NHS BEDFORDSHIRE CLINICAL COMMISSIONING GROUP and NHS LUTON CLINICAL COMMISSIONING GROUP - PRESCRIBING SPECIFICATION FOR THE MENTAL HEALTH CONTRACT PROVIDED BY EAST LONDON FOUNDATION TRUST (2019-21) – Subject to Annual Review.

1. INTRODUCTION

This specification document describes the principles and standards of prescribing practice that should be observed by Providers and includes the East of England CCG Collaborative Commissioning Arrangements for High Cost Drugs and Technologies (to include Devices) 2019-21 (Appendix A).
Mental Health Trust variation:-
The CCGs accept that some aspects of this document do not currently apply in full to the Mental Health Trust. Where this is the case, the CCG will not contractually apply the contract for these aspects at this time.

1.2 Guidance on the responsibility for prescribing between secondary/tertiary care clinicians and general practitioners (GPs) was issued by NHS England (but produced in partnership with the British Medical Association, the Royal College of General Practitioners, the Royal College of Nursing, NHS Clinical Commissioners and the National Association for Patient Participation) in January 2018 - 'Responsibility for prescribing between Primary & Secondary/Tertiary Care'. https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf This document, together with the NHS Standard Contract for 2017/19 (see Section 11, P14-15)) https://www.england.nhs.uk/wp-content/uploads/2018/05/2-nhs-standard-contract-2017-19-particulars-service-conditions-may-2018.pdf supersedes the NHS England in EL (91) 127 "Responsibility for Prescribing between Hospitals and GPs" issued by the NHS Executive.

1.3 Commissioning arrangements in relation to prescribing are governed by the Department of Health National Tariff.

1.4 The principles contained in 'Responsibility for prescribing between Primary & Secondary/Tertiary Care', the NHS Standard contract, the National Tariff and recommendations made by the Bedfordshire and Luton Joint Prescribing Committee (JPC)[1] and JPC/CCG ratified recommendations of the East of England Priorities Advisory Committee (PAC) and Regional Medicines Optimisation Committees (RMOCs) form the basis of this specification to the contract.

[1] The Bedfordshire and Luton Joint Prescribing Committee consists of CCG and Trust representatives and makes recommendations on the managed introduction of new drugs and prescribing issues that arise across the primary and secondary care interface.

1.5 The following issues are covered by this specification:

- National Guidance
- Primary / Secondary Prescribing Responsibilities, including clinical responsibility and financial considerations
- Shared Care Arrangements
- Managed introduction of new drugs and treatments including funding mechanisms for drugs
- Clinical Guidelines
- Specialist Service/Hospital Inpatient and Discharge Arrangements
- Specialist Service/Hospital Outpatient Prescribing Arrangements
- Services provided outside Inpatient and Outpatient (section 7&8)
- Homecare
- Patient Safety Alerts (issued by e.g. National Patient Safety Agency {NPSA} or National Patient Safety Alerting System {NPSAS})
- Pharmaceutical Specials
- NHS to Private Care
- Pharmaceutical and other commercial sponsorship
- Risk-Sharing/Patient Access Schemes
- Controlled Drugs
- Key Performance Indicators

2. NATIONAL GUIDANCE

2.1 Trusts/Providers are expected to follow prescribing and medicine management advice set out in all relevant circulars, national (e.g. National Institute for Health and Care Excellence Technology Appraisal Guidance) guidance, both current and future. This includes any necessary alignment as a result of BLMK Integrated Care System (ICS) formerly known as the Sustainability and Transformation Plan (STP) footprint.

3. PRIMARY / SECONDARY CARE PRESCRIBING RESPONSIBILITY

3.1 Guidance on the responsibility for prescribing between primary and secondary/tertiary has been issued by NHS England. (see paras 1.2 and 1.4). This section of the document aims to reaffirm the principles contained in that document and the NHS Standard Contract.

3.2 Prescribing issues arising that are not considered in this policy may be referred to the Bedfordshire & Luton Joint Prescribing Committee for discussion.

3.3 CLINICAL RESPONSIBILITY

3.3.1 It is important that clinical responsibility for prescribing is placed with the most appropriate clinician. In addition prescribing should be undertaken by the clinician that has clinical responsibilities for monitoring therapy and making dosage changes. An exception to this is in the case of shared care protocols/guidelines where an agreement between the specialists in provider services and GP has been reached. In such cases, legal responsibility for prescribing, lies with the clinician who signs the prescription. It is expected that the risks and benefits of treatment are discussed with the patient by the prescriber initiating treatment.

3.3.2 Where clinical responsibility for prescribing should remain with consultants/ Specialist Service:

- Acute drug treatments that form part of a complete package of acute care, for example all medicines required for an intravenous antibiotic course.
- Medicines used as part of a provider-initiated clinical trial or the continuation of a provider initiated clinical trial or compassionate use, where no arrangement has been made in advance with the commissioner to meet the extra cost of treatment. It is important that drug supply after the clinical trial has ended is considered at the **outset** of the trial/compassionate use, for example, will the patient stop the drug, will the Specialist Service/Provider continue to prescribe it, or will a shared care protocol be established with the GP? (If a shared care protocol is to be established then this should be discussed at the Bedfordshire and Luton Joint Prescribing Committee before the clinical trial is initiated).
- Drugs that are prescribed for treatment of conditions not covered by product licences (i.e. unlicensed products and licensed products used off-label). This does not include:
  - **accepted** widespread use of non-specialist drugs used outside the product licence e.g. paediatric drugs used in accordance with recommendations contained in the BNF for children.
  - where licensed indications differ for drugs that are generically available
  - where there is agreed shared care
- Where a GP is asked to prescribe a drug that is unlicensed then it would be expected that the patient has already formally consented and that evidence to support prescribing should be provided by the consultant. NB. Transfer of clinical responsibility should be in accordance with section 3.3.3.
- The GP has insufficient information to participate in a shared care prescribing arrangement where applicable.
- No shared care guideline or patient specific prescribing agreement exists.
- The GP does not feel competent in taking on clinical responsibility for the prescribing of a specialist medicine.[2]

[2] If a GP is unwilling to prescribe, and the request is deemed clinically appropriate, the CCG Medicines Optimisation Team will be asked for assistance in facilitating a discussion between the Specialist and the GP, accepting that the CCG cannot mandate a GP to prescribe.

- Medicines, which are only available through the provider, i.e. are not available on FP10, including any 'borderline' products when used outside approved indications.
- Medicines requiring ongoing specialist intervention and specialist monitoring.
- Medicines and other prescribable products, which that have not been approved for use by the Provider/Specialist Service, for example, not approved by the Hospital Drugs and Therapeutics Committee (or equivalent).
- Patients receive the majority of ongoing care, including monitoring from the provider and the only benefit of transferring care would be to the provider costs.
- Medicines subject to High-tech Hospital at Home Guidance (EL(95)5).
- All other treatments funded by NHS England unless specifically agreed through a shared prescribing agreement, or other process as agreed by the Bedfordshire and Luton Joint Prescribing Committee or CCGs.
- Without collaboration and agreement with the patient and/or carer.

3.3.3 Where clinical responsibility for prescribing may be transferred to the general practitioner from secondary care or where tertiary care may be transferred to secondary care:

- Chronic drug treatment where prescribing responsibility does **not** need to remain with the specialist service clinician as listed above and the general practitioner (secondary care consultant in the case of a tertiary referral) is familiar with the drug and agrees to take over clinical responsibility for prescribing the drug or
- Chronic drug treatment when prescribing responsibility does **not** need to remain with the specialist service as listed above and a shared care protocol/guideline between the specialist and the general practitioner (secondary care consultant in the case of a tertiary referral) has been agreed and the GP is willing to accept prescribing responsibility.

3.4 FINANCIAL CONSIDERATIONS

3.4.1 Financial responsibility should rest with the Trust/Provider that has clinical responsibility for prescribing the drugs, unless an agreement to jointly manage a patient's drug treatment has been reached or it is beneficial to the whole Health Economy for prescribing to remain in the specialist service. Financial responsibility for prescribing should be included as part of the policy development/shared care process e.g. as recommended by the JPC, and endorsed by Commissioning and Provider Executive teams. Legal responsibility for prescribing remains with the clinician who signs the prescription, even under a shared care agreement.

The following sections relate to ongoing prescribing of drugs in the outpatient setting:-

3.4.2 For continued prescribing of drugs restricted to specialist prescribing only, the commissioner and Provider/Trust will locally determine a mechanism for funding, where appropriate on a drug by drug basis.

