Integrated Care Northamptonshire

Prescribing and Medicines Optimisation

Standards at the Interface between Primary and Secondary Care Settings

April 2025

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Contents

Introduction

This document defines the agreed prescribing and medicines optimisation standards across care interfaces in Northamptonshire. The agreement applies to:

- **Northamptonshire Integrated Care Board (NICB)**
- **University Hospitals of Northamptonshire (UHN)**
  - **Kettering General Hospital (KGH)**
  - **Northampton General Hospital (NGH)**
- **Northamptonshire Healthcare Foundation Trust (NHFT)**
- **General Practices (GP) within Northamptonshire ICS**
- **Independent Sector Healthcare Providers (ISHPs) holding medicines-associated contracts with NICB**

Prescribing responsibilities and length of prescriptions at the interface between primary and secondary care are clarified.

The Primary Care Portal has details of the prescribing traffic light classification system.

Principles

The Northamptonshire Health Community is committed to promoting evidence-based, cost-effective prescribing including at the interface between primary and secondary care settings.

Patient-centred systems of communication will be advocated, and patients will not be utilised to communicate between primary and secondary care.

Medicine choices will be based on the local formulary.

Northamptonshire Prescribing Advisory Group (NPAG) processes must be followed for all new medicines introduced within Northamptonshire (except those that will be used only in hospitals where the local Trust processes will be followed). This includes new formulations and indications and where relevant, new devices.

Prescribing responsibility should be taken by the most appropriate clinician. Legal responsibility for prescribing lies with the doctor or health professional who signs the prescription. In many cases, this may sit with the GPs as providers of continuous care. Effective collaboration is essential among GPs, hospital consultants, and other prescribers in making informed decisions about patient care.

When a recommendation to prescribe a medication is received from another prescriber, the prescriber taking responsibility should make a decision as to whether the request is appropriate, and they are competent to take on the prescribing acting in the best interest of the patient, in line with General Medical Council guidance on Good Practice in prescribing and managing medicines. If a decision is made not to prescribe, the clinician who made the recommendation should be informed (electronically, by letter or using the agreed template).

Communication to the GP must include information on rationale for initiation of the medication prescribed and proposed treatment plan.

New Treatments and Interventions

The ICB medicines optimisation team must be notified of any significant developments concerning prescribing, and particularly changes in prescribing practice which will impact on prescribing across the System. Changes should be agreed via NPAG, Northamptonshire

Prescribing Management Group (NPMG) or the annual planning process with the ICB as appropriate.

The Provider will agree with ICB commissioners the introduction of any new medicine, formulation, licensed indication, intervention, or device which is excluded from the national tariff for which the ICB is the responsible commissioner. This should usually occur via the annual planning process. Outside the annual planning process, the ICB Head of Medicines Quality and Value must be notified so that approval can be sought.

New high-cost treatments (excluded from the National Tariff), devices, procedures, and treatment pathways not mandated by NICE for which the ICB is the responsible commissioner (unless specified within contracts or within exceptional circumstances) will usually be considered as a low priority for funding in year. They will be considered as part of the commissioning discussions for the following financial year.

The ICB will be notified of any new medicines supplied via homecare where the ICB is the responsible commissioner. The commissioner will be involved in agreeing any additional costs (above the medicines costs) associated with homecare medicines in advance of contract signing.

Treatment initiated under the Early Access to Medicines Scheme will not automatically be funded on licensing of that medicine. In the absence of a positive NICE TA this should be initially discussed at NPAG and, where appropriate, a business case should be submitted through the annual planning process.

Treatment initiated under an extended access scheme, a 'Zero cost' scheme or a Free of Charge scheme (FoC scheme) where free or nominal cost medicines are supplied to providers, whether in anticipation of a positive NICE TA or otherwise, will not automatically be funded. Such schemes should be consistent with local policy and be discussed and approved at NPAG before any patients are commenced on treatment.

The requesting clinician will ensure patient communications are suitably managed for any medicine or treatment that requires specific approval from the ICB whether via prior approval or Individual Funding Request (IFR).

The Provider will ensure that its clinicians follow due process for the introduction of new medicines or therapies for individuals or groups of patients. This process will ensure:

- Consideration of the medicine by the Trust's Formulary / Medicines Management Committee, followed by:
    - A paper to NPAG for consideration if the treatment will impact on ICB budget (be it primary or secondary care) or
    - A request to the ICB Individual Funding Request (IFR) panel as appropriate.

Where a Commercial Access Arrangement exists, an intervention will be funded at a value no higher than the pricing agreement.

Supply standards for inpatients at discharge

Admissions of 48 hours or less

For admissions of less than 48 hours duration, it can be assumed that patients will continue with supplies of existing medicines when discharged home and only new medicines or medicines that have changed will be supplied. These new / changed medicines will be supplied in accordance with the standards agreed for admissions over 48 hours duration.

Supplies of regular medication will not routinely be provided. However, there must be a commitment to ascertain whether the patient has enough regular medication available and if not, then a supply will be provided. The Trust will supply medicines if a risk of missed doses (due to lack of availability) is identified during the admission.

Patients attending for day case surgery will be provided with sufficient dressings / antibiotics to meet their post-operative needs. