North East London Health & Care Partnership

North East London Integrated Care System

Interface Prescribing Policy

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Interface Prescribing Policy

1. Introduction

This policy was adapted and adopted from the guidance document developed by the NHS London Procurement Partnership (NHS LPP) in partnership with the five London Integrated Care Systems(ICS) via the Pan-London Interface Prescribing Guidance short-life working group (SWLG). The group included representation from Regional Community Pharmacy, General Practice, mental health, paediatrics, primary, secondary and tertiary care and patient representation.

The aim of this policy is to:

- Harmonise key elements of interface prescribing across all North East London taking into consideration the relevant requirements of the standard NHS provider contract [1].
- Reduce inequalities in prescribing that may happen during transfers of care across the interface.
- Improve access to timely, safe, and correctly prescribed items for patients accessing care in North East London.
- Improve access to patient health information required for safe transition of care.
- Support system efficiencies across primary, secondary and tertiary care.
- Support an improved patient journey experience and outcomes.

2. General Principles

- **Legal and National Standards**

2.1.1 Providers should ensure all prescribing is in line with the Medicines Act 1968 and any other relevant national or local guidance.

2.1.2 Providers of NHS and independent hospital pharmacy services, including those in hospitals, mental health facilities, community services, prisons, hospices, and ambulance settings, should adhere to the Royal Pharmaceutical Society professional standards outlined in the Professional Standards for Hospital Pharmacy Services, 2022 [3].

2.1.3 Providers of NHS and independent hospital pharmacy services should ensure that written guidance is in place covering information flow on discharge from inpatient, outpatient, urgent or emergency care, as recommended by the Care Quality Commission (CQC) [4].

2.1.4 Providers are also expected to give due consideration to national and regional recommendations, such as those from NHS England, NICE, LMPG and the Best Value Medicines Implementation Group (BVMIG). These recommendations aim to promote consistency of access to medicines across London, ensuring optimal value whilst minimising duplication of effort in the decision-making process.

- **Prescribing**

2.2.1 The legal responsibility for prescribing rests with the prescriber who signs the prescription, and it is their duty to prescribe within their level of competence. For further guidance, please refer to the General Medical Council's document, "Good practice in prescribing and managing medicines and devices", 2013 [5] and the Royal Pharmaceutical Society's document, 'A Competency Framework for all Prescribers' [6].

2.2.2 Prescribing can occur in various settings and involves medical and non-medical prescribers. These settings may include:

- Hospital or GP settings;
- Community settings;
- Remote consultations;
- Private to primary care arrangements;
- Use of the Electronic Prescription Service (EPS) from specialist services;

- Prescribing arrangements for patients on virtual wards;
- Homecare medicines services.

- All non-medical prescribers (NMPs) are expected to work within the policies and guidelines of their employing organisation and the established agreed local prescribing guidelines.

- The provider must ensure that NMPs:
- Are accountable for and prescribe within their competence and expertise;
- Seek advice and refer appropriately to other healthcare professionals with different expertise when necessary;
- Adhere to the Code of Conduct and Ethics of their regulatory body;
- Have appropriate indemnity cover for their prescribing role [6].
- Maintain competencies through continuous professional development and clinical supervision.

- **Selection of Medicines**

2.3.1 Local health economies should strive to enhance medicine usage to improve health outcomes by facilitating timely, safe, and effective medicine-related care tailored to individual patient needs across the local health economy.

2.3.2 The North East London (NEL) Formulary and Pathways Group (FPG) provides a single joint forum for the assessment and approval of new medicines and medicines related pathways, with the aim to decrease duplication, improve equity of access, improve health outcomes and help decrease health inequalities for patients across NEL [7]. The NEL FPG is a sub-group of the NEL System Prescribing and Medicines Optimisation (SyPMO) Board.

2.3.3 All prescribing and recommendations should be based on the agreed provider formulary or equivalent. The agreed formulary should take into account the clinical and cost-effectiveness of new medicines and their overall impact on both primary and secondary care. Adequate documentation of the decision-making process is

essential. Providers should have internal processes to ensure prescribers are informed of any updates and to prevent prescribers from bypassing restrictions by requesting GPs or other primary care prescribers to prescribe non-formulary items, except in exceptional circumstances approved by individual trust governance processes.

Where a non-formulary item is prescribed and requested across the interface, the reasons why formulary items are not an option should be provided, to inform clinical decision-making.

2.3.4 Generic nomenclature should be uniformly used unless there is a specific need to specify the brand, such as for biologics or biosimilars, drugs with variance in bioavailability or excipients, or standardisation of liquid strength, as documented in the local ICS formulary. [8,9].

2.3.5 Local prescribing guidance and advice should be followed (e.g. in the case of drug shortages or prescribing efficiencies) which may recommend the prescribing of generic/ alternative branded medicines. This allows flexibility of prescribing and dispensing between brands and classes of medicines where safety, evidence and bioavailability allow.

2.3.6 Providers are expected to support the principles of antimicrobial stewardship to ensure the appropriate use and selection of antimicrobials. This includes addressing patient beliefs about the clinically appropriate use of antibiotics and ensuring consistency in the messages given to patients in both primary and secondary care, particularly for patients attending urgent and emergency care settings who may already have consulted a healthcare professional in primary care.

Prescribers should comply with the North East London (NEL) Management of Infection Guidance for Primary Care and EOLAS platform which hosts Trust antimicrobial guidance.

2.3.7 Independent Prescribers in Primary Care or other primary care prescribers should not be asked to initiate products specified in the NHS England guidance, 'Items which should not routinely be prescribed in primary care: policy guidance' [10] and 'Policy guidance: conditions for which over the counter items should not be

routinely prescribed in primary care [11] unless the patient has exceptional circumstances identified by the guidance (Independent Prescribers in Primary Care may be able to prescribe in exceptional circumstances based on their professional judgement) or in locally approved arrangements.

