Barking and Dagenham, Havering & Redbridge CCG Interface Prescribing Policy

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Name of responsible committee/individual:	Area Prescribing sub-Committees
Date issued (placed on Intranet):	
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Target audience:	Acute Trust commissioners (Barking Havering and Redbridge University Hospitals Trust, Barts Health NHS Trust, North East London Foundation Trust) and Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups

This policy has been developed by the BHR CCG medicines management team (MMT) and Pharmacy teams in Barking, Havering and Redbridge University Hospitals Trust, Barts Health Hospital Trust and North East London Foundation Trust and has been agreed by the Trust Drugs and Therapeutics Committees and Area Prescribing sub-Committees.

1. General Principles

1.1 All patients should receive safe and effective drug therapy in the most appropriate healthcare setting.

1.2 The individual who signs the prescription assumes full medico legal responsibility regardless of whether they are acting under the guidance or instruction of another practitioner (e.g. hospital specialist or General Practitioner (GP)).

1.3 Clinicians and pharmacists must recommend, prescribe, dispense or label by generic name except where local or national guidelines recommend brand prescribing.

1.4 The hospital must dispense medicines routinely as patient packs where appropriate as recommended by the European Community directive 92/27/EEC on pharmaceutical labelling, and the provision of information to patients.

1.5 Clinical Commissioning Groups (CCGs) expect providers to adhere to the guidance contained within the government circulars. These include:

- GMC Good practice in prescribing and managing medicines and devices (2013)
- EL(94)72 ' Purchasing and Prescribing'
- Commercial sponsorship in the NHS, Dept of Health Nov 2000 - http://www.uhb.nhs.uk/pdf/DohGiftsGuide.pdf
- Technical patient safety solutions for medicines reconciliation on admission of adults to hospital NICE / NPSA December 2007 -http://www.nice.org.uk/psg001

This list is not exhaustive and compliance with all relevant circulars and guidance is required.

1.6 Hospital trusts should have a written discharge policy that includes arrangements for the transfer of prescribing information to GPs in a timely manner (within 72 hours in BHRuT or within 10 days maximum in Barts Health).

1.7 GP prescribing under joint prescribing arrangements (otherwise called shared care) may only be considered when the patient's clinical condition is stable or predictable, prior agreement of the GP has been obtained, and the GP has sufficient information to safely prescribe for the patient.

1.8 The Hospital trust in conjunction with the CCG will have a New Drugs Group that manages the entry of new drugs into the local health economy (if this is not part of the Drug & Therapeutics Committee [DTC]) and a DTC that co-ordinates drug use in the trust. The Formulary Committee will be responsible for the development and updating of a joint hospital- CCG formulary. The majority of prescribing should be in line with the joint formulary or if this is yet to be developed, the hospital formulary.

1.9 Hospital clinicians should not usually ask GPs to prescribe drugs which have not been approved by the Trust DTCs and neither should GPs prescribe non-formulary drugs**.** Where, exceptionally, a patient's treatment necessitates the prescribing of a non-formulary drug, the hospital clinician should discuss the choice of drugs and reasons for prescribing outside the formulary with the DTC to obtain permission to prescribe. Hospital staff should not bypass this route by contacting GP's to prescribe.

1.10 Where a joint agreement about formulary recommendations is not in operation, hospital clinicians should be encouraged to recommend a class of drug for GPs to prescribe, rather than a specific drug.

2. In-patients

2.1 All drugs and dressings prescribed for administration for in-patients are the responsibility of the consultant concerned. All necessary drugs and dressings will be supplied by the Hospital Trust (subject to paragraph 2.3).

2.2 Patients should be encouraged to bring in their drugs with them into hospital. This facilitates medicines reconciliation on admission and reduces risk of medication errors. Barts Health aim to maintain a single supply of medicines to reduce confusion.

2.3 Patients own drugs may, with the agreement of the patient, be used while the patient is in hospital until a supply is made where appropriate by the hospital pharmacy. They may be used to fulfil discharge medicine requirements provided they are still appropriate.

2.4 Patients own drugs remain their own property. Any medicines not used during the admission in accordance with the hospital's patients own drugs policy must be returned to the patient on discharge from hospital unless it is clinically inappropriate and the patient/ patient's representative has agreed to have the medicines destroyed. If it is clinically inappropriate to return a patient's own medication, the patient should be made aware of the change and advised to dispose of similar medicines at home.

2.5 When a patient is discharged from hospital, a minimum of **14 days supply of drugs** should be supplied (subject to paragraph 2.2) unless the full course of treatment calls for a shorter supply. A minimum **of 5 days supply of dressings** should be made.
Where a medicine compliance aid (MCA) is in use (not in use in BHRuT), the hospital team will aim to ensure appropriate medication continuity through the following approaches;

- communication with the patient's community pharmacy,
- A 7 day MCA with accompanying Medication Administration Record (MAR) sheet
- or an interim conventional supply is made as appropriate.

The community pharmacist would then review the need with the community prescriber

2.6 A policy should be in place for use of patients' own drugs, self-administration of medication, dispensing medicines for discharge, and the use of compliance aids (including monitored dosage systems) and or Medication Administration Record (MAR) sheets where applicable; this should include making appropriate arrangements for continuity of care after discharge.

2.7 In Barts Health Patients will not be initiated on medicine compliance aids by the hospital, with the exception of selected patients requiring antiretrovirals for HIV and patients on multiple medicines post renal transplantation. In the case of renal patients, the hospital will ensure that there is a plan for continuation of the aid in primary care where appropriate. Where a patient is admitted into hospital with a medicine compliance aid, and where no changes to regular medication are made, the hospital will liaise with the patients GP and community pharmacist and arrange for a further medicines to be prescribed and dispensed to be collected/delivered to the patient on discharge. The prescriber and community pharmacist will subsequently review the patient for on-going need.

2.8 Clinicians must provide the patients GP with information on:

- Diagnosis and;
- Reason for admission,
- A brief update from the inpatient stay, patient's medication on discharge, including whether to continue or stop, any medication changes and reasons for the changes.
- In addition, any relevant clinical or biochemical monitoring parameters should be communicated highlighting further monitoring to be undertaken by the GP

This information must be made available **to the patient's GP urgently if possible within 24 hours for safety and always within 10 days of discharge** to allow ongoing treatment to be maintained. If this cannot be guaranteed, then the hospital should prescribe for as long a period as necessary.

3. Accident and Emergency

3.1 A 7 days (a minimum of 5 days in Barts Health) supply of drugs (exception is analgesics where 48 hours supply is issued) and / or dressings needed should be given unless the clinical requirement is for a shorter supply.

3.2 Patients own drugs should remain with the patient during the time of their assessment and transferred with them if they are admitted or sent home, unless clinically inappropriate. If it is clinically inappropriate to return a patient's own medication, the patient should be made aware of the change and advised to dispose of similar medicines at home.

3.3 Where appropriate, patients with self-limiting conditions can be referred to the local Minor Ailments scheme if available.

3.4 Medicines supplied by A&E are subject to prescription charges. Therefore, arrangements will be in place where possible to collect prescription charges from patients who would normally pay and patients should be reminded it is a criminal offence to falsely declare exemption to charges.

4. Day Case Patients

4.1 Drugs and dressings prescribed for administration during day case treatments are the responsibility of the consultant concerned.
All necessary drugs and dressings for administration as a day case will be supplied by the Hospital Trust (subject to paragraph 2.3).

4.2 A minimum of 14 days (7 days in Barts Health) supply should be provided (in the form of a patient pack wherever possible), unless the full course of treatment requires a shorter supply. In such cases dressings will require a minimum of 5 days supply.

4.3 Where medicines are given on discharge of day patients, arrangements must be in place to collect prescription charges from patients who would normally pay for their prescriptions or for patients who are exempt from prescription a declaration of exemption.

5a. Outpatients – BHRuT

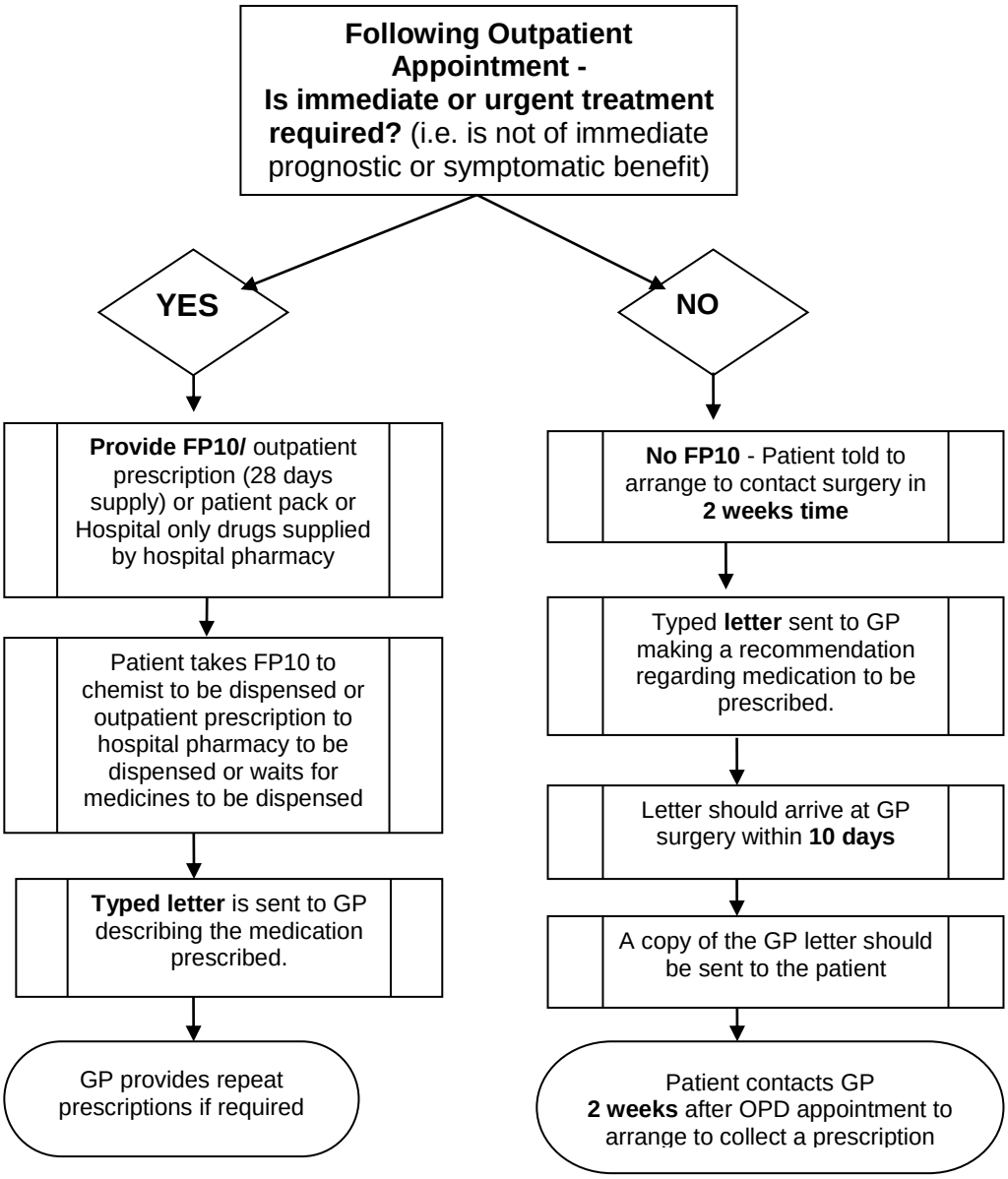
5.1 Drugs and dressings prescribed for administration during a hospital outpatient consultation must be provided by the Hospital Trust.

