
Digital exclusion[3]	N/A	N/A
Domestic abuse	N/A	N/A
Homeless people People on the street; staying temporarily with friends/family; in hostels or B&Bs	This group may not be registered with a GP so historical information on medicines may not be available when presenting in other provider settings. Medicines reconciliation maybe more difficult to complete but would still be undertaken as far as possible.	Issue would be wider than medication history. No specific mitigations/actions identified for medicines. Discharge planning for vulnerable patients is noted in the policy.
Looked after children & young people	N/A	N/A
People living in remote ad rural locations	N/A	N/A
People or families on a low income	N/A	N/A
People living in deprived areas	N/A	N/A
People with addictions and/or or substance misuse issues	N/A	N/A

[3] Digital exclusion is where a section of the population has continuing unequal access and capacity to use Information and Communications Technologies (ICT) that are essential to fully participate in society (Schejter, 2015; Warren, 2007).

Groups who face health inequalities[2]	Summary explanation of the main potential positive or adverse impact of your proposal. Describe concerns regarding the proposal/policy for these groups.	Main recommendations from your proposal to reduce any key identified adverse impact or to increase the identified positive impact.
People involved in the criminal justice system. Offenders in prison/on probation; ex-offenders	N/A	N/A
People with poor literacy or health literacy e.g. poor understanding of health services, poor language skills	Inclusion of requirement for “Information referred to in this policy which is to be shared with patients must be provided in line with the Accessible Information Standard and language requirements to ensure optimal medicines use”	N/A
Refugees, asylum seekers or those experiencing modern slavery	This group may not be registered with a GP so historical information on medicines may not be available when presenting in other provider settings. Medicines reconciliation maybe more difficult to complete but would still be undertaken as far as possible	Issue would be wider than medication history. No specific mitigations/actions identified for medicines
Other groups experiencing health inequalities (please describe)	N/A	N/A

Quality Impact Assessment

Note: Whilst the outcome may be similar, you need to tailor your response and rationale to each section. Do not enter the same answer for every row.

In the table below describe the positive and negative impacts associated with the scheme for each area.

If any area is identified as having a potential negative effect, you must calculate the overall risk score for this by multiplying the score for level of impact and the score for likelihood of occurrence together, using the risk matrix in Appendix 3. Insert the total in the appropriate box.

If a negative effect is identified, please also provide any suggested mitigations.

Area	**Positive Impacts:** Describe any positive impacts your scheme could have on each area.	**Negative Impacts:** Describe any negative impacts your scheme could have on each area. (Pre any mitigations already in the scheme/policy)	**Risk Score Pre-Mitigations** Appendix 3	**Suggested mitigations:** (These can be mitigations already identified within the scheme/policy, or new in response to the QEIA)	**Risk Score Post-Mitigations** Appendix 3
Patient Safety:	Standardises expectations from service providers to ensure safe handling of medicines.	None			
Staff Safety:	None	None			
Clinical Effectiveness:	Standardises expectations from service providers to ensure safe handling of medicines in line with best practice	None			

Area	Positive Impacts: Describe any positive impacts your scheme could have on each area.	Negative Impacts: Describe any negative impacts your scheme could have on each area. (Pre any mitigations already in the scheme/policy)	Risk Score Pre-Mitigations Appendix 3	Suggested mitigations: (These can be mitigations already identified within the scheme/policy, or new in response to the QEIA)	Risk Score Post-Mitigations Appendix 3
Patient Experience:	Standardises expectations from service providers to give similar outcomes.	None			
Staff Experience:	The policy ensures consistency and a reference for all staff	None			
Organisation Experience:	The policy ensures clarity for organisations	None			

Recommendation

Based on your assessment, please indicate which course of action you are recommending to decision makers.

Outcome No.	Description	Tick
Outcome One	**No major change to the service/function/policy required.** This QEIA has not identified **any** potential for discrimination or negative impact, and all opportunities to promote equality have been undertaken. Proceed and review QEIA periodically.	☒
Outcome Two	**Adjust the service/function/policy** to remove barriers identified by the QEIA or better advance equality. Are you satisfied that the proposed adjustments would remove the barriers you identified?	☐

	Proceed with adjustments, amend and review QEIA periodically.	
Outcome Three	**Continue with the service/function/policy** despite potential for negative impact or missed opportunities to advance equality identified. You will need to make sure the QEIA clearly sets out the justifications for continuing with it. You need to consider whether there are: • Sufficient plans to stop or minimise the negative impact, • Mitigating actions for any remaining negative impacts and plans to monitor the actual impact. Proceed, monitor, and evaluate. Discuss with SRO.	☐
Outcome Four	**Stop and rethink** the service change/proposal/policy when the QEIA shows actual or potential unlawful discrimination. Review with the SRO for this area of work within 28 days of completion of QEIA.	☐
Please explain in the blank box below the rationale for your recommendation and how your proposal gives due regard to the Public Sector Equality Duty by aiming to: • Eliminate discrimination. • Advance equality of opportunity. • Foster good relations between different people		
• This policy has been in place for a number of years and is reviewed on an annual basis. The small number of amendments to be made have been assessed and are not considered as having any impact on quality or equality. • The policy is published on Surrey Prescribing Advisory Database and Surrey Heartlands internet. • It is also included in NHS standard contracts with our providers		
Signature (Director / Senior Responsible Officer)	**Linda Honey**	
Job title	**Director of Pharmacy**	
Organisation	**NHS Surrey Heartlands**	
Date	09/04/2024	