3.4.3 Where it is beneficial to the whole health economy (and safer/practical for the patient) for prescribing to remain in secondary/tertiary care (see section 3.4.1), the commissioner of CCG will agree a local mechanism for funding ongoing supply of drug treatment and sharing benefits on a drug by drug basis.

3.4.4 Funding agreements reached (as per points 3.4.2 and 3.4.3) will be added as an in-year variation to the contract.

4. SHARED CARE ARRANGEMENTS

4.1 Shared care protocols/guidelines are typically agreements between the specialist service clinician and a general practitioner, which state the responsibility of each in the management of an individual patient's drug therapy. The types of drugs that are normally involved in shared care protocols include specialist drugs and drugs that require close patient monitoring. Normally the patient's drug therapy will be initiated by the specialist service clinician and then the general practitioner will be asked to jointly manage the patient's treatment. Shared care does not necessarily mean that a GP will prescribe, but that s/he will offer routine care to the patient. The good practice shared care guidelines template as agreed by the Bedfordshire & Luton Joint Prescribing Committee should be followed (Appendix B).

The discharge letter should provide an electronic link to the shared care protocol and ideally should include a hard copy.

4.2 Shared care arrangements for individual patients do not always require that a comprehensive written guideline as produced by the Bedfordshire and Luton Joint Prescribing Committee is prepared. A verbal agreement between the consultant/specialist service clinician and GP may suffice **provided that written confirmation is supplied to the GP in the form of a patient specific shared care protocol/guideline** using the general framework above and should include:

- the roles and responsibilities of each prescriber, and of the patient/carer
- details of the medicines included in the shared care arrangement
- how the patient will be monitored (including follow-up schedules)
- the circumstances in which treatment will be modified or stopped.
- anticipated side-effects.
- action to be taken in the event of difficulties.

The patient is a partner in the shared care arrangement and should agree to it and be provided with a copy of the shared care protocol/guideline by the clinician initiating the treatment if appropriate.

It is the responsibility of the secondary care doctor to perform (or have knowledge of in the case of shared care arrangements) all necessary physical checks, investigations or blood tests pertinent to a particular drug before prescribing or altering a dose, and be aware of any relevant medical history and potential drug interactions. All such investigations and checks , if required prior to initiation, or directly related to drug monitoring, should be done by the psychiatrist at the time of seeing the patient unless they can only be performed by requesting from another provider or primary care; in which case they should facilitate their procurement directly or via an agreed shared care protocol. Such tests might include ECG's, but not the majority of blood and pathology tests or radiology. The GP may refuse taking over prescribing unless assured that such checks have been made.

Patients must be reviewed by the mental health team prior to discharge from the specialist service. This review must take account of any medication being prescribed by GPs as part of shared care arrangements.

5. MANAGED INTRODUCTION OF NEW DRUGS

5.1 Bedfordshire Clinical Commissioning Group and Luton Clinical Commissioning Group with other CCGs in the East of England area has agreed commissioning principles for the Management of High Cost Drugs and Technologies (to include devices) for 2017/19.

5.2 The Bedfordshire and Luton Joint Prescribing Committee makes recommendations to GPs, Clinical Commissioning Groups (CCGs) and Provider Trusts on the managed introduction of new drugs.

5.3 Providers/Trusts are expected to follow CCG ratified recommendations made by the Bedfordshire & Luton Joint Prescribing Committee, East of England Priorities Advisory Committee, and the Regional Medicines Optimisation Committees.

5.4 It is expected that Trusts will have internal mechanisms for managing the introduction of new drugs such as a Drug and Therapeutics Committee. Where possible, there should be collaboration between the Bedfordshire & Luton Joint Prescribing Committee and the Specialist Service Drug and Therapeutics Committee to ensure consistent policies.

6. CLINICAL GUIDELINES

6.1 It is expected that Providers/Trusts will work in partnership with GPs, CCGs, Community Health Services and NHS England to ensure local implementation of national guidelines produced, for example by the National Institute for Health and Care Excellence (NICE).

6.2 In addition, there may be occasions when local guidelines may need to

be developed. It is expected that Providers/Trusts will work with local practitioners and CCGs. Any professional disagreement will necessitate the involvement of CCGs, and the Local Medical Committee.