5.2 If immediate treatment is required following an outpatient consultation, the clinic must provide a minimum of 14 days supply, unless the full course of treatment requires a shorter supply. This may be increased in order to provide a patient pack including patient information.

5.3 If the patient does not require an immediate supply (i.e. the medication is not of immediate prognostic or symptomatic benefit) the patient should be informed that their treatment is not urgent, and asked to contact their GP in 14 days. All relevant information enabling the GP to prescribe, should reach the GP practice within 72 hours. Patients should be advised to allow enough time for this information to reach their GP before contacting them for a prescription.

5.4 Arrangements must be in place to collect prescription charges from patients who would normally pay for their prescriptions or for patients who are exempt from prescription a declaration of exemption.

Quick Reference Guide – OUTPATIENTS (BHRuT)



5b. Outpatients – Barts Health

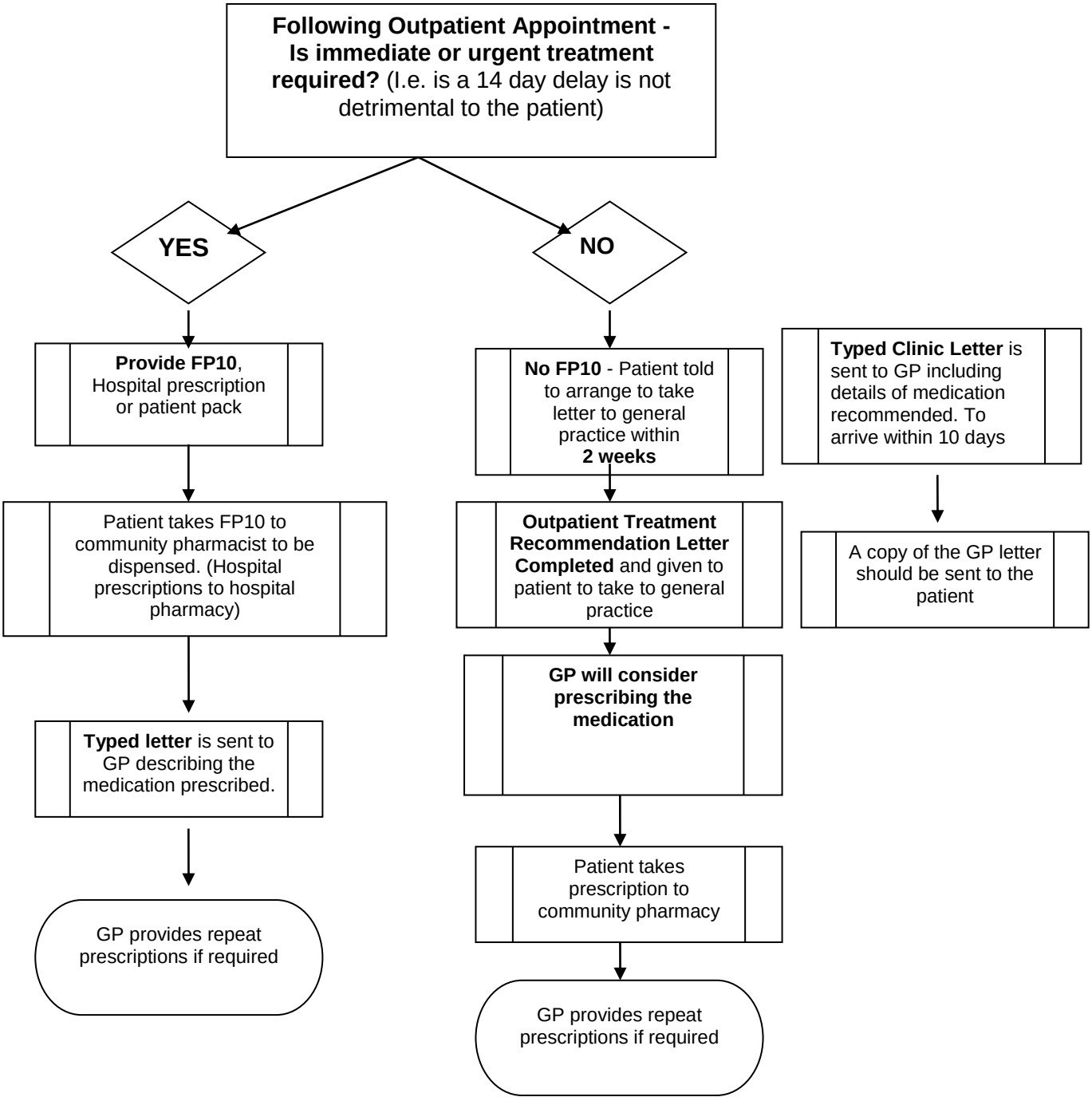
5.1 Drugs, dietetic products and dressings prescribed for administration during a hospital outpatient consultation must be provided by the Hospital Trust.

5.2 If immediate treatment is required following an outpatient consultation, the clinic must provide **a minimum of 14 days** supply (in the form of a patient pack wherever possible), unless the full course of treatment requires a shorter supply. In such cases dressings will require a minimum of 5 days supply.

5.3 If the patient does not require an immediate supply (i.e. a delay of 2 weeks would not be clinically detrimental for that patient) the patient should be informed that their treatment is not urgent, and asked to make a routine consultation with their GP within 14 days. All relevant information enabling the GP to prescribe, should reach the GP practice within 10 days. Patients must be provided with a 'Non-urgent Outpatient Recommendation for GP Prescribing letter' (Appendix 1).

5.4 Arrangements must be in place to collect prescription charges from patients who would normally pay for their prescriptions or for patients who are exempt from prescription a declaration of exemption.

Quick Reference Guide – OUTPATIENTS (Barts Health comprising Royal London Hospital, Mile End Hospital, St Bartholomew's Hospital, Newham Hospital, London Chest Hospital, Whipps Cross Hospital)



5c. Outpatient clinics/community teams – NELFT

5.1 Drugs and dressings prescribed for administration during an outpatient consultation or a home visit must be provided by NELFT.

5.2 If immediate treatment is required following an outpatient consultation, the clinic must provide a **minimum of 14 days supply**, unless the full course of treatment requires a shorter supply. This may be increased in order to provide a patient pack including patient information.

5.3 Drugs and dressings required for administration during a home visit, where the nurse is not a prescriber, they should arrange for a prescription from a member of the team or service who is a prescriber, prior to the visit. Prescriptions should not routinely be sourced from GPs.

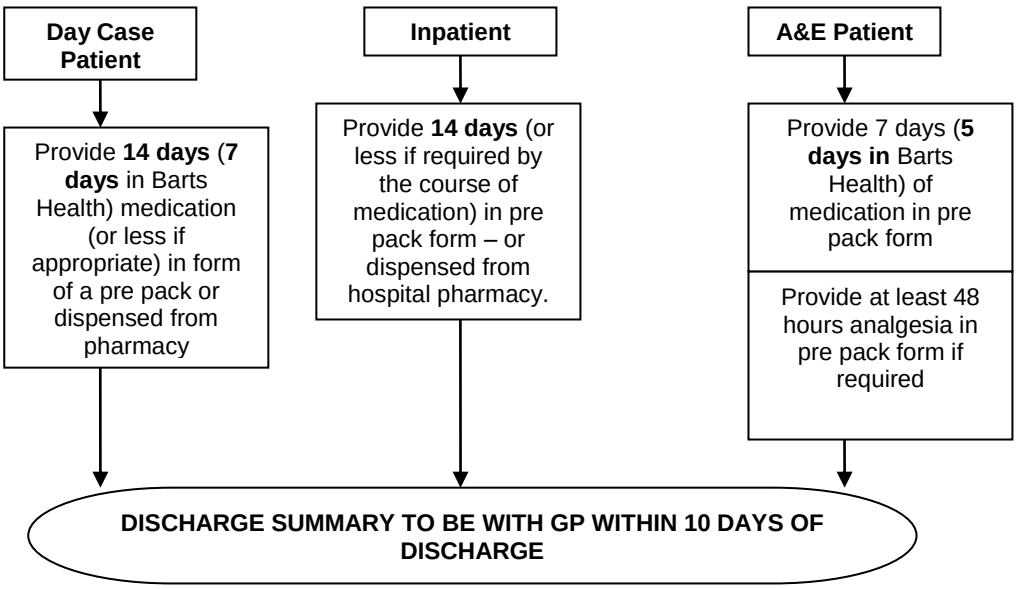
5.4 If immediate treatment is required following an outpatient consultation with a nurse that is not a prescriber, the nurse will arrange for an urgent prescription from a member of the team or service who is a prescriber and communicate this to the patient.

5.5 If the patient does not require an immediate supply (i.e. the medication is not of immediate prognostic or symptomatic benefit) the patient should be informed that their treatment is not urgent, and asked to contact their surgery in 14 days. All relevant information enabling the GP to prescribe, should reach the surgery within 72 hours. Patients should be advised to allow enough time for this information to reach their GP before contacting them for a prescription.

6. GP "direction to administer medication" to patients in their own homes or care homes-NELFT

6.1 GP's referring patients to community teams for medicines administration in their own homes/care homes, must use the NELFT approved documentation ensuring all relevant information is completed, signed and dated. See Appendix 2.

Quick Reference Guide - INPATIENTS, DAY CASES AND A&E (BHRuT and Barts Health)



7. Transfer of Prescribing from Secondary to Primary Care

7.1 It is usually more convenient for patients to access ongoing repeat prescriptions from their GP however the safety issues and monitoring requirements relating to some drugs will require on going hospital prescribing.

7.2 The Trust JPG/DTC as part of its decision making on drugs will advise on the appropriate setting (hospital or primary care) for drugs to be initiated and continued. Joint prescribing arrangements will be considered as part of the application to include drugs in the joint formulary.

7.3 Responsibility for Prescribing

GMC prescribing guidance on Good practice in prescribing and managing medicines and devices suggests that a GP should not accept responsibility unless he or she feels confident in prescribing for that condition, but recognises that he or she may prescribe any drug that is not on the Blacklist - Part XVIIIA of the Drug Tariff

GPs are encouraged to accept responsibility for prescribing whenever it is appropriate. If the GP feels s/he has not been given sufficient information by the hospital to undertake prescribing, then the GP should contact the relevant hospital clinician for further information / guidance to enable them to prescribe. The GP may also contact the medicines management team in the CCG for advice.

- Legal responsibility for prescribing lies with the doctor issuing the prescription

- Hospital doctors should not ask GPs to prescribe new treatments that have not been approved by the Trust DTC/ DTG neither should GPs prescribe non-formulary drugs

- When prescribing responsibility is transferred from secondary to primary care, the GP must have confidence in prescribing the necessary drugs. The GP should receive a full discharge summary, including detailed clinical information, within 10 days of discharge from the hospital

- If there is insufficient clinical information, the GP should defer prescribing and contact the consultant for more information. The consultant will arrange for the patient to receive a prescription until such time as the GP has sufficient information to be satisfied to accept responsibility for prescribing

If a GP decides not to prescribe, the reasons should be put in writing to the consultant and a copy may be sent to the CCG prescribing adviser if considered appropriate. GPs may also use the CCG's 'Form for Reporting Issues with Secondary Care' form to indicate their unwillingness to prescribe a drug. Please refer to Appendix 3 for the 'Form for Reporting Issues with Secondary Care'.

- **Refusal should not be on grounds of cost alone as this will cause the clinician to be in breach of GMC practice guidance.** If necessary, in exceptional circumstances, the CCG Deputy Chief Pharmacist and Trust Chief Pharmacist will liaise with clinicians to determine ongoing arrangements for prescribing.

- Responsibility for prescribing will rest with the specialist clinician when:
    - the drugs are used in a hospital based clinical trial
    - clinical risk management arrangements recommend (e.g. Tolvaptan) that the secondary care clinician takes full responsibility for the prescribing, monitoring and dose adjustment of these drugs
    - the drug is only available through hospitals
    - the GP is unable to prescribe the drug for clinical or professional reasons which cannot be addressed by additional information and the MMT has been informed

- involves a test that will be carried out in the hospital as part of a hospital episode of care

7.4 *Joint prescribing arrangements (Shared Care)*

7.4.1 Therapy initiated in hospital which requires specialist knowledge, training and/or has complex monitoring schedules would not normally be prescribed in primary care. However it is possible that the GP and hospital clinician can agree joint prescribing arrangements for a named patient with a named drug once the patient's condition is stable and predictable, the Trust chief pharmacist and CCG MMT should be informed of these arrangements as appropriate.

7.4.2 Successful joint prescribing and monitoring arrangements allow the seamless sharing of patient treatment from secondary care to the community. This section relates to those drugs where shared prescribing /monitoring arrangements may be appropriate.

- Clinical responsibility should be considered for sharing care with primary care only when it is agreed that the patient's clinical condition is stable or predictable. See Area Prescribing sub-Committees (APC) approved North East London Medicines Management Network (NELMMN) decision flow chart (Appendix 5)

- The consultant must provide the GP with a locally agreed shared care protocol which is only legitimate if agreed to by the GP. The guidelines should include management of the clinical condition, drug dosage, administration, monitoring

- If a treatment is not licensed for a particular indication, this must be stated and full justification for its use should be given.

- Information must be sent to the GP before s/he is asked to consent to a joint prescribing arrangement. This should be within 2 weeks (10 working days) of the last consultation

- The joint prescribing arrangement should identify the areas of care for which each partner has responsibility and should be patient specific.

Agreed communication should include the telephone, facsimile or email contact of an appropriate specialist healthcare professional for when problems arise. Progress reports should be produced to an agreed timescale with regular review.

7.4.3 The provision of joint prescribing arrangements does not automatically mean the GP prescribes the medication.

7.4.4 If the GP is unable to accept clinical responsibility, s/he should contact, the consultant concerned within 2 weeks (10 working days) from receipt stating the reasons and notifying them that the patient requires that they provide the medication. The case should be referred to the CCG medicines management team who will attempt resolution. GPs cannot be forced to prescribe and the decision about whether to take on responsibility for prescribing will ultimately lie with the individual GP.

7.4.5 If a GP has accepted a joint prescribing arrangement for a patient and the patient does not attend the hospital for monitoring, the GP and or consultant must be informed and GP prescribing should stop until suitable monitoring can be commenced.

7.4.6 Where the APC has approved a drug to be managed through a joint prescribing arrangement and the GP declines, it should be noted that this could impact on the "new to follow up" ratios agreed with the trust. In cases where the hospital continues with prescribing and monitoring outside what is usual practice, this may result in a review of how work is charged to the commissioner.

8.0 New, complex and specialist drugs
This applies to the Hospital-only list and or specialist commissioned drugs under the remit of NHS England. These are based on where it is most appropriate for a patient to receive care and not cost. The convenience to the patient for long-term treatment is also important.

8.1 Hospital –only Drugs
8.1.1 The APC considers that it is inappropriate for a GP to prescribe these drugs and only the hospital should prescribe these drugs.

8.1.2 Responsibility for prescribing will remain with the hospital consultant where:

- Drugs are undergoing or included in a hospital based clinical trial
- The consultant considers that only s/he is able to monitor the patient's response to medication because, for example, of the need for specialised investigations
- A drug or appliance is not available on an FP10 or is only available through hospitals
- Drugs subject to Home Care arrangements
- Drugs where a GP is unable to take responsibility for prescribing under a suggested joint prescribing arrangement – until resolution of outstanding prescribing /monitoring issues

8.1.3 Where a patient requires a medication and hospital only prescribing has been agreed for that medication, information about the medication should be provided to the patient's GP sufficient to allow them to identify and refer specific problems that the patient is experiencing due to that medication.

8.2 Shared Care Drugs
These drugs should only be prescribed by a GP if approved joint prescribing arrangements have been agreed between GP and consultant. The GP needs to acknowledge acceptance of clinical responsibility for the drug management.

The NELMMN will update this list of drugs regularly. This list is not intended to restrict a GP's freedom to prescribe.

There may be other drugs not included on this list for which a GP has concerns about accepting prescribing responsibility. GPs are advised to contact their CCG prescribing adviser in the first instance to discuss how these concerns may be addressed.

9. Transfer of Information between Secondary and Primary Care

9.1 On referral to a hospital consultant, it is the responsibility of the GP to give comprehensive details of a patient's medical history, drug treatment, previous adverse reactions and allergies. Where possible this should include any treatments that are prescribed by the hospital (e.g. antiTNFs, bisphosphonates)

9.2 It is the responsibility of the hospital clinician on discharge to give the GP comprehensive details of a patient's diagnosis and drug treatment. On discharge from a hospital inpatient stay, clinicians must provide the patients GP with explicit and legible information on diagnosis and reason for admission, patient's medication on discharge including whether to continue or stop any medication started, any medication changes and reasons for the changes. Any relevant clinical or biochemical monitoring parameters should be communicated, highlighting further monitoring to be undertaken by the GP. This information must be made available to the patient's GP within 72 hours (10 days in Barts Health) of discharge to allow treatment to be safely maintained.

10. Unlicensed Medicines

10.1 Unlicensed drugs remain the responsibility of the hospital consultant except where:
- a drug is included in the joint formulary and
- a substantial body of evidence exists to support the use of an unlicensed medicine or a licensed medicine outside its licensed indications e.g. the current BNF for Children is considered a substantial body of evidence.

10.2 Where a treatment is not licensed for a particular indication and has not been previously agreed via the JPG/ DTC or APC, the GP must be informed and the consultant should give full justification for the use of the drug to the GP.

11. New Drugs and Clinical Trials

11.1 Hospital clinicians should refer to the Trust's policy for Introduction of New Drugs and the Trust Policy for: Access to unlicensed Investigational Drugs Outside of Clinical Trials via Expanded Access or Compassionate Use Programmes before prescribing any new product.

11.2 The process for managing the entry of new drugs is via the Trust DTC/ DTG and APC. The NELMMN could be utilised for recommendations to these decision making committees.

11.3 GPs are informed of the Trust's DTC/DTG decisions for new drugs via the 'Prescription Pad' newsletter.

11.4 All clinical trials must have been subject to Ethics Committee approval. GPs should be adequately informed if a patient is participating in a clinical trial.

11.5 Prescribing and supply of clinical trial material is the responsibility of the Hospital Trust.

11.6 Patients should routinely be made aware that funding for clinical trial medication may not be available once the trial comes to an end. Trust must discuss financial plans with commissioners as part of annual cost pressure negotiation.

12. Tertiary Care Referrals

12.1 It is expected that the care and treatment of patients referred to tertiary care (outside the Trust) will remain the responsibility of the tertiary centre while they continue to require specialist care.

12.2 In some circumstances it may be appropriate for the tertiary centre to share care with a secondary care provider or more rarely with a GP. In these circumstances the principles outlined under General Principles (Section 1 of this document) and New Drugs and Clinical Trials (Section 10 of this document) will apply.

12.3 In cases of shared care, tertiary and secondary care prescribers should ensure that the GP is informed of all prescribed drug treatments, including those where the GP is not asked to prescribe as specified in the Hospital-only list. This is to ensure that patient's records contain current and accurate information of all drug treatments. Where GPs are not required to prescribe (e.g. of hospital only drugs), discharge and outpatient letters should clearly state that the affected drugs are to be supplied by the hospital only.

13. High Tech Homecare

In circumstances where it is clinically appropriate for the patient to be cared for at home, under the supervision of the specialist centre, the Trust should make appropriate arrangements in respect to supply of medication (e.g. Homecare arrangements, FP10 (HP)s). This should be reflected in commissioning arrangements. If this is not the case, individual care packages will need to be agreed between commissioners and trusts, when necessary.

14. Clinical Governance

Providers will ensure that appropriate arrangements are established to meet the requirements of clinical governance, as described in “A First Class Service, Quality in the New NHS” (HSC 1998/113), with respect to prescribing practice. This will include a comprehensive programme of quality improvement activity, such as clinical audit and evidence based practice, and ensuring that clinical standards of National Service Frameworks and NICE recommendations are implemented.

Appendix 1: Barts Health Outpatient recommendation letter to GPs

Dear Patient please take this letter to your GP surgery
to make arrangements about getting suitable medication within 14 days.
The letter tells your GP what medicine your specialist has recommended for you.
These medicines are non-urgent.

NHS

Non Urgent Outpatient Recommendation for GP Prescribing

Barts Health NHS Trust

Patient Details or affix patient label

Hospital Number	Date of Birth
Last Name Please Print	Weight (kg)
First Name Please Print	Hospital Site

Clinician making recommendation

Last Name Please Print		Designation: Cons/SPR/SHO/Nurse/Pharmacist/AHP
First Name Please Print		Contact (Bleep/Mobile/Registrars Number) Number
Signature	Date	Name of Consultant
Professional Registration Number	Speciality	Consultant/Secretary contact number

Drug Allergies / Sensitivities

Name of Drug	Type of reaction

Diagnosis & Advice for Drug Treatment/Prescription

Diagnosis (including tests done) / Indication for Treatment and other issues

Effects anticipated and monitoring required

Benefits and risks discussed with patient:

Drug Name (+specific formulation if required)	Dose	Frequency	Number of Days or Amount to supply	Length of Treatment Monitoring Requirement

Recommended changes to current drug treatment for condition reviewed and explanation:

For GP use only: Notes for receptionist	1 Ask the patient to see GP 2 Phone consultation 3 Issue recommended drugs as a prescription 4 File letter in notes	Yes/No Yes/No Yes/No Yes/No	5 Other action:	Yes/No

Appendix 2a: GP "direction to administer medication" to patients in their own homes or care homes-NELFT

Direction to supply* and/or administer medication (*applies to specific sites only)

For attention of …… (please specify team)

In agreement with the Acute Trust, the CCG and NHS NELFT Medicines policy, drugs cannot be administered without an authorised signature below. All sections must be clearly completed in capitals otherwise this may cause a delay in treatment.

Patient name	**DOB**	**NHS number**	**Weight and surface area** (paediatrics)
Patient address	**Allergy status**		**GP details**

Date	**Medication**	**Dose**	**Route**	**Time of administration (morning/lunch /evening/night)**	**Duration**	**Review date**	**Signature, name and contact details e.g. bleep**

Appendix 2b:

Direction to administer insulin

For attention of …… (please specify team)

In agreement with the Acute Trust, the CCG and NHS NELFT Medicines policy, drugs cannot be administered without an authorised signature below. All sections must be completed otherwise this may cause a delay in treatment.

Patient name	**DOB**	**NHS number**	**Weight and surface area** (paediatrics)
Patient address	**Allergy status**		**GP details**

Date	**Insulin**	**Route**	**Time of administration (State number of units to be given)**				**Review date**	**Signature, name and contact details e.g. bleep**
			Before breakfast*	**Before lunch***	**Before dinner***	**Bed time**		
			units	units	units	units		
			units	units	units	units		
			units	units	units	units		
			units	units	units	units		
			units	units	units	units		
			units	units	units	units		

*Maximum 30 minutes before meals or patient is at risk of hypoglycaemia

Appendix 3

Form for Reporting Issues with Secondary Care

Please use this form when you would like a prescribing issue taken up by the Medicines Management team with Barking Havering and Redbridge University Trust (BHRuT), Barts Health NHS Trust (BH) & or North East London Foundation Trust (NELFT).

These may be instances where you feel the prescribing or recommendation to prescribe from BHRuT / BH / NELFT is not in line with National or local guidance e.g. choice of statin, poor information provided etc.

Please don't use this form for urgent issues regarding a specific patient. Please continue to call the team in such instances.

Date of Prescription/Recommendation

_____

Clinician at BHRuT / BH / NELFT

_____

Please outline the issue as you see it
(You may enclose the relevant letter from BHRuT / BH / NELFT blanking out any patient details)

Your Name _____

Practice _____

Date _____

Please fax the completed form to: Medicine Management Team 0203 182 3124 or bhrmedicines.management@nhs.net

Appendix 4

Barking, Havering and Redbridge University Hospitals NHS Trust	NHS

PRESCRIBING OF MEDICINES RECOMMENDED BY BHRUT CONSULTANTS

Please complete this form if the GP is unwilling to take on responsibility for prescribing medicines that you have initiated or if there are any other issues with continuity of care affecting your patient. To prevent unintended breaks in the patient's treatment, call the pharmacy department to discuss how the patient will obtain treatment in the interim on Ext 8521 (KGH) or Ext 2346 (QH).

Please post /fax a copy of this form to: the Assistant Chief Pharmacist, Clinical Services at the contact details provided below.

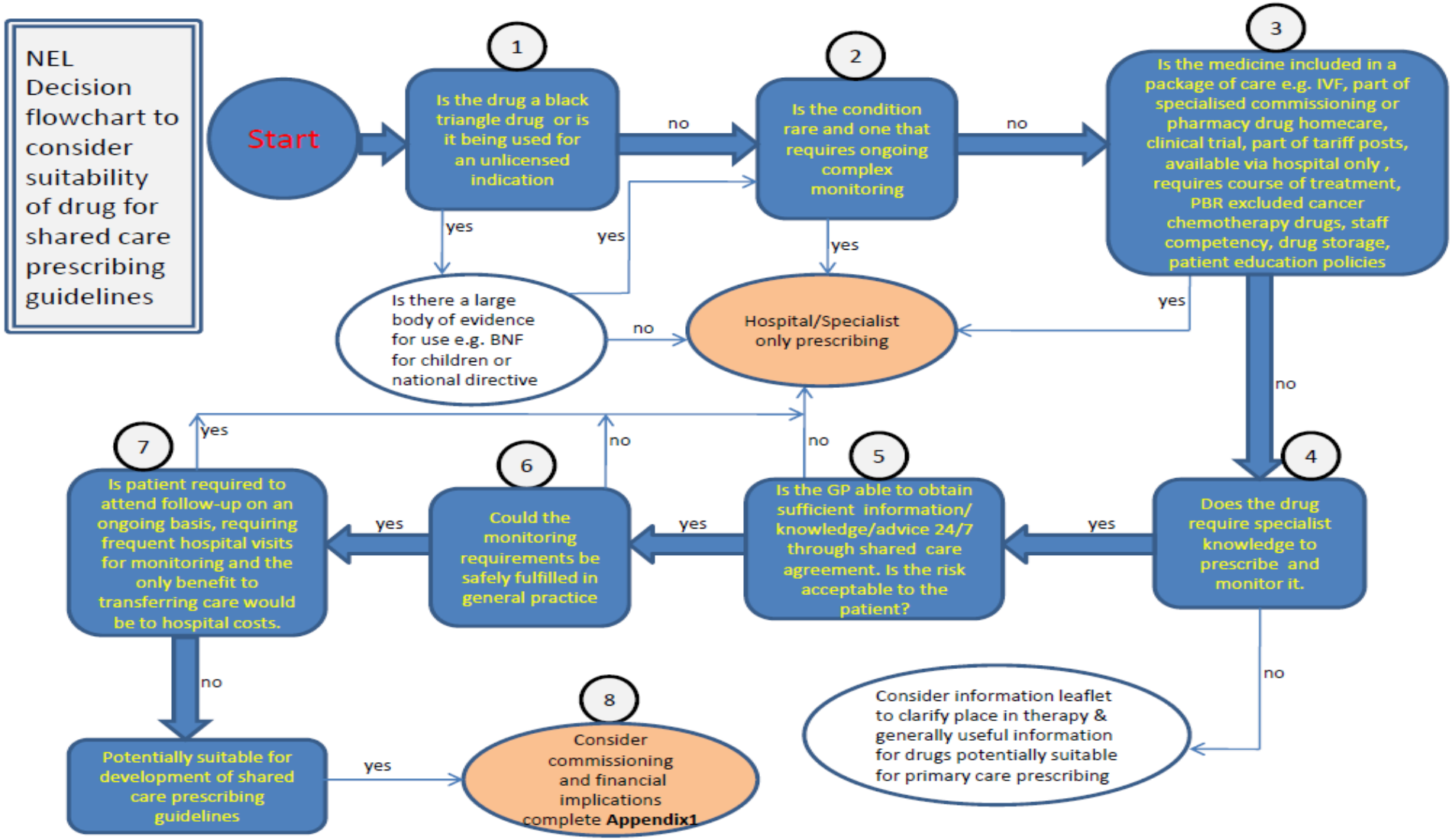
Patient's name		Consultant Name		
Date of birth		Name of prescriber **(if different from above)**		
NHS number		***Date of prescribing***		
Hospital number if known		***Hospital***	***KGH***	***QH***
GP Name		***Practice Address***		

Name of drug Please fill in a separate form for each drug.	**Dose & frequency**	**Indication**	**Duration of treatment**

Please mark	**The GP feels unable to accept clinical responsibility for prescribing because**:	**Hospital Consultant or doctor's comment:**
☐	The drug is not included in the BHRuT Trust drugs formulary / prescribing not in accordance with formulary restrictions set out for this drug. Hospital doctors are asked not to ask GPs to initiate treatment with drugs which have not been approved by the Trust New Drugs Group.	
☐	The Drug is included in the list of products approved by BHRuT Trust for ***hospital only prescribing***	
☐	Drug requires regular specialist monitoring and/or the majority of care and monitoring should be provided by the hospital (delete as appropriate)	
☐	**Patient is not stabilised on a drug initiated by the specialist**	
☐	**No initial prescription and/or correspondence from specialist - patient was instructed to request prescription**	
☐	**Hospital clinical trial drug**	
☐	**Unlicensed drug, dose or indication**	
☐	High cost drug / practice not funded for prescribing this drug or undertaking monitoring	
☐	Newly licensed drug where place in therapy and / or risks due to the drug unknown by the GP.	
☐	**Drug is included in the list of products approved by BHRuT for shared care prescribing but no shared care guidance has been provided**	
☐	**The practice does not recognise any shared care prescribing agreement for this drug.**	
☐	**There are problems with availability of this medication in primary care**	
☐	**The patient is not registered with this GP practice**	
☐	**It is not within the GP scope of practice**	
C. **General comments / other reasons (list here what additional information or correspondence has been provided to the GP to support prescribing)**		

Send to: Dinesh Gupta, Assistant Chief Pharmacist, Clinical Services. Pharmacy department, Queens Hospital, Rom Valley Way, Romford, Essex RM7 OAG. Fax 01708 435200 Please also send / fax the form to the initiating hospital Consultant.

Appendix 5a



Adapted with permission from South West London PCTs by NELMMN, January 2013

Appendix 5b

Decision box number on chart	Discussion points below for each question on flowchart when deciding on hospital only or shared care suitability
1	
2	
3	
4	
5	
6	
7	
8	