This guidance provides recommendations for conditions that are:

- Self-limiting and do not require medical advice or treatment;
- Minor illnesses suitable for self-care and treatment with over-the-counter items readily available from a pharmacy;
- Items of limited clinical effectiveness, lacking robust evidence for clinical effectiveness.

2.3.8 In line with national guidance to promote self-care and NHS England guidance on prescribing over-the-counter medicines, providers are expected to direct patients to local pharmacies for advice and purchase of such products where appropriate.

2.3.9 Advisory Committee Borderline Substances (ACBS) products, dressings, appliances, and devices will have local prescribing arrangements in place, but the general principles of good prescribing for medicines can also be applied to these products.

2.3.10 Medicines account for 25% of emissions within the NHS [12]. When engaging in shared decision-making with patients regarding treatment options, consideration of sustainability and carbon footprint should be part of these decisions.

2.3.11 Where medication initiated by a provider and continued in primary care faces a national shortage, providers and commissioners will collaborate to ensure patient care is not adversely affected, providing advice on alternative options during the shortage while considering national guidance. In such scenarios, it may be necessary to temporarily amend formulary restrictions or make non-formulary and/or un-licensed products available if deemed the most appropriate clinical course of action using the agreed formulary governance process.

2.3.12 The following guidance has been developed to help manage the continuity of care for people prescribed medicines that are in short supply:

- Medicines Shortages: Solutions for empty shelves [13]
- A Guide to Managing Medicines Supply and Shortages, Department of Health & Social Care [14]

2.3.13 Providers should assess available services to support vulnerable individuals within their ICS. Please refer to local policies and procedures for further guidance.

2.4 Clinical Governance

2.4.1The North East London (NEL) Formulary and Pathways Group (FPG) provides a single joint forum for the assessment and approval of new medicines and medicines related pathways, with the aim to decrease duplication, improve equity of access, improve health outcomes and help decrease health inequalities for patients across NEL. The NEL FPG is a sub-group of the NEL System Prescribing and Medicines Optimisation (SyPMO) Board.

2.4.2 Provider Trusts (including acute settings and mental health) should ensure they have robust governance procedures in place for managing the processes related to medicine use.

2.4.3 It is the responsibility of the provider trust, through its governance processes, to ensure that formularies and guidelines, along with associated processes, are adhered to by all prescribers and healthcare professionals involved in patient care provided by (or on behalf of) the provider trust.

2.4.4 Any service, resource or financial support offered by a pharmaceutical company, or other commercial or external partner, either directly or indirectly, must be evaluated through the provider's governance process to ensure that a comprehensive impact assessment considers implications for the overall health economy.

2.4.5 Any value-added service offered with devices, dressings, appliances, ACBS borderline products, glucose monitoring strips and any other items that are issued on prescription, similarly to medicines, should go through the provider's governance processes. Cost alone should not be the sole determinant for selecting one product over another. For items suitable for prescribing on FP10, such decisions should involve the Pharmacy and Medicines Optimisation ICB team if prescribing is to be continued in primary care or if the product cost is charged to the ICB.

2.5 Patient Centred Care

2.5.1 Patients should remain at the heart of all clinical decisions. It is reported that 10% of prescription items dispensed through primary care in England are inappropriate for patients' circumstances and wishes, and they could be better served with alternative treatments including non-pharmacological options [15].

2.5.2 Many people wish to be active participants in their healthcare and to be involved in making decisions about their medicines. Patient decision aids can assist healthcare professionals in adopting a shared decision-making approach during consultations, ensuring that patients, along with their family members or carers where appropriate, can make well-informed choices aligned with the patient's values and preferences. Please refer to NICE guidance on decision-making and mental capacity [16] and shared decision-making [17].

2.5.3 Prescribers should, where suitable, consider reducing inappropriate unnecessary polypharmacy and deprescribing wherever possible, guided by recommendations from the Department of Health and Social Care's national review on overprescribing [15,18]. Overprescribing occurs when patients receive medicines that are inappropriate or no longer necessary, or when harms outweigh benefits. This is recognised as an increasingly significant issue, particularly with growing concerns about the adverse effects of polypharmacy as the population ages.

2.5.4 Patients (or their family members and carers) should receive information enabling them to use / administer medicines and equipment correctly, including

details on treatment duration, appropriate monitoring, and follow-up requirements [19].

2.5.5 Social prescribing and non-medicine interventions can support patient centred care. Please refer to NHS England's guidance on social prescribing [20].

2.6 Dispensing

2.6.1 Pharmacies should routinely dispense medicines in their original packs, unless there are clinical reasons not to comply with Directive 2001/83/EC of the European Parliament and the Council of 6th November 2001 on the Community code relating to medicinal products for human use [21]. An example of this may be a Medicine Compliance Aid.

2.6.2 New legislation grants pharmacists the flexibility to dispense up to 10% more or less than the quantity prescribed if it enables dispensing in the manufacturer's original pack [22,23].

2.6.3 The flexibility to dispense up to 10% more or less than the quantity prescribed will not apply to:

- Controlled Drugs
- Medicine in a form that makes it impracticable to dispense the exact quantity ordered
- Medicine in a container that has an integral means of application, or from which it is not practicable to dispense an exact quantity
- Medicine that cannot be dispensed in the quantity ordered without adversely affecting the medicine such as inhalers or where the packaging is keeping the medicine sterile [22].

2.6.4 Where original packs are not clinically appropriate (e.g., medications with a high potential for misuse and abuse or limited duration antibiotics), provider trusts and community pharmacies should make alternative arrangements to ensure patients receive patient information such as the manufacturer's patient information leaflet. From the 11th October 2023, valproate products must only be supplied in the

original pack. In rare cases, pharmacists can make an exception to the requirement to dispense valproate-containing medicines in the manufacturer's original full pack on an individual patient basis. This can only happen where a risk assessment is in place that refers to the need for different packaging. For example, the patient may need a monitored dosage system. In these exceptional cases, the pharmacist must ensure that the patient is given the Patient Information Leaflet which contains information about the risks of valproate-containing medicine for the unborn child. For example, valproate products must only be supplied in the original pack. In rare cases, pharmacists can make an exception to the requirement to dispense valproate-containing medicines in the manufacturer's original full pack on an individual patient basis [23].