7. HOSPITAL/SPECIALIST SERVICE IN-PATIENT / DAY CASE AND DISCHARGE ARRANGEMENTS

7.1 All clinically appropriate drugs, dressings and appliances will be made available by the Provider/Trust for in-patients and day cases whilst in the care of the Trust (N.B. all references to drugs below include dressings).

7.2 Patients' drugs brought into hospital (i.e. the patient's own drugs) are the property of the patient. They may be prescribed for use by the patient in hospital. Unused drugs will be returned to the patient on discharge. This paragraph does not apply to illicit drugs.

7.3 Medicines reconciliation should be initiated for all patients within 72 hours in accordance with the Provider/Trust Medicines Reconciliation Policy.

7.4 If treatment of a condition has resulted in a change of drug therapy, patient's own drugs no longer required may be disposed of by the Provider/Trust, with the permission of the patient.

7.5 In order to supplement printed information on drug labels, patient information leaflets must be supplied to patients where they are available.

7.6 The writing and dispensing of discharge medication provide an opportunity to review the appropriateness of a patient's medications. Drugs started during an admission may not need to be continued after discharge. Changes in the patient's long term prescription of drugs should be discussed with and explained to the patient. Communication of this information (including rationale for changes to drug therapy and specified end date for short term prescriptions) must be sent to the GP in line with the mandatory timescales outlined in the Local Quality Schedule i.e. the GP practice must be sent the discharge letter within 24 hours or the next operational day (excluding weekends and bank holidays) of discharge.

7.7 Prescriptions will be dispensed within the following timescales on presentation of the prescription:

- In-patient – by the time of the next but one due dose (this assumes that the prescriptions reaches pharmacy at least 3 hours prior to next administration time);
- Discharge prescriptions – before the patient is due to leave hospital;

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7.8 Drugs for inpatients/day case should normally be prescribed by the hospital/specialist service and dispensed by the hospital/specialist service pharmacy, where possible, for 28 days or the nearest patient pack and on

discharge the patient should leave the hospital/specialist service/ provider with at least 14 days supply of medicines dispensed by the hospital/specialist service except in the following circumstances:-

- Drugs are not clinically necessary for so long a period, e.g. a 5 day complete course of antibiotics.
- Patient's own drugs are used in hospital/specialist service (after assessment) and the patient either has a minimum of 14 days supply on discharge, or patient has at least 14 days supply at home.
- Elective episodes (<7 days) or short stay emergency patients (<72 hours) – only new prescribed medicines supplied with the caveat that the patient has sufficient quantities of current medication at home (see point above).
- For mental health patients, there may be occasions where a 14 day supply or more of medication would be inappropriate as a result of safety concerns. Should this be the case, it is expected that the Trust makes alternative arrangements for supply of follow-up prescriptions e.g. contact GP by phone confirmed in writing (fax/email) to agree a further supply.
- Where the clinical responsibility for prescribing would remain with consultants (see section 3.3.2)

7.9 Trusts/specialist service should ensure that a consultant or named deputy be available to respond to prescribing enquiries about a patient under their care within a reasonable timescale. This acknowledges that legal responsibility lies with the doctor signing the prescription.

7.10 Sufficient information (e.g. discharge summary) about medicines, requiring community nurse administration to be continued in the community, to be provided to the patient upon discharge.

7.11 Trusts/specialist service discharging to Community Hospitals/Care Homes must provide a copy of the discharge letter prescription and the current medication profile for the patient. A copy of current drug card to be provided.

7.12 A mechanism for liaison between the transferring hospital/specialist service and community pharmacists should be in place to cover special circumstances where a continuity of supply of the drug is essential e.g. advice on how to obtain a specific preparation.

7.13 The CCG will not accept unilateral changes to these arrangements by Trusts in an attempt to implement cost savings or for any other reason.

7.14 Where the Trust is responsible for the longer term or repeat prescribing of a patient's medication, it may issue prescriptions on form FP10 (HP) for dispensing in a community pharmacy.

7.15 Trusts will normally be expected to prescribe drugs for use in the community which have particularly high costs via homecare or another agreed arrangement.

7.16 Where patients are discharged into the community with a care package, social services teams should be provided with the necessary information for the care provider to manage care including an accurate list of medication with times of administration on discharge highlighting any changes since admission.

7.17 Patients should receive a face to face medicines optimisation counselling service, provided by pharmacy staff (pharmacist or pharmacy technician) or a trained member of the healthcare team prior to discharge. Appropriate patients should be encouraged to visit their regular community pharmacies to obtain the appropriate service e.g. Medicines Use Review (MUR); New Medicines Service (NMS).

8. OUT-PATIENT PRESCRIBING ARRANGEMENTS

8.1 It is expected that the Hospital Consultant/specialist service clinician should provide a prescription during the out-patient consultation in the following circumstances:-

- The clinical responsibility for prescribing should remain with the Consultant/specialist service clinician (See section 3.3.2).
- When a new medication is started or when changes are made to existing medications.

The prescribing and dispensing of outpatient medication provide an opportunity to review the appropriateness of the patients' medication. Any changes to patients' medication needs to be discussed with and explained to the patient. Communication of this information (including rationale for changes to drug therapy and specified end date for short term prescriptions) must be sent to the patients GP in line with Schedule 4 – Local Quality Requirements which sets out the required safe timescales for the transmission of outpatient letters to GPs. This communication is required to ensure the safety of prescribing administration of medicines in primary care and to assist GPs in accepting clinical responsibility for prescribing and supporting ongoing care of their patients.

8.2 For out-patient attendance, the patient should receive a 28 day supply of medication or the nearest patient pack (unless another clinically indicated amount is necessary). If a quantity less than 28 days is provided, the patient must be reviewed by the Specialist to receive additional supplies of medication and a total of 28 days treatment (in installments, if necessary) should be provided. Where the hospital consultant/specialist service clinician takes responsibility for continuing supplies (see section 3.4.2), the quantity prescribed should be adequate to last to the next review. It is not acceptable for the Trust to schedule 28-day outpatient appointments for the purposes of supplying medication. (Refer to section 3.5 for financial considerations).

8.3 When a hospital consultant/Specialist Service considers that a patient's condition is stable he may seek the consent of the GP concerned to form

a shared care agreement. Such agreements should follow the principles contained in section 3.

8.4 Where a drug has not been agreed locally (through management of new drug process in primary and/ or secondary care), the hospital/specialist service will be required to provide on-going prescriptions and take financial responsibility for this supply.

9. Services outside Inpatient and Outpatient services (sections 7&8)

9.1 Patients seen in acute hospital or community services, or assessed by clinical workers outside of the usual inpatient / outpatient regime and not specifically covered by section 7 and section 8, should have any new or altered medicines supplied from the Trust. Non-prescribers seeing patients must liaise with the doctors in their own team or organisation to provide treatment and should not approach GP's for new or altered medications. Where the GP is expected to continue treatment then patients should be provided with sufficient medication, currently 28 days, and GP's should be made aware of prescription as per section 8.1. The GP will have the opportunity to raise any concerns with regards to taking over responsibility for continuing prescribing. Short courses of less than 28 days can be given in cases where a shorter duration of treatment is appropriate either for patient safety (but see section 8.2) or because the treatment will terminate before 28 days.

9.2 Patients will be given FP10 prescriptions in these settings.

10 HOMECARE

10.1 A homecare medicine delivery and service can be described as being one that delivers ongoing medicine supplies and, where necessary, associated care, initiated by the hospital/specialised service prescriber, direct to the patient's home with their consent. The purpose of the homecare medicines is to improve patient care and choice of their clinical treatment. Associated care may include equipment such as refrigerators, infusion pumps or additional nursing care in addition to the drug itself. These treatment packages are usually provide by a home care provision agency or through similar arrangements. They are also tailored to individual patient requirements

10.2 Trust/Providers should seek the approval of the CCG before such therapy is started to ascertain funding arrangements as these schemes are excluded from the National Tariff.

10.3 Trusts/Providers are expected to negotiate high quality, cost-effective contracts with the home care provider agency or through similar supplying arrangements as outlined in The Department of Health document, Homecare Medicines Towards a Vision for the Future published on 30 November 2011. This document recommends the clinical

governance and contractual framework arrangements between NHS Trusts and homecare suppliers to ensure development of safer, effective and efficient homecare medicine (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213112/111201-Homecare-Medicines-Towards-a-Vision-for-the-Future2.pdf)

The information contained in the Department of Health document is also included in Royal Pharmaceutical Society Professional Standards for Homecare Services: http://www.rpharms.com/support-pdfs/homecare-standards-final-sept-13.pdf

11. PHARMACEUTICAL SPECIALS

11.1 Hospital/specialist service Pharmacists should assist prescribers in ensuring that a pharmaceutical special is only used where there is no possible licensed alternative.

11.2 Providers are expected to follow the Royal Pharmaceutical Society Professional Guidance for the Procurement and Supply of Specials, issued December 2015. https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Support/toolkit/specials-professional-guidance.pdf

12. NHS TO PRIVATE CARE

12.1 Trusts are expected to have policies and procedures in place to ensure compliance with the Department of Health Guidance on NHS patients who wish to pay for additional private care, issued March 2009.

13. PHARMACEUTICAL AND OTHER COMMERCIAL SPONSORSHIP

13.1 Trusts/Providers must ensure they follow current Trust/Provider Guidance on working with the Pharmaceutical industry.

14 RISK-SHARING/PATIENT ACCESS SCHEMES

14.1 Trusts should not enter into local or national risk-sharing/patient access schemes related to drugs without notifying the CCG.

15 MEDICATION ERRORS/PATIENT SAFETY ALERTS (including those previously issued by the NPSA and those that will be issued by the NPSAS)

15.1 The Trust is expected to monitor medications errors/NPSAS in line with the information contained in the Local Quality Schedule.

16. CONTROLLED DRUGS

16.1 The Trust must have a policy for the safe and secure handling of Controlled Drugs which includes the following:-

- Compliance with medicines legislation.
- Standard operating procedures in place for the safe management, use, transportation and disposal of controlled drugs including the prescribing, supply and administration of controlled drugs and the clinical monitoring of patients who have been prescribed controlled drugs.
- A system for recording education and training in relation to these standard operating procedures, good practice and the law in relation to the safe management and use of controlled drugs.
- A system for monitoring, assessing, investigating and taking action in relation to relevant individuals with regard to well-founded concerns.
- A system for assessing and investigating concerns, incidents, intelligence and complaints.
- A system for monitoring and assessing individual health professionals performance in relation to the safe management of controlled drugs.
- A system for reviewing the effectiveness of the above arrangements.

- Participation in Local and Regional Intelligence Networks.
- The Trust NHSE Occurrence Report – Controlled Drugs Concerns to be provided quarterly to the CCG via the quarterly Quality Report.

16. KEY PERFORMANCE INDICATORS

The key performance indicators are outlined in the table overleaf:-

No	KEY PERFORMANCE INDICATOR	THRESHOLD	METHOD OF MEASUREMENT	CONSEQUENCE OF BREACH
1.	There will be systems and policies in place to ensure the efficient management of medicines, including:- • An effective multidisciplinary Drugs and Therapeutics Committee to include representation from primary care. • Systems for formulary management and prescribing audit. • A policy for the planned introduction of new drugs. • A policy for the use of patients own drugs and their reissue to patients on discharge. • A policy for the safe and secure handling of medicines (to include Controlled Drugs) • Sponsorship policies as agreed by Providers • Adequate quality assurance systems • An antimicrobial policy • The implementation of NICE recommendations. Trusts should bring to the attention of the CCG any policies which are not compliant with NICE Guidance. All providers should maintain adequate records to demonstrate compliance with NICE	100% compliance	CCG participation in the Trust Medicine Committee provides assurance on this KPI.	Referred to the Trust DTC. Escalate through contractual processes (via Quality Meetings as appropriate) to CQG (Contracts and Quality Group).

	guidance.			
2.	New Treatments and Interventions The Trust will ensure that its clinicians follow due process for the introduction of new drugs or therapies for individuals or groups of patients. This process will ensure:- a) Consideration of the drug by the Trust's Medicines Committee) b) A paper to the JPC for consideration or c) A request via the CCG Individual Funding Process. Referrals via the Individual Funding Request Process should only be for individual patients – Consult the CCG Individual Funding Request Policy for further information.	100% compliance	Exception reporting by GPs/CCG	Unless specifically agreed by the JPC and ratified by the CCG, new treatments and therapies introduced without following due process will not be funded. Escalate to Trust DTC and through contractual processes (via Quality Meetings if appropriate) to CQG.
3.	Compliance with JPC Classification for Prescribing i.e.:- • Prescribing not recommended. • Consultant only prescribing. • Initiated by Specialist, may be continued by GPs • Initiated by Specialist, may be continued by GP under a shared care arrangement. • May be initiated and continued by GPs	For each drug no more than 3 breaches reported annually	Exception reporting by GPs/CCG	Initial contact between GP and Consultant to resolve issues. Consider recharging Trusts for the cost of drugs inappropriately passed to GPs to prescribe, where the cost of the drugs would have been covered by national tariff prices or local contracts. Direct contact between CCG Medicines Management Team and Trust/Hospital Pharmacists to avoid recurrence. Escalate to Trust DTC and through contractual processes (via Quality Meetings as appropriate) to CQG.
4.	Shared Care Guidelines	For each drug no	Exception reporting by	Initial contact between GP and Consultant to

	In the transfer of management and prescribing responsibilities to the GP, it is essential that:- • The patient's condition is sufficiently stabilised following treatment (i.e. treatment has been effective); • Dissemination of sufficient information to the GP and other carers has occurred (including providing a copy of the shared care guidelines to relevant primary care clinicians and relevant information from the shared care guideline to the patient); • Prior agreement has been reached between the GP and consultant before clinical responsibility is transferred; • The GP is in a position to monitor treatment and adjust dose if necessary; • The drug has been approved by the JPC. • If there is a formal JPC approved shared care guideline – this should be followed. The GP has the right to refuse to enter into a shared care agreement, but to refuse on the grounds of drug cost to the CCG alone is unacceptable.	more than 3 breaches reported annually.	GPs/CCG	resolve issues. Direct contact between CCG Medicines Management Team and Trust/Hospital Pharmacists to avoid recurrence. Escalate to Trust DTC and through contractual processes (via Quality Meetings if appropriate) to CQG.

5.	The Hospital specialist must provide a prescription during the out-patient consultation when:- • The clinical responsibility for prescribing should remain with the specialist (see section 3.4.2) • When a new medication is started or when changes are made to existing medications. . Any changes to patients' medication needs to be discussed with and explained to the patient. Communication of this information (including rationale for changes to drug therapy and specified end date for short term prescriptions) must be sent to the patients GP in line with Schedule 4 – Local Quality Requirements which sets out the required safe timescales for the transmission of outpatient letters to GPs.	No more than 20 breaches reported annually.	Exception reporting by GPs/CCG	Direct contact between CCG Medicines Management Team and Trust/Hospital Pharmacists to avoid recurrence. Escalate to Trust DTC and through contractual processes (via Quality Meetings if appropriate) to CQG.
6.	Where a drug is initiated by the hospital specialist (out-patient), 28 days or the nearest patient pack will be supplied unless a shorter course of treatment is indicated or clinically appropriate. .	Less than 25% of total number of outpatient prescriptions dispensed annually.	Exception reporting by GPs/CCG. Information to be checked using Epact on a quarterly basis.	Direct contact between CCG Medicines Management Team and Trust/Hospital Pharmacists to avoid recurrence. Escalate to Trust DTC and through contractual processes (via Quality Meetings if appropriate) to CQG.
7.	In-patients on discharge shall receive a minimum of 14 days treatment (i.e. drugs and appliances) unless patient falls into the exception categories outlined in section. Communication of information on discharge medication (including rationale	Less than 10% of the total number of TTOs dispensed annually.	Exception reporting by GPs/CCG	Direct contact between CCG Medicines Management Team and Trust/Hospital Pharmacists to avoid recurrence. Escalate through contractual processes (via Quality Meetings if appropriate) to CQG.

