North Central London

NHS

Barnet - Camden - Enfield
Haringey - Islington

NORTH CENTRAL LONDON
PHARMACY AND MEDICINES MANAGEMENT NETWORK
PRESCRIBING GUIDANCE

This operational guidance has been agreed at the NCL Pharmacy and Medicines Management Network (NCL PMMN) to facilitate continuity of prescribing and governance at primary, secondary and tertiary care interfaces. The guidance should be used by all NHS Trusts (Acute and Mental Health) and PCTs.

Start Date: June 2011
Next Review date: June 2013

NB: This guidance is an update to the guidance agreed in August 2007

Version 4

1. Introduction

This policy has been developed by the North Central London Medicines Management Pharmacy Network and has been agreed by Acute Hospital, Mental Health and Primary Care Trusts, Drug and Therapeutics/ Prescribing Committees in the North Central London Sector.

The aim is to facilitate consistent prescribing policies across North Central London and is included in the North Central London generic contract. The Appendices may be subject to amendment.

It is recommended that Acute, Mental Health and Primary Care Trusts seek the advice of their Chief Pharmacist/Pharmaceutical Adviser during the commissioning process and Local Delivery Plan discussions to ensure that implications for pharmacy and prescribing are taken into account.

Apart from specific exclusions medicines are included in the National Tariff. For all nationally defined PBR excluded medicines, commissioners and providers should agree local prices and arrangements for commissioning and monitoring.

The North Central London red list and shared care document (Appendix 5) is reviewed and updated on quarterly basis. Please contact your local Chief Pharmacist for the latest version.

2. General Principles

The following general principles apply to all Primary care, Acute and Mental Health Trusts

2.1 Acute and Mental Health Trusts should ensure they have a Drug and Therapeutics Committee (or equivalent) in place to co-ordinate medicine use. The Drug and Therapeutics Committee should maintain an up to date formulary with the involvement of PCT prescribing advisers and PCT prescribing lead GP or nominated deputy. Hospital prescribing should be from the Hospital Trust formulary and prescribers should not seek to avoid restrictions by asking GPs to prescribe non-formulary medicines, apart from in exceptional circumstances when agreement has been reached, in advance, with the PCT and the individual GP.

2.2 Acute and Mental Health Trusts will contribute to the local arrangements for the managed entry of new medicines. This should consider the clinical and cost-effectiveness, and safety of new medicines and the impact on primary as well as secondary care.

2.3 Prescribers and pharmacists should recommend, dispense and label by generic name except where this is clinically inappropriate.

2.4 All Providers should usually dispense medicines in patient packs, in order to comply with European Community directive 92/27/EEC on pharmaceutical labelling, and the provision of information to patients.

2.5 The Acute and Mental Trust should have policies approved by their Drug and Therapeutics Committee for

- The use and disposal of patients own medicines in hospital.
- Self-administration of medicines by patients
- Use of unlicensed medicines and medicines used for unlicensed indications.
- Dealing with the pharmaceutical industry.

2.6 Acute and Mental Trusts should comply with principles contained in local, national and professional guidance including National Service Frameworks, NICE Technology Appraisal Guidance and relevant Health Service Circulars & Guidance, Executive Letters and Audit Commission reports.

3. Admission arrangements

3.1 PCTs and local Acute and Mental Health Trusts should ensure that written guidance is in place covering information flow on admission as recommended by the Care Quality Commission (CQC).

3.2 The recommended minimum dataset for information provided on patient admission to hospital is listed in **Appendix 1** and should be agreed locally between PCTs and Hospital Trusts.

3.3 PCTs should develop a standard template letter that GP practices can use to ensure all information required is readily available.

3.4 Information on prescribed medicines should be available to the hospital as soon as possible and ideally within 24 hours of admission where possible.

3.5 An agreement should be made between the hospital and PCT to enable audits to be undertaken to monitor the quality and timeliness of information provided on admission and ensure compliance with CQC recommendations.

3.6 Health economies should support the use of Green Bags as a way of reminding and encouraging patients to bring all their own medicines into hospital with them.