2.6.5 Patients in different healthcare settings will require varying supply arrangements, but the principles outlined above should be followed. Different considerations may need to be taken into account for high-risk medicines, drugs requiring monitoring, or vulnerable/high-risk patient groups.

The following outlines the number of days' supply in various healthcare settings:

Setting	**Definition**	**Number of days' supply**
Emergency Department / Urgent Care Centre[1]		A minimum of five days, or shorter if the medicines are not required for that length of time (for example, a shorter course of analgesia or sedatives). Full courses of antibiotics and steroids should be supplied if the duration is known.
Outpatients (immediate supply)[1]	Medication which needs to be started within 24 hours.	Original dispensing pack should be provided to a minimum of 14 days supply unless this is clinically

		inappropriate such as where the full course length required is shorter.
Outpatients (non-urgent supply)	Medication which does not need to be initiated immediately	The patient should be informed that their treatment is not urgent and asked to contact their GP within 14 days but not later than 28 days to commence this treatment. Prescriber should inform the GP of this arrangement. If the prescriber is not able to ensure timely GP notification, the responsibility for treatment will remain with the specialist.
Discharge from inpatient settings		Ascertain patients' medication supply availability on the ward and at home and dispense if the patient has less than 14 days of their medication left. Where medication needs to be dispensed from hospital a minimum of 14 days should be supplied (in the form of original pack dispensing), unless this is clinically inappropriate.
Advisory Committee Borderline Substances (ACBS) products, dressings,		An appropriate supply of the ACBS product should be agreed upon locally (due to variations in contracts and supply arrangements).

appliances, and devices		

[1] Arrangements must be in place to collect prescription charges from patients who would normally pay for their prescriptions. Patients should be reminded it is a criminal offence to falsely declare an exemption to charges.

2.7 Virtual wards

2.7.1 For further information refer to your local Provider Trust ward policy/ guidance

3. Admission arrangements

3.1 The GP (and other healthcare providers) referral letter should be sent at or before admission and must include relevant information about the patient and their medicines, as per the NICE guideline, “Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes”, 2015 [26].

3.2 The referral letter should include, but is not limited to, the following information which may be available within the summary care record:

- Patient details
- Medicine history, including current medicines: name, form, strength, dose, timing, frequency, indication, date of review (including length of treatment if applicable) and any monitoring requirements
- Other prescribed items e.g. devices, dressings, appliances, ACBS borderline products, glucose monitoring strips, and any other relevant items
- Date and time of last dose(s) if appropriate, such as for weekly/monthly/yearly medicines, including injections
- Known allergies and reactions to medicines or their ingredients, and the type of reaction experienced (see NICE clinical guideline, Drug allergy: diagnosis and management, 2014 [27])

- Any significant medical history
- Reason for referral, confirmed and/ or suspected diagnosis
- Any relevant medication adherence issues, including support required to take medicines and details of compliance aids issued (e.g. carers who support drug administration and reminder charts)
- Any additional information necessary for specific patient groups, such as paediatric patients

3.3 The National Care Record Service (NCRS) or alternative system should be used to facilitate the transfer of medicine information. Developing a standard template letter that GP practices can use is recommended to ensure all necessary information is readily available.

3.4 Information on prescribed medicines should be available as soon as possible and ideally within 24 hours of admission across all care settings to maintain patient safety [28].

3.5 An agreement between the provider trust and ICB should enable audits to monitor the quality and timeliness of admission information, ensuring compliance with CQC recommendations.

3.6 Patients are encouraged to inform their community pharmacy of planned admissions to ensure awareness and prevent dispensing of unrequired medication during that time period and thus reduce wastage. Any medicines that have been changed and are no longer appropriate after admission, should be returned to their community pharmacy for safe destruction.

3.7 Encouraging patients to bring their medicines and other prescribed items into the hospital (e.g. via the green bag scheme) facilitates medicine reconciliation on admission and reduces the risk of errors, aligning with NICE guidance.

3.8 The patient's medicines and other prescribed items may, with the agreement of the patient, be used while the patient is in the hospital and in accordance with local practice/policies. However, compliance aids should not routinely be used by nurses to administer medicines as they cannot assure themselves that the correct

drug and dose are contained within. Exceptions to this may be administration from compliance aids when filled by a pharmacist and at the pharmacist's discretion, particularly for time-critical medicines like clozapine. (The Site Liaison Team for the local Mental Health Trust should be informed if a patient on clozapine is admitted to a ward, to ensure monitoring and safe continuation.)

3.9 Patient's medicines and other prescribed items 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 (e.g. controlled drugs or medicines that have been stopped). The Trusts Medicines Management Policy should be followed to include use of patients own drugs and destruction of patients' medicines.

3.10 Primary care should not be responsible for prescribing medicines or items intended for hospital use only. The North East London Joint Formulary should be used to identify Hospital only medicines.

4. Inpatients

4.1 All new or continued medicines, dressings, appliances, enteral feeds, oral nutritional supplements (ONS), glucose monitoring strips, devices and other prescription items administered or required for inpatient use are the responsibility of the consultant. The hospital should provide these if needed, or if the patient's own supply has less than 14 days remaining. This may exclude continuing care units and exceptions such as medications which are NHSE funded, where prescribing and supply is limited to specific trusts.

4.2 The responsibility for prescribing medicines on the hospital only/red list should remain with the provider trust (see sections 11 and 13 for further details).

5. Outpatients and Day Case Patients

5.1 Primary healthcare teams should advise patients to take a list or share information from the NHS app of all current medicines they are taking to all outpatient consultations to enable comprehensive assessment by the clinician.

5.2 This should take into account national and local guidance to promote self-care and NHS England guidance on prescribing over-the-counter medicines.

5.3 The following categories must be supplied by the provider trust:

- Medicines required for immediate treatment
- Hospital/specialist-only medicines determined through national or local processes, including Home Care.
- Provider-based clinical trials (exceptions may apply, e.g. where one arm of therapy is standard of care and would routinely be prescribed in primary care (and patients would continue to receive this treatment following trial completion) e.g. endocrine therapy in oncology patients)

5.4 If immediate treatment is needed after an outpatient consultation, the clinic should provide a minimum of 14 days' supply (in the form of original pack dispensing), unless clinically inappropriate (see recommendation 2.6). In exceptional circumstances the GP may be asked to prescribe treatment, however this must be agreed by the GP in writing and should be documented by the requesting clinician. Please note adequate medication must be supplied to the patient until the GP will be able to take over prescribing responsibility.

5.5 Hospital pharmacy scripts authorised by secondary care should not be taken to the GP surgery for rewriting on an FP10 prescription thereby generating inappropriate work and transfer of clinical risk. These must be dispensed within the hospital. Exceptional circumstances, such as urgent treatment recommendations when the patient cannot attend the hospital, may be agreed locally. A hospital generated EPS solution to community pharmacy can also be used where available.

5.6 If the patient does not need immediate supply they should be informed that their treatment is not urgent. The patient should be asked to contact their GP within 14 days but not later than 28 days. If the prescriber is not able to ensure timely GP notification, the responsibility for treatment will remain with the specialist.

5.7 The clinic letter containing relevant prescribing information should reach the GP practice within seven -working days. Patients should also receive written

information which clearly explains that their medicine is not urgent, that the letter is not a prescription and that the provider trust will be contacting their GP to prescribe the medication required.

5.8 Hospital outpatient clinics must ensure sufficient supply of urgent medication and other items until the outpatient letter reaches the GP for ongoing prescribing

5.9 It is the provider Trusts responsibility to supply medicines on an ongoing basis if they are:

- Hospital Only (Red),
- Unavailable in primary care via community pharmacies (excluding manufacturer supply problems),
- If the request is for a specialist medicine not subject to a shared care agreement,

If GP feels they have insufficient experience to prescribe or required further training they should contact the ICB Pharmacy and Medicines Optimisation team at the ICB via the email: nelondonicb.prescribingqueries@nhs.net in the first instance for advice and training support options

Clear mechanisms for GP referral back to the provider trust for a prescription should be in place if the GP is unable to prescribe after discussing with the ICB Pharmacy and Medicines Optimisation Team.

5.10 Primary care should not be asked to prescribe medicines and other items intended for use in provider's out-patient clinics, day-care surgery (e.g., intra-uterine levonorgestrel systems, subdermal implants, topical anaesthetic creams), or in the patient's home as part of a package of care or required for a planned procedure unless this has been approved by the NEL FPG

6. Emergency Department / Urgent Care Centre

6.1 Although the NHS Standard Contract does not specify requirements, patients in urgent and emergency care settings should receive a minimum five-day supply of prescription medicines, or a shorter supply if not required for that duration (e.g. a shorter course of analgesia or sedative).

6.2 Full courses of antibiotics and steroids should be supplied.

6.3 Patients should not be required to attend ED for a prescription of their regular medicines if they have run out or need these out of hours. In such situations, patients should be advised to call NHS 111 for support in obtaining an emergency supply of required medicines. [29].

6.4 For patients presenting with minor ailments, the ED/UCC can refer homeless, asylum seekers and refugees to the NEL Community Pharmacy Self-Care Advice Service; all other patients should be advised to call their own GP first if registered or NHS111.

6.5 Patients presenting with one of the current seven clinical conditions can be sign posted to a local community pharmacy of their choice. Currently, the seven clinical conditions are: - Acute otitis media, impetigo, Infected insect bites, shingles, sinusitis, sore throat, uncomplicated UTI. NB- inclusion/ exclusion – including those for age and gender apply [30].

6.6 Patient's own medicines should remain with them during assessment and be transferred with them upon admission or discharge, unless clinically inappropriate.

7. Discharge Arrangements

7.1 Provider Trusts should have a policy in place that includes arrangements for transferring prescribing information to Independent Prescribers in Primary Care.

7.2 Patients should normally be discharged with a minimum supply of 14 days, (unless this is clinically inappropriate, or patient has sufficient supplies at home).

7.3 Patients should be encouraged, wherever possible, to obtain their existing prescription via their usual supply.

7.4 According to NHS Standard Contract 2023/24 technical guidance, discharge summaries following inpatient, day-case care, or ED attendance must be issued to general practice within 24 hours [1]. Clinic letters must be issued within 7 calendar days [1].

7.5 Discharge summaries and clinic letters must be sent to general practice only by direct electronic transmission [1].

7.6 All medications the patient is taking should be listed on the discharge summary or outpatient clinic letter and recorded in the patient's records.

7.7 The Trust Medicines Management Policy (or equivalent) should be followed where the admission has been less than 24 hours and there are no changes to the patient's regular medication with regards to drug listing on discharge.

7.8 Medicines that will continue to be supplied by the tertiary care centre (according to the host commissioner's hospital/red list) or through a homecare provider should clearly be stated as 'hospital prescribing only' (or equivalent) and the GP should not prescribe.

7.9 Hospitals should review templates for electronic discharge systems to ensure compliance with the required minimum dataset as per NICE guideline, "Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes", 2015 [26].

7.10 Patients and their Independent Prescribers in Primary Care should receive appropriate information about prescribed medication, treatment duration, and obtaining further supplies.

7.11 The Discharge Medicines Service (DMS) aims to improve communication of medication changes upon discharge and reduce avoidable harm caused by medicines [32].

7.12 A DMS referral should be offered in the following scenarios:

- Patients with adherence issues
- Patients with changes to their medication including patients with an MCA
- Paediatrics patients with new unlicensed medicines that the GP is being asked to prescribe.

8. Multi-compartment compliance aids

See North East London ICS MCCA separate policy for further information.

9. Communication with primary care colleagues after inpatient discharge (including virtual wards) or outpatient clinic visits

9.1 When a provider trust requests a GP to prescribe, it must be clearly communicated that the benefits and risks of the treatment, along with instructions on how the treatment should be taken, its frequency, and potential side effects, have been discussed with the patient.

9.2 The GP should be provided with relevant information about the patient and their medicines, as outlined in the NICE guideline, “Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes”, 2015 [26]. This information should include, but not be limited to:

- Contact details of the patient.
- Details of other relevant contacts identified by the patient and their family members or carers, where appropriate, such as their nominated community pharmacy.
- Diagnosis and reason for admission or outpatient visit, including a summary of the encounter, interpretation of findings and results, differential diagnoses, opinion, and specific action(s) in line with NHS Digital specifications [39].
- Any new medicine allergies and reactions to medicines or their ingredients, and the type of reaction experienced.
- Details of the medicines the patient is currently taking including prescribed, over the counter and complementary medicines, specifying the name, strength, form, dose, timing, frequency and duration, and indication.
- Changes to medicines, including medicines started or stopped, dosage changes, formulation changes and the reason for the change.
- For all new medication, the duration of treatment should be provided where appropriate (e.g., steroids and antibiotics).
- Communication of arrangements for ongoing supply for any new medicines classified as "hospital/specialist only" on the discharge summary.

- Clear documentation of the strength and medication supplier for patients initiated on unlicensed (specials) oral liquids, along with communication to the patient (and their family) and community pharmacist through a DMS referral (see section 8).
- If patients are initiated on oral nutritional supplements, enteral feeds, 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. These may be changed to local formulary choices where appropriate.
- Details of information provided to the patient and their family members or carers, where appropriate.
- Any other necessary information, such as when the medicines should be reviewed, potential medication interactions and impacts on other conditions, ongoing monitoring needs, including future anticipated dosage changes, and any support required by the patient to continue taking the medicines, such as the use of reminder MAR charts. Additional information may be needed for specific groups of people, such as children.

9.3 There may be circumstances where a patient objects to their information being shared for the purposes of their individual care. In such cases, this information should not be disclosed unless it is deemed to be in the overriding public interest [40].

10. Tertiary care referrals and prescribing and supply of medicines requiring specialist monitoring

10.1 For treatments that are not hospital-only (according to the host commissioner's hospital/red list), some initiated in tertiary care may be retained for a period of stabilisation but following this there is an expectation of primary care continuation, in line with agreements with the host commissioner ICB. Examples include but are not limited to antiepileptics used in paediatric neurology, medications used for spasticity in multiple sclerosis, phosphate binders recommended from renal centres, etc. The principles outlined under sections 11-13 inclusive should be applied.

10.2 In cases where prescribing is transferred to primary care they should be informed of any changes to prescribed treatment(s).

10.3 When patients are transferred from a tertiary care centre to a secondary care centre, there should be a robust process in place to ensure timely and accurate transfer of a patient's medication details to appropriate professionals responsible for their care. This includes a detailed discharge summary and appropriate transfer of medications (including the patient's own medications) to help with seamless care.

10.4 If NHS England Commissioned Services offer an advisory service to assess and develop a treatment plan, once this process is complete, the responsibility for making prescribing decisions about the referral lies with the original referrer, not with the advisory service.

10.5 Where it is clinically appropriate for the patient to be cared for at home, under the supervision of the tertiary centre, the centre should make appropriate arrangements for prescribing and supply of specialist medicines (e.g. high-tech home health care schemes EL (95)5 or using FP10 (HNC)), which are classified as "hospital only" on the Tertiary Care Providers formulary.

10.6 Where patient has been transferred from tertiary care to secondary care, due diligence should be exercised to check when patient's next review is at Tertiary Centre, so this is not missed, or is carried out by alternative means.

11. When responsibility for prescribing remains with hospital providers including for medicines on the 'Red List'

11.1 Medication hospital-only/ red lists may vary between ICBs. Primary care prescribing may be considered if the treatment aligns with the provider trust host commissioner's recommendations – see section 19.

11.2 Care should be taken to ensure that the patient does not suffer due to the NHS decision-making process and collaboration on both sides is sought in achieving resolution in difficult cases.

11.3 It is recommended that disagreements over the principles of prescribing responsibility are best resolved at local ICS's System Prescribing and Medicines Optimisation (SyPMO) Board. or equivalent. Cases should be referred to the relevant ICB chief pharmacist via the provider Chief Pharmacist who should seek resolution.

11.4 The provider should make arrangements for issuing medication in between clinical reviews as appropriate, e.g. by extending the length of prescriptions to last until the next clinical review, use of FP10HP prescriptions which can be posted to the patient, arranging for the patient to collect repeat medication from the hospital pharmacy at agreed intervals.

11.5 Primary care should be informed of any medicines that continue to be supplied by the hospital. Discharge and outpatient letters should clearly state that these medicines are to be supplied by the provider and that primary care is not expected to prescribe. GP practices should include this information on clinical systems to ensure that they have a full medication history for their patients. Refer to, recording medicines prescribed elsewhere into the GP practice record, NHS Digital, 2019 [39] for further guidance.

12. Prescribing and Monitoring of Complex Specialist Drugs

12.1 The prescribing and monitoring of complex specialist drugs may be shared across the system were deemed appropriate and accepted by the clinicians involved in the patients care.

There could be different commissioning models to support this service provision.

12.2 The prescribing and monitoring of complex specialist drugs maybe be appropriate for retaining with the hospital/specialist setting in the following circumstances:

- Medicines designated as Red (specialist or hospital only prescribing) on the North East London netFormulary® electronic platform.
- Medicines which are only available through a provider i.e. not available on a FP10.

- A commissioned model is used where specialists continue to prescribe and monitor complex specialist drugs.

12.3 A Shared care Guideline is a document that can be used to support the sharing of clinical responsibility between a hospital or specialist service with a non-specialist prescriber (e.g. a GP or other independent prescriber).

This involves prescribing and monitoring by the non-specialist prescriber, supported by an agreement in line with medicines designated as suitable for Shared Care on the North East London netFormulary® electronic platform.

In each case the non-specialist prescriber should have access to a copy of the shared care prescribing guideline, including baseline monitoring information.

12.4 The North East London NHS and Private Interface Guidance aims to assist primary care prescribers in dealing with requests to supply medicines by patients who have been recommended treatment following a private consultation. The decision of whether to prescribe or not always remains with the individual prescriber.

12.5 Patients should not be responsible for informing the non-specialist prescriber about the prescribing and monitoring of their complex specialist drugs or relaying information from the non-specialist prescriber to specialist teams. The specialist team should ensure that the non-specialist prescriber has accepted the prescribing and monitoring responsibility before transferring care or informing the patient to obtain further supplies from the non-specialist prescriber.

12.6 A non-specialist prescriber should not decline to prescribe a medicine based on cost. Any financial concerns should be raised with the NEL ICB Pharmacy and Medicines Optimisation Team.

12.7 Clinician to clinician dialogue and engagement is recommended to help resolve disagreements over the principles of the prescribing and monitoring of complex specialist drugs with the involvement of the local Medicines Optimisation Team and/or the Trust Formulary team as necessary.

Recurring themes may require escalation to the SyPMO Board (or equivalent) for discussion and resolution. The hospital/specialist team should continue to prescribe medications until they are sure that non-specialist prescriber can continue the prescription through an agreed arrangement.

12.8 In the event that existing shared care arrangements cease to be acceptable to the non-specialist prescriber in primary care, transition back to specialist care must be done safely and in a co-ordinated manner. This includes informing secondary care colleagues of the intention and the patients that may be impacted and performing an effective patient handover. This will ensure that patient safety is maintained in any transition arrangement.

13. Unlicensed and off-label medicines

13.1 Generally before prescribing an unlicensed or off-label medicines, initiating prescribers should ensure:

- The medication has been approved for use in the ICS area's joint formulary (or other local governance process);
- They take responsibility for prescribing the medicine and for overseeing the patient’s care, including monitoring and follow-up;
- They record the prescribed medicine and, where common practice is not being followed:
- Document any relevant discussions with the patient and/or their family, including sufficient information about the proposed treatment and known serious or common adverse reactions, confirm the availability of the medicine to avoid unnecessary stress for both the patient and the dispensing team, who may not stock the preparation or may be unable to obtain it.

13.2 Unlicensed medicines are commonly used in some areas of medicine, such as in paediatrics, psychiatry and palliative care.

13.3 Many medicines that are given to children are not licensed for the particular indication, the age of the child or for the route of administration. Additionally, they

may not be in a suitable formulation and licensing change differ between each preparation

13.4 Independent Prescribers in Primary Care or other primary care prescribers should not be asked to prescribe unlicensed specials when there is an alternative dosage form or licensed product available that meets the individual needs of a patient.

13.5 If the primary care prescriber is unable or unwilling to prescribe an unlicensed special, the responsibility remains with the secondary care / specialist clinician who initiated treatment.

14. Research and clinical trials

14.1 NHS Treatment Costs associated with research studies, including Excess Treatment Costs (ETCs), are the responsibility of the NHS and should be funded through normal commissioning arrangements in accordance with Department of Health and Social Care guidance.

14.2 Communication with primary care is facilitated through a letter from the principal investigator, according to the Research Ethics Committee requirements.

14.3 Independent Prescribers in Primary Care should be adequately informed of a patient's participation in a clinical trial, including obtaining patient consent and documenting it in the patient's notes, to respond effectively to any suspected adverse events or potential drug interactions.

14.4 Any excess treatment costs must be agreed upon with the host commissioner and aligned with the latest national guidance on funding Excess Treatment Costs related to non-commercial research studies.

14.5 Prescribing and supplying of clinical trial medicine is the responsibility of the trial site.

14.6 Standard outpatient or inpatient treatment costs for patients on a trial are covered as required by HSG (97)32. However, the cost of trial medicines during or

after the trial is not typically included unless specifically agreed with the host commissioner.

14.7 Patients participating in a clinical trial must be informed that continuation of the medicine after the trial is not guaranteed, regardless of the trial's results. This information should be clearly stated in patient materials.

14.8 post-trial funding and prescribing implications must be agreed by the ICB before the trial commences. Trial documentation must outline an agreed exit strategy for trial medication.

15. National Medicines Value Programme

15.1 The Medicines Value Programme (MVP) was established to enhance health outcomes and ensure the best value from medicines. This informs local priority areas which clinicians and prescribers across the systems should adhere to where possible whilst ensuring a safe and patient centred approach.

15.2 Its objectives include:

- Ensuring patients have access to the most effective treatments and outcomes that align with their needs;
- Enhancing the quality of prescribing and medicines usage, focusing on safety, clinical effectiveness, and patient experience;
- Improving the efficiency of medicine procurement and supply while ensuring the NHS retains its position as a world leader in medicines [46].

15.3 The NHS England Medicines Optimisation Executive Group (MOEG) has identified 16 national medicines optimisation opportunities aligned with the ICB's key objectives:

- Improving population health and health outcomes.
- Addressing disparities in outcomes, experience and access.
- Enhancing productivity and value for money.
- Supporting broader social and economic development goals of the NHS.

15.4 Initiatives covered by the MVP include:

- Rationalising the use of medicines which are neither clinically- nor cost-effective.
- Promoting self-care initiatives.
- Increasing the utilisation of best-value biological and generic medicines, including biosimilar medicines where appropriate.
- Supporting antimicrobial stewardship.
- Implementing guidance from the NHSE Regional Medicines Optimisation Committee (RMOC).

15.5 Collaboration among NHS organisations within local healthcare systems is vital for promoting and implementing the MVP.

16. Host Commissioner Rules

16.1 Providers and commissioners within an ICS jointly establish commissioning policies and formulary recommendations. These are classified as host commissioner rules under the NHS Contract, and providers must adhere to them for all patients undergoing treatment, regardless of their referring commissioner.

16.2 This encompasses adherence to the provider trust's local formulary position on medicines used in the service, red list status and prescribing arrangements.

16.3 Out-of-sector referrers are considered associates under the provider's contract with their host commissioner and must comply with local formulary guidelines and medication pathways. They should be prepared to continue medications eligible for transfer of care (i.e., not on the red list) before referral.

16.4 Patients in an Out of Sector Provider should receive the same treatment as those registered with a GP practice within the respective ICB. i.e., out-of-area patients should not be treated in line with another ICB’s pathway.

17 Appendix 1: Nutrition and Appliances

17.1 Whilst it is outside the remit of this policy, provider trusts should consider, the following:

- Clinicians discharging patients on oral nutritional supplements (ONS) must follow their local ICS formulary.
- Due to nutrition supply contracts providing ONS for hospitals, clinicians should be mindful of the risk of overprescribing and waste. Patients may eat better in their own homes and once medical issues are resolved/improved. Hospitals are encouraged to resource a dietetic-only model of ONS.
- ICSs should work towards usage of the SNOMED CT diagnosis and clinical justification for prescription requests in nutrition transfers of care (in line with ACBS criteria). Please note nutrition transfers of care cover dietitian to dietitian/GP only.
- Adoption of the Patients Association Nutrition Checklist (PANC) to identify the potential risk of undernutrition in adults, aiming to encourage conversations and raise awareness of the potential for undernutrition.

17.2 For patients who are tube fed, clinicians should ensure an adequate supply of feeds as per their nutrition supply contract (there will be cases where local discretion will need to be used e.g., patient choice and practical arrangements), ensuring there is no risk to patients will be left without sufficient stock.

17.3 Onward prescribing of tube feeds is assumed in line with contracts as patients will be familiar with the product and for continuity of care for this patient group (and will have been trained on the pump and set up for home delivery).

17.4 Onward prescribing of ONS cannot be assumed in line with NHSE Medicines Value and Access Team guidance. Shared care decision-making around different options for food-based management at home, additional packages of care, meal delivery services and social eating opportunities may be more patient-centred once home. If an ONS is agreed upon as indicated, a discussion around an expectation for a change of ONS product in line with the community formulary is needed.

17.5 Initiation of specialist infant feeds in emergency settings should be in line with the community formulary (this should be an exception rather than a standard part of emergency care).

17.6 Where an ONS is recommended on discharge, the provider should be mindful that it may take time for this to be arranged in the community setting. Adequate supplies should be provided to the patient. It is recommended that this should be 14 days' supply where possible. It is noted that in the majority of Trusts, the Pharmacy does not supply ONS, and this stock comes from the ward/ kitchens.

17.7 The NEL Formulary and Pathways Group (NEL FPG) provides a forum for discussion and decisions on the entry to the NEL Formulary for prescribable appliances/devices closely associated with medicines. Requests for any such appliances/ devices closely associated with medicines that are not currently on the NEL formulary must be discussed and submitted to the NEL FPG via nelondonicb.nelfpg@nhs.net or the Trust Formulary Pharmacy team.

17.8 There should not be any requests to primary care for prescribing of appliances/ devices not on the NEL Formulary.

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19. Glossary

Name	Acronym	Description
Advisory Committee Borderline Substances	ACBS	The ACBS is responsible for advising on the prescribing and use of borderline substances in NHS primary care and the community. Borderline substances are nutritional or dermatological products that have been specially formulated to manage medical conditions. Products approved and recommended by the ACBS are listed in Part XV of the Drug Tariff.
Acute Services		Medical and surgical interventions usually provided in hospital. Specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.
Aligned payment and incentive	API	Covers almost all NHS provider activity and comprises fixed and variable elements. Almost all elective activity, and all activity which form part of the ERF, is included in the variable element and paid for using 100% of NHSPS unit prices.
Best Value Medicines Implementation Group	BVMIG	Subgroup of the RMOC
Commercial Medicines Unit	CMU	The Commercial Medicines Unit is responsible for buying and securing the supply of medicines prescribed in NHS hospitals in England.
Care Quality Commission	CQC	The independent regulator of health and social care in England
Discharge Medicines Service	DMS	The NHS Discharge Medicines Service is an essential service provided by community pharmacy contractors to patients being

		discharged from hospital. The service has been established to ensure better communication of changes to a patient's medicine when they leave hospital and to reduce incidences of avoidable harm caused by medicines. Any hospital that has NHS inpatients can refer into NHS DMS, including community trusts, mental health and specialist trusts.
Early Access to Medicines scheme	EAMS	The Early Access to Medicines Scheme helps to give people with life threatening or seriously debilitating conditions early access to new medicines that do not yet have a marketing authorisation but where there is a clear unmet medical need.
	EL (95) 5	DH NHS executive letter with recommendations on purchasing high-tech healthcare for patients at home
General Practitioner	GP	The general practitioner is a specialist trained to work in the front line of a healthcare system and to take the initial steps to provide care for any health problem(s) that patients may have.
General Pharmaceutical Council	GPhC	The General Pharmaceutical Council is the regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain.
Health Care Provider	HCP	A Health Care Provider is an organisation acting as a direct provider of health care services. The following organisations may act as Health Care Providers: • GP Practice • NHS Trust • NHS Foundation Trust • Registered non-NHS Provider (e.g. Independent Provider, Independent Sector Healthcare Provider etc) • Unregistered non-NHS Provider • Care Trust • Local Authorities with social care responsibilities • Other agencies

Hospital at Home	H@H	Virtual ward hybrid service model that blends digital monitoring and face-to-face care to support patients with acute needs.

Hospital Trust		An NHS trust that provides secondary health services within the English National Health Service.
Integrated Care Board	ICB	Integrated care boards replaced clinical commissioning groups (CCGs) in the NHS in England from 1 July 2022. They are statutory bodies that are responsible for planning and funding most NHS services in the area.
Integrated Care System	ICS	Integrated care systems are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.
Investigational Medicinal Products	IMP	Investigational Medicinal Products are a pharmaceutical form of an active substance or placebo being tested or used as a reference in a clinical trial.
London Medicines Pathway Group	LMPG	Subgroup of the RMOC
Medication Administration Record	MAR	MAR charts are the formal record of administration of medicine within the care setting.
Multi-Compartment Medicines Compliance/ Compliance aids	MCA	A multi-compartment compliance aid is a general term for a device designed to contain individual doses of medicines in separate compartments or blisters.
Medicines Value Programme	MVP	The Medicines Value Programme is made up of: • The policy framework, which governs access to and pricing of medicines within the NHS. • Working with the Department of Health and Social Care (DHSC) and the National Institute for Health and Care Excellence (NICE). • Commercial arrangements that influence price, including the work of NHS England's Commercial Medicines Unit, and its commercial team.
Medicines Optimisation and Pharmacy Procurement	MOPP	The Medicine Optimisation and Pharmacy Procurement team is made up of clinical specialists who support medicines optimisation through a pan-London approach aligned with the national priorities of quality, safety and value.
National Care Record	NCRS	
National Institute for Health and Clinical Excellence	NICE	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

National Health Service England	NHSE	NHSE leads the NHS in England to deliver high-quality services for all.
NHS London Procurement Partnership	NHS LPP	NHS London Procurement Partnership is one of four national procurement hubs serving the health community in London and beyond
Oral Nutritional Supplements	ONS	Oral Nutritional Supplements are sterile liquids, semi-solids or powders, which provide macro and micronutrients. They are widely used within the acute and community health settings for individuals who are unable to meet their nutritional requirements through oral diet alone. ONS use must be approved by the Advisory Committee on Borderline Substances (ACBS).
Patient Access Scheme	PAS	A way for pharmaceutical companies to make high-cost drugs affordable for the NHS. Companies may submit a patient access scheme proposal for any technology going through the NICE single or multiple technology appraisal processes, and highly specialised medicines process.
Patient Group Direction	PGD	A Patient Group Direction is a written instruction for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.
Pharmacy First		The Pharmacy First service builds on the NHS Community Pharmacist Consultation Service which has run since October 2019. The consultation service enables patients to be referred into community pharmacy for a minor illness or an urgent repeat medicine supply.
Prescriber		This term is used for both medical and non-medical prescribers.

Primary Care		Healthcare delivered outside hospitals. It includes a range of services provided by Independent Prescribers in Primary Care, nurses, health visitors, midwives and other healthcare professionals and allied health professionals such as dentists, pharmacists and opticians. It includes community clinics, health centres and walk-in centres.

Regional Medicines Optimisation Committee	RMOC	There are four RMOCs in England (South, North, Midlands & East, London) which bring together decision makers and clinicians from across each geography. Although there are four committees, the RMOCs operate together as a single organisation and have a shared work programme. The RMOCs produce once-for-England guidance on a range of Medicines Optimisation topics for adoption by NHS organisations regionally and locally
Systemic Anti-Cancer Treatment	SACT	All anti-cancer drug treatments such as chemotherapy and immunotherapy are known as systemic anti-cancer therapy.
Secondary Care		Secondary care is healthcare provided in hospitals. It includes accident and emergency departments, outpatient departments, antenatal services, genitourinary medicine and sexual health clinics
Tertiary Care		Care for people needing complex treatments. People may be referred for tertiary care (for example, a specialist stroke unit) from either primary care or secondary care.
Trust		An NHS Trust is a legal entity, set up by order of the Secretary of State under section 25 of, and Schedule 4 to, the National Health Service Act 2006, to provide goods and services for the purposes of the health service.
Virtual Ward		A virtual ward (including Hospital at Home) is defined as a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment in their own home.

20. Acknowledgments

This policy is based on an amalgamation of existing Interface Prescribing Policies in use across London with some adaptations. The guidance produced was developed in consultation with the Pan-London Interface Prescribing Guidance Working Group, with representation from the five London ICS, paediatrics, mental health, general practice, community pharmacy, patient representatives and the Medicines Optimisation Pharmacy and Procurement team at NHS LPP.

Equality Impact Assessment

Title of the change proposal or policy:

North East London Interface Prescribing Policy

Brief description of the proposal:

This policy aims to harmonise key elements of interface prescribing across all North East London taking into consideration the relevant requirements of the standard NHS provider contract
It is based on an amalgamation of existing Interface Prescribing Policies in use across London with some adaptations. The pan London guidance produced was developed in consultation with representation from the five London ICS, paediatrics, mental health, general practice, community pharmacy, patient representatives and the Medicines Optimisation Pharmacy and Procurement team at NHS LPP.

The pan London guidance was updated for use as NEL Interface Prescribing Policy following consultation with:
-NEL Pharmacy Leads Network
-Provider Trusts across NEL
-ICB senior Pharmacy and Medicines Optimisation Team
-ICB Associate Medical Director
It has been agreed with all providers in North East London who are also taking through their individual organisation governance process.

Name and role of staff completing this assessment:

Zafiat Quadry, Head of Medicines Optimisation- Commissioning and Transformation

Date of Assessment:

21st January 2025

Please answer the following questions in relation to the proposed change:

Will it affect employees, customers, and/or the public? Please state which.

Public- harmonising key elements of interface prescribing across all North East London

Is it a major change affecting how a service or policy is delivered or accessed?

Nil major changes expected

Will it have an effect on how other organisations operate in terms of equality?

It will ensure equity of care across the interface. This policy aims to reduce inequalities in prescribing that may happen during transfers of care across the interface and

improve access to timely, safe, and correctly prescribed items for patients accessing care in North East London.

If you conclude that there will not be a detrimental impact on any equality group, caused by the proposed change, please state how you have reached that conclusion:

Nil detrimental impact on equality is expected as this policy aims to reduce inequalities in prescribing that may happen during transfers of care across the interface and improve access to timely, safe, and correctly prescribed items for patients accessing care in North East London.