	for changes to drug therapy and specified end date for short term prescriptions) must be sent to the Patient's GP in line with the Local Quality Schedule i.e. the GP practice must be sent the discharge letter within 24 hours or next operational day (excluding weekends and bank holidays) of discharge			
8.	There must be CCG involvement in any significant developments concerning prescribing/dispensing, and particularly changes in hospital prescribing practice which will impact on GP prescribing/dispensing. This involvement may be via the Trust's Drugs and Therapeutic Committee (or equivalent) or the JPC depending on the nature of the change.	100% compliance	Exception reporting by GPs/CCG	Any significant change will not be supported unless the CCGs are fully engaged in discussions. Escalate to Trust DTC and through contractual processes (via Quality Meetings if appropriate) to CQG.
9.	Responsibility for the prescribing of unlicensed drugs or drugs used for unlicensed indications will not be transferred to GPs without their prior agreement.	For each drug no more than 3 breaches reported annually.	Exception reporting by GPs/CCG	Direct contact between CCG Medicines Management Team and Trust/Hospital Pharmacists to avoid recurrence. Escalate to Trust DTC and through contractual processes to CQG.
10.	Pharmaceutical Specials should only be used where there is no clinically appropriate possible licensed alternative.	100% compliance	Exception reporting by GPs/CCG and quarterly ePACT reporting by the provider.	Direct contact between CCG Medicines Management Team and Trust/Hospital Pharmacists to avoid recurrence. Escalate to Trust DTC and through contractual processes (via Quality Meetings) to CQG.
11.	The Trust is expected to prescribe standard release medication generically.	95%	Exception reporting by GPs/CCG or ePACT	Direct contact between CCG Medicines Management Team and Trust/Hospital

			reporting.	Pharmacists to avoid recurrence. Escalate to Trust DTC and through contractual processes (via Quality Meetings) to CQG.
12.	NICE TAs should be adopted into the Trust formulary in accordance with the NICE Good Practice Guidance 'Developing and Updating Local Formularies', Dec 12	100% Compliance	Discussions at Trust DTC meeting.	Escalate through contractual processes (via Quality Meetings if appropriate) to CQG.
13.	Medicines reconciliation should be initiated for all patients within 72 hours in accordance with the Trust Medicines Reconciliation Policy.	90% to be maintained during the 2019/20 Financial year.	Quarterly reports to the BCCG Prescribing Committee.	Escalate to Trust DTC and through contractual processes (via Quality Meetings) to CQG.
14.	During admission, patients/carers to be offered written information about their psychotropic medication. (This applies to patients who have had a Medicines Reconciliation Review). Acceptance or refusal of written information must be documented. This can be done by any members of the healthcare team (during stay).	85% to be maintained throughout 2019/20 Financial year.	Quarterly reports via the Quality Report	Escalate to Trust DTC and through contractual processes (via Quality Meetings) to CQG.
15.	During admission, patients/carers will be offered one-to-one discussion with a pharmacist or pharmacy technician about their medication. (This applies to patients who have had a Medicines Reconciliation Review). Acceptance or refusal of one-to-one discussion must be documented (during stay)	80% average overall for 19/20 Financial year to be maintained.	Quarterly reports via the Quality Report	Escalate to Trust DTC and through contractual processes (via Quality Meetings) to CQG.
16.	All inpatients/carers are offered face-to-face discharge counselling. This should be with a pharmacist or a pharmacy	20% by the end of the Financial year.	Quarterly reports via the Quality Report	Escalate to Trust DTC and through contractual processes (via Quality Meetings) to CQG.

	technician, or a trained member of the healthcare team. The counselling would involve working through a discharge checklist. Acceptance or refusal of discharge checklist. Acceptance or refusal of discharge counselling must be documented (discharge)			

For further information relating to this document, please contact:-

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Appendices to this document:
APPENDIX A: East of England CCG Collaborative Commissioning Arrangements for High Cost Drugs and Technologies (to include devices) 2019/2020.
APPENDIX B: Bedfordshire and Luton Joint Prescribing Committee Shared Care Guideline Template

PRESCRIBING SPECIFICATION
FOR THE EAST LONDON FOUNDATION TRUST

Between THE EAST LONDON FOUNDATION TRUST
And
NHS BEDFORDSHIRE CCG and NHS LUTON CCG

Period of agreement – 1 April 2019 to 31 March 2021 (With Annual Review)

The following people have been involved in the review of the document and have agreed it:-

Jennifer Melville, Chief Pharmacist, East London Foundation Trust
Raj Shergill, Deputy Chief Pharmacist, East London Foundation Trust
Natasha Patel, Bedfordshire and Luton Lead Pharmacist, East London Foundation Trust
Fiona Garnett, Assistant Director and Head of Medicines Optimisation, BCCG
Jacqueline Clayton, Assistant Head of Medicines Optimisation, BCCG
Tess Dawoud, Assistant Head of Medicines Optimisation, LCCG