3.7 Medicines management arrangements on admission should include:

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

4. In-patients

4.1 The Hospital Trust is responsible for the supply of any new medicine started or continuation of existing medicine for in-patients. Patients at risk of experiencing problems managing their medicines should be identified and, if appropriate, a referral made for pharmaceutical support.

5. Discharge Arrangements

5.1 PCTs and local Hospital Trusts should ensure that written guidance is in place covering information flow on discharge as recommended by the Care Quality Commission (CQC).

5.2 Patients should be discharged from hospital with a minimum of 14 days supply, unless the full course of treatment is less, a smaller supply is deemed appropriate on mental health grounds, or after assessment it is clear the patient already has appropriate supplies at home.

5.3 The recommended minimum dataset for information provided on patient discharge is listed in **Appendix 2** and should be agreed locally between PCTs and Hospital Trusts.

5.4.1 Discharge summaries should be sent to the GP at the time of discharge and ideally received within 24 hours of patient discharge. Consideration should be given to the

most convenient form of communication to ensure appropriate information transfer across the interface (for example fax or email).

5.5 Hospitals should review templates for electronic discharge systems (where applicable) and adapt where necessary to ensure the fields comply with the required minimum dataset.

5.6 An agreement should be made between hospital and PCT to enable an audit to be undertaken to monitor the quality and timeliness of information provided on discharge and ensure compliance with CQC recommendations.

5.7 Patients should be provided with appropriate written information about the medication prescribed, duration of treatment and obtaining further supplies of medicine.

5.8 Monitored Dosage Systems and other Compliance Aids:
Hospital Trusts are encouraged to develop discharge planning arrangements for vulnerable patients. Where these include supply of monitored dosage or other similar systems there should be a policy in place for their use, including assessment of need and making appropriate arrangements for continuity after discharge. This arrangement should reflect guidance on support to people with disabilities, compliance with the Disabilities Discrimination Act (see www.primarycarecontracting.nhs.uk/98.php for a resource tool) and include community pharmacies, where appropriate.

6. Out-patients/Day Case

6.1 If medicines are required immediately they should be provided from the hospital.

6.2 It is appropriate to write to the GP and suggest a medicine if it is required routinely and there is not an immediate or urgent need, provided it is in the Hospital Trust's formulary and suitable for prescribing by GPs. In this case the patient should be told that the medicine is not urgent and that they should contact their surgery in **10 to 14 days** time when the full information in writing must have been received by the GP. The Outpatient form must be completed fully and legibly.

6.3 If the hospital doctor is recommending that the GP prescribes, the GP cannot make an informed decision before receiving the full outpatient letter. If the patient requires any medicine before the hospital can guarantee that the practice will receive such a letter, it is the responsibility of the hospital to provide the prescription. It is the responsibility of the hospital to provide medicine if it is a hospital only medicine.

6.4 Information provided to the GP must include details of any medicines that have been stopped, the reason why the medicine has been prescribed and the intended duration of the new medicine. It is recommended that hospitals and PCTs agree an outpatient template letter to ensure this information is communicated effectively.

6.5 If medicine is required patient packs (a minimum of 14 days or 28 days where locally funded) should be dispensed unless the full course of treatment is less or a smaller supply is deemed appropriate on clinical health grounds.

6.6 GPs should not be asked to prescribe medicines and dressings which are intended to be used/administered in hospital out-patient clinics or day-care surgery. (e.g.: intrauterine levonorgestrol implants).

(Note: this does not apply to those medicines which have been prescribed by the GP for patient's use at home and which the patient has brought into hospital as a "patients own medicine" for an in-patient stay: see section 3)

7. Dressings and Appliances

7.1 Suitable local arrangements should be in place for the supply of dressings and appliances. Sufficient information about a patient's dressing and appliance treatment should be supplied to ensure continuity of care in the community.

7.2 Hospital Trusts should not make arrangements with appliance contractors for ongoing supplies of dressings or appliances in the community without involving patients in the decision about where their prescriptions are dispensed. Patients should be informed of the other providers available, e.g. community pharmacists.

8. Patients attending Accident and Emergency

8.1 If a medicine is necessary, an original pack/ pre-pack should be supplied, unless the full course of treatment is less in line with paragraph 2.4 and Medicines Act.

9.Unlicensed Medicines

9.1 Prescribing of unlicensed medicines should be initiated by the clinician in the Acute Trust, however continuation therapy may be transferred to Primary Care if a risk assessment has been completed and provided to the GP and Community Pharmacy with accompanying information for the product including manufacturer and purchasing requirements.

9.2 Informed consent for the use of unlicensed medicines should be obtained from patients before the prescription is written.

9.3 GPs should not be asked to prescribe unlicensed "specials" when a suitable alternative, more cost effective dosage form/licensed product is available.

10. Drugs Used Outside of Their Licensed Indications (often referred to as 'off-label')

10.1 Ideally, informed consent for the use of use of licensed medicines outside their licensed indications should be obtained from patients before the prescription is written.

10.2 Where there is a substantial body of evidence to support the use of a licensed medicine outside of its licence (e.g. in paediatrics), the GP may be asked to prescribe. However, the licensed state of the medicine should be brought to the attention of the GP or other prescriber. The full agreement of the GP concerned must be obtained before prescribing is transferred.

11. 'Red List' When Responsibility for Prescribing Remains with Hospital Trust Consultants (see Appendix 3)

11.1 The Hospital Trust is expected to retain prescribing responsibility where:

- Medicine has been commenced in the hospital and specialist ongoing intervention and monitoring is needed (see Appendix 5 for the NCL red list and shared care document).
- Medicines are only available through Hospital Trusts.
- Medicines are part of a Hospital Trust initiated clinical trial.
- Medicines are not available on FP10.
- Medicines have not been approved by the Drugs & Therapeutics Committee (or equivalent).

11.2 If there is disagreement about where prescribing of a patient's treatment should best take place the case should be referred to the PCT, via the Chief Pharmacist who will seek resolution.

12. Transfer of Prescribing Medicines Requiring Specialist Monitoring *(see Appendix 3)*

12.1 Increasingly, patients with continuing specialist clinical needs can be cared for at home or in the community. There are medicines which could be prescribed by GPs if sufficient support, review and information is shared between the GP and consultant.

12.2 It is the responsibility of the consultant to ensure that the GP is willing to prescribe before mentioning the possibility of shared care to the patient. In no circumstance should the patient be used as the vehicle for informing the GP that prescribing could be transferred to the GP.

12.3 A GP should not decline to prescribe a medicine solely on the basis of cost. Likewise, if the patient is to receive the majority of their ongoing care through the hospital then prescribing must remain with the hospital and must not be transferred solely on the basis of cost.

12.4 The following conditions should be met before the shared care takes place:

- the patient's condition is stable;
- the agreement of the patient's GP is sought prior to the transfer of prescribing and
- the GP is sufficiently informed and able to monitor treatment, identify medicine interactions and adjust the dose of any medicines as necessary.
- Resources are available to ensure (where required) the safe administration of any specialist medication in the community e.g. IV therapy. This would usually be agreed with the community nursing services.

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

12.6 A framework for the production and use of shared care guidelines for medicines in North Central London is detailed in Appendix 4.

12.7 A list of shared care guidelines and the organisations which approve their use is detailed in part B of Appendix 5.

12.8 It is essential that a copy of the shared care guideline including the baseline monitoring information is provided to the GP in order to facilitate the shared care transfer.

13. Tertiary Care Referrals and Prescribing Medicines Requiring Specialist Monitoring

13.1 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 (HP)s).

13.2 In some circumstances it may be appropriate to transfer prescribing to a more local Hospital Trust or more rarely to a GP. In all situations there should be robust processes in place between the tertiary centre, Hospital Trust and GP to ensure timely and accurate transfer of a patient's medication details to appropriate professionals responsible for his/her care.

13.3 The principles outlined in Section 12 should be applied.

14. Clinical Trials & Ethics Committees

14.1 All clinical trials must have been subject to Ethical Committee approval and research governance approval, where the arrangements for consulting and informing should be considered. In order to respond appropriately to any suspected adverse events that occur outside hospital, the GP should be adequately informed if a patient is participating in a clinical trial.

14.2 Prescribing and supply of clinical trial medicine is the responsibility of the Hospital Trust. Standard out-patient or in-patient treatment costs will be met for patients on a trial as required by HSG(97)32; this will not include the cost of the trial medicines either during or after the trial.

14.3 Patients participating in a clinical trial must be made aware that there is no guarantee that the medicine will be continued at the end of the trial, irrespective of the results and this should be clearly stated in the information for patients. Where trial results indicate that treatment should continue, there must be discussion between the Hospital Trust and PCT in time for mechanisms to be in place for supply at the completion of the trial.

This document is based on a London Framework Pharmacy & Prescribing Policy and has been approved by the following Acute Hospital and Primary Care Trusts, Drug and Therapeutics/ Prescribing Committees:

University College London Hospitals, Whittington Hospitals, Moorfields Eye Hospital, Royal Free Hospital, Royal National Orthopaedic Hospital, North Middlesex Hospital, Barnet and Chase Farm Hospitals, Great Ormond St Hospital, Camden and Islington Mental Health Trust, Barnet, Enfield and Haringey Mental Health Trusts NHS Camden, NHS Enfield, NHS Haringey, NHS Islington NHS Barnet.

Appendix 1

Standard dataset for information on medicines required on admission to hospital

Introduction

In October 2009 the Care Quality Commission (CQC) published a report on a national study which raised concerns about the quality and timeliness of information on patients' medicines transferred between acute trusts and general practitioners and vice versa when patients are admitted to and discharged from hospitals. This paper lists the minimum dataset for information which should be provided on admission to hospital, adapted from the CQC self-assessment tool.[1] The CQC recommends that written guidance be in place covering information flow at admission.

Minimum dataset for information provided on admission

- ☐ Complete patient details (full name, date of birth, NHS number, GP, date of admission)
- ☐ Presenting condition plus co-morbidities
- ☐ A list of all medicines currently prescribed for patient (furthermore, it is good practice for this to additionally include those bought over the counter)
- ☐ Dose, frequency, formulation and route of all medicines listed
- ☐ An indication of medicines not intended to be continued
- ☐ Known allergies
- ☐ Major side effects / sensitivities / adverse reactions to previously taken medicines (if relevant)

Other recommendations

- ☐ This information should be available to hospital when a patient is admitted for planned admissions and as soon as possible (ideally within 24 hours of admission) for unplanned admissions.
- ☐ Guidance may set out schemes / systems for ensuring that a patient's medicine is brought with them into hospital – this could apply to either elective or emergency admissions (or both). An example of this would be the 'Green Bag' scheme. This will assist the reconciliation process. This recommendation is considered good practice and not an expectation.

References

1. Care Quality Commission. Managing patients' medicines after discharge from hospital - A Self Assessment Tool. October 2009. Accessed at http://www.cqc.org.uk/_db/_documents/Managing_patients%E2%80%99_medicine_after_discharge_%E2%80%93_A_self-assessment_tool.doc

Acknowledgement with thanks: Imperial College Healthcare NHS Trust
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April 2010

Appendix 2

Standard dataset for information on medicines required on discharge from hospital

Introduction

In October 2009 the Care Quality Commission (CQC) published a report on a national study which raised concerns about the quality and timeliness of information on patients' medicines transferred between acute trusts and general practitioners and vice versa when patients are admitted to and discharged from hospitals. This paper lists the minimum dataset for information on medicines which should be provided on discharge from hospital, adapted from the CQC self-assessment tool[1] and National Prescribing Centre recommendations.

Minimum dataset for information on medicines provided on discharge

This information is also included in the NHS standard contract.[2]

- ☐ complete patient details (full name, date of birth, NHS and hospital number, GP, date of discharge)
- ☐ key diagnosis made during the patient's admission, plus co-morbidities, and any procedures carried out
- ☐ medication prescribed at the time of discharge, including any medication not dispensed
- ☐ dose, route, frequency, formulation (where relevant) and length of course for all medications, with details of any variable prescriptions
- ☐ the reasons for any medications started or stopped
- ☐ any adverse reactions or allergies to medications or treatments observed in the patient during admission, and any previous reactions
- ☐ the name of the responsible Consultant at the time of the patient's discharge
- ☐ any immediate post-discharge requirement from the primary healthcare team
- ☐ any planned follow-up arrangements
- ☐ whether the patient has any relevant infection, for example MRSA
- ☐ who should be contacted in the event of a query (e.g. responsible doctor and their contact details)

Other recommendations

- ☐ Discharge summaries must be received by the GP within 24 hours[2]
- ☐ The patient should be given a copy of the discharge letter
- ☐ The PCT should have considered how community pharmacists can be included in the flow of discharge information.

References

1. Care Quality Commission. Managing patients' medicines after discharge from hospital - A Self Assessment Tool. October 2009. Accessed at http://www.cqc.org.uk/_db/_documents/Managing_patients%E2%80%99_medicine_after_discharge_%E2%80%93_A_self-assessment_tool.doc

2. Department of Health. Guidance on the NHS Standard Contract for Acute Services 2010/11. 16 January 2010. Accessed at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111267.pdf

Acknowledgment with thanks: Imperial College Healthcare NHS Trust

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Appendix 3

Management of the North Central London 'Red List' of Medicines That Hospital Doctors Should Not Ask GPs to Prescribe

Hospital New Drugs Panels or Drug and Therapeutics Committees (NDP or D&TC) consider published evidence on the effectiveness of a new medicine and its cost-effectiveness before deciding whether to add it to the hospital's formulary. All such committees in NCL have representation from local PCTs. When a medicine is added to a hospital formulary, the committee will also consider whether it is reasonable for a hospital doctor to ask a GP to prescribe the medicine, or whether it should be added to the red list (see Appendix 4 for criteria for shared care, and Appendix 5 for the red list).

When NDP or D&TC decide a new medicine should be added to the red list or that shared care be developed, the NCL Medicines Management Network (NCLMMN) will be informed. It has generally been easy to reach consensus support of the decision, in which case the medicine will be added to the NCL red list or shared care guidance developed were appropriate.

Any North Central London Primary Care, Hospital or Mental Health Trust can request that a medicine is added to or removed from the red list. The trigger for consideration for the red list is normally following the review of a new medicine at a hospital NDP or D&TC. The Trust's Chief Pharmacist (or equivalent) should make the case for the change at a NCLMMN meeting. The NCLMMN will normally take a view on red list decisions at the first meeting to which the decision is presented.

The following criteria are used by NDPs, D&TCs and the NCLMMN in deciding whether a change to the red list should be made:

Criteria for <u>adding</u> a medicine to the red list:

- Safe or effective use of the medicine, throughout its use, requires expertise or facilities that a GP will not normally have.
- Medicines added to the red list will normally be 'specialist medicines' that a GP will see infrequently.
- Relevant changes to a medicine's licensing or to national policy (e.g. NICE guidance).

Criteria for <u>removing</u> a medicine from the red list:

- Guidance from NICE states that it is reasonable for GPs to prescribe the medicine, perhaps in the context of a shared care agreement.
- New trial evidence or a change in licence has made the medicine easier to use than at the time it was added to the red list (e.g. by demonstrating that less monitoring is needed than previously thought).

A medicine will not be added to the red list:

- If, although the medicine should only be initiated by a hospital specialist, it is reasonable for a GP to continue to prescribe it once the patient and treatment are stable (e.g. monitoring, dose changes and stopping treatment require no specialist expertise or facilities).
- Simply because it is expensive.

There should be an annual review of the red list and regular review of shared care guidelines to incorporate any change in national policy and if a significant incident occurs in clinical practice.

If a NDP or D&TC decision appears inconsistent with these criteria, the NCLMMN will check the decision against the criteria. If there still appears to be inconsistency, the NCLMMN will recommend that the NDP or D&TC reviews its decision.

NHS North Central London will be responsible for updating the red list and circulating to NCL MMPN members.

Appendix 4

Framework for the Production and Use of Shared Care Guidelines for Medicines in North Central London Strategic Health Authority

1. Background

'Red lists' list medicines that hospital doctors should not ask GPs to prescribe. The NCL Medicines Management Network has considered the 'red lists' that existed in NCL London in 2007 and used them as the basis of a single NCL 'red list'. Most medicines that were considered were not controversial (PCT and hospital Chief Pharmacists readily agreed which should appear on the red list). It was not possible to reach agreement on some medicines however, with some advocating and some opposing inclusion of the medicine on the 'red list'.

One way of achieving effective and efficient use and supply of some of these medicines might be for hospital Consultants to seek agreement with GPs relating to individual patients. In such instances shared care documents are produced and agreed across the hospital and PCT to ensure the responsibilities of the Consultant and the GP are clearly defined. Transfer of prescribing arrangements is never an emergency and continuity of supply should be ensured to prevent the need for urgent transfer of care. In order for such 'shared care' to work well it is essential that the following principles are applied.

2. Essential features of effective shared care agreements

- **Best interests of the patient**

Any shared care arrangement should never be detrimental to the patient.

- **Individual, patient by patient arrangements**

Shared care documents should be accompanied by information about the patient in question, outlining all relevant aspects of that patient's care. The hospital doctor and GP must agree which elements of the patient's care each will undertake. If the GP agrees to undertake a specific element of care subject to receiving appropriate support the onus is on the hospital to provide this support.

- **The GP should never be asked to initiate prescribing for shared care medicines**

- **Reasonably predictable clinical situation**

Sharing care with primary care should only be considered where a patient's clinical condition is stable or predictable.

- **Willing and informed consent of all parties, including patients and carers**

All parties must have sufficient accurate and up-to-date information in a form they can understand. Consent must be given voluntarily.

Consultants and GPs are encouraged to communicate directly when questions arise around shared care for a particular patient. If issues about prescribing remain after these discussions, the Chief or Senior Pharmacist at the PCT or Hospital Trust should be contacted for advice.

- **Clear definition of responsibility**

The areas of care for which each party has responsibility must be clearly defined and should be patient specific. The documentation should include details of any specialist resources that may be available.

- **Communication network and emergency support**

A telephone contact number, fax number and email address must be provided so that the GP can access advice and information if problems arise. Out-of-hours contact numbers must be provided so that the GP can contact an appropriate hospital doctor out-of-hours.

The documentation should state how often the patient will be reviewed and must detail a 'route of return' should the patient's condition become less predictable (e.g. return of symptoms, development of adverse effects). Progress reports should be produced to an agreed timescale.

- **Clinical information**

Shared care documentation should not duplicate information that is available in the BNF; it should direct the reader to the BNF when appropriate. It may be appropriate to include the following:

- A brief overview of the disease
- A note of relevant NICE or other guidance (and a weblink to the full guidance)
- Intended duration of treatment
- Common and important adverse effects (incidence, identification, importance and management)
- Clear information regarding monitoring requirements (eg LFTs, renal function), who is responsible for this, frequency of testing and what to do when adverse test results occur.

It is envisaged that all prescribers will want to keep reasonably up-to-date with important developments in therapeutics. Practitioners have a duty to keep themselves informed of the medicines that are recommended for their patients.

- **Review**

Shared care documentation must be reviewed by the authors, every 3 years or sooner if indicated (e.g. when NICE guidance is reviewed or updated).

3. Circumstances in which shared care is not appropriate

Hospitals must normally retain responsibility for prescribing in the following instances:

- When the GP does not feel competent to take over responsibility for prescribing.
- Where patients receive the majority of care, including monitoring, in hospital and the only benefit achieved by sharing care would be a reduction in hospital expenditure.
- Where the medicine is unlicensed, only available through hospital or being used as part of a hospital-initiated clinical trial.
- Where the medicine is included on the NCL red list of medicines that hospital doctors should not ask GPs to prescribe (see Appendix 5).

4. Checklist for GPs when considering sharing care

GPs should only agree to prescribe if, after reading the shared care document, they can answer YES to the following questions:

- Is the patient's condition predictable or stable?
- Do you have the relevant knowledge, skills and access to equipment to allow you to monitor treatment as indicated in this shared care document?
- Have you been provided with relevant clinical details including monitoring data?
- Have the document and BNF provided sufficient information for you to feel confident in accepting clinical and legal responsibility for prescribing?

If the answer is NO to any of these questions the GP should write to the consultant, within 14 days, outlining his or her reasons for NOT prescribing. Refusal to prescribe must ONLY be on the grounds of clinical responsibility. The cost of the medicine should not be a barrier to sharing care nor should a hospital seek to transfer prescribing on the grounds of cost alone.

5. Involving the patient

The consultant should only obtain the consent of the patient (and his or her carers if appropriate) after the GP has agreed in principle to share care.

Patients should never be used as a conduit for informing the GP that prescribing is to be transferred. Nor should they ever be placed in a position where they are unable to obtain the medicines they need because of lack of communication between primary and secondary care.

6. Process for development and approval of shared care arrangements

6.1 Hospital Consultants should work with their Chief Pharmacist and their local prescribing committee to seek agreement in principle from their local PCT's Medicines Committee (or Professional Executive Committee [PEC] if there is no PCT Medicines Committee) before commencing any work on developing a document.

6.2 If there is an existing shared care document covering the medicine(s) in question, Hospitals are encouraged to adopt existing documents (or adapt documents if not appropriate to adopt existing document) that are being used successfully elsewhere in North Central London to improve consistency, avoid duplication and streamline the review process.

If there is no existing shared care document:

6.3 Hospital staff should draft a shared care document using the standard template. The draft should be sent to the hospital or MHT's Chief Pharmacist and the PCT's Chief Pharmacist and put through local arrangements for approval. The approval process will include approval at the local PCT MMC and hospital D&TC or equivalents.

6.4 Once a shared care document has been approved locally the PCT's Chief Pharmacist should send a copy to the Medicines Management lead at the sector who will maintain a register of documents that have been approved across NC London.

6.5 The NCLMMN will be updated on any new shared care documents at the quarterly meetings where the tracking document will be tabled.

6.6 Each shared care document should be reviewed every 3 years or sooner if indicated (eg if new NICE guidance or MHRA/NPSA medicine safety alerts are issued).

Adapted by the North Central London Medicines Management Pharmacy Network from NWL Prescribing policy, which was in turn adapted from 'Effective Shared Care Arrangements' issued by the Midlands Therapeutic Review & Advisory Committee.

Appendix 5

North Central London Red List and Shared Care Document

This document is updated quarterly at the NCL Medicines Management Pharmacy Network meeting following on from discussions held at local Hospital Drugs and Therapeutics or New Drug Panel meetings. It contains medicines that are on hospital formularies but owing to their speciality, safety or monitoring requirements, GPs should not be asked to continue the prescribing. The responsibility for prescribing these medicines should remain with the hospital trust consultant unless shared care has been agreed or in exceptional cases where transfer of treatment for an individual patient has been agreed with both the consultant and GP.

Part B highlights priority medicines for development of shared care and where existing documents have been already agreed.

Further information on the background of the Red list and Shared Care can be found in Appendix 1 and 2 of the NCL Prescribing Policy. If you have any queries on any of the information contained in this document, please contact your local NCL Medicines Management representative.

PART A: Red list

GPs should not be asked to take on the prescribing of any of the following drugs. It relates to all formulations unless a specific formulation is given.

BNF Section	BNF Section Title	Generic Name
2.1.2	Phosphodiesterase inhibitors	Enoximone, milrinone
2.5.1	Vasodilator antihypertensive drugs	Ambrisentan, Bosentan, iloprost, sildenafil, treprostinil, tadalafil
2.8.1	Parenteral anticoagulants	Epoprostenol
3.4.2	Allergen immunotherapy	Grass Pollen Extract (Graxax®), Omalizumab
4.1.1	Hypnotics	Sodium oxybate
4.2.1	Antipsychotic drugs	Clozapine
4.8.1	Control of epilepsy	Rufinamide
4.9.1	Dopaminergic drugs used in parkinsonism	Apomorphine
4.9.3	Drugs used in essential tremor, chorea, tics and related disorders	Botulinum toxins type A and B
5.1	Antibacterial drugs	All IV and inhaled antibacterials (or according to locally agreed primary care services – contact your local PCT for further information)
5.2	Antifungal drugs	Voriconazole, posaconazole
5.3.1	HIV infection	All antiretroviral drugs for treatment/prophylaxis of HIV infection
5.3.2.2	Cytomegalovirus	Cidofovir, ganciclovir, foscarnet, valganciclovir
5.3.3	Viral hepatitis	Entecavir, interferon alpha, peginterferon alfa, ribavirin, adefovir, lamivudine, telbivudine, tenofovir
5.3.5	Respiratory syncytical virus	Palivizumab, ribavirin

5.4.8	Drugs for pneumocystis pneumonia	Pentamidine
6.5.1	Hypothalamic and anterior pituitary hormones and anti-oestrogens	Chorionic gonadotropin, choriogonadotropin alfa
	Infertility treatments	Follitropin alfa and beta, Human menopausal gonadotrophins, Lutropin alfa, Urofollitrophin
	Growth hormone receptor antagonists	Pegvisomant
6.6.1	Calcitonin and parathyroid hormone	Teriparatide
6.6.2	Bisphosphonates and other drugs affecting bone metabolism	Disodium pamidronate, sodium clodronate (injection), zoledronic acid, ibandronic acid (injection), denosumab
6.7.2	Drugs affecting gonadotrophins	Cetrorelix, ganirelix
6.7.4	Somatomedins	Mecasermin
7.4.5	Drugs for Erectile Dysfunction	Alprostadil, apomorphine, sildenafil, vardenafil, tadalafil (unless for indications in Schedule 11 as stated in the BNF and Part XVIIB of the Drug Tariff- Drugs, Medicines and other substances that may be ordered only in certain circumstances).
8.1	Cytotoxic Drugs	Oncology use of all I.V and oral cytotoxics; all use if injectables
8.2.2	Corticosteroids and other immunosuppressants	Basiliximab, daclizumab,
8.2.3	Rituximab and alemtuzumab	Rituximab, alemtuzumab
8.2.4	Other immunomodulating drugs	Interferon alfa, peginterferon alfa, interferon beta, aldesleukin, glatiramer, thalidomide, lenalidomide, natalizumab
8.3.4	Hormone Antagonists	Fulvestrant
9.1.3	Drugs used in hypoplastic, haemolytic, and renal anaemias	Desferrioxamine (adults only), deferasirox, deferiprone, erythropoietin, darbepoetin alfa, pegzerepoetin alpha
9.1.4	Drugs used in platelet disorders	Anagrelide
9.1.6	Drugs used in neutropenia	Filgrastim, lenograstim, pegfilgrastim, molgramostim
9.5.1.2	Hypercalcaemia and hypercalciuria	Cinacalcet
9.8.1	Drugs used in metabolic disorders	Imiglucerase, agalsidase alfa and beta, laronidase, mercaptamine, idursulfase, galsulfase, nitisinone, carglumic acid, miglustat
10.1.3	Drugs that suppress the rheumatic disease process	Abatacept, adalimumab, anakinra, certolizumab, etanercept, infliximab, methotrexate injections, tocilizumab (not in BNF 58), leflunomide
10.2.2	Skeletal muscle relaxants	Cannabis Extract (Sativex®)
11.8.2	Ocular diagnostic and peri-operative preparations and photodynamic treatment	Ranibizumab, Pegaptanib, Verteporfin, bevacizumab(unlicensed indication)
13.5.1	Preparations for eczema	Alitretinoin
13.5.2	Preparations for psoriasis	Acitretin

13.5.3	Drugs affecting the immune response	Ustekinumab
13.6.2	Oral preparations for acne	Isotretinoin
14.5	Immunoglobulins	Intravenous and sub cutaneous immunoglobulin

PART B: Shared care for drugs that would otherwise be considered red listed

The following medicines reflect the priorities for developing shared care guidance across NCL for drugs on the red list. They should be managed according to local policies and prescribing responsibility should remain with the hospital doctors until shared care is agreed locally. Reference is given if shared care has already been agreed and these documents are available for local adaptation.

BNF section	BNF Section Title	Generic name	Sharing organisations	Date agreed	Review date
4.11	Drugs used in Dementia	Memantine			

Please note that the red list is updated quarterly. Please contact your PCT to ensure you have the most up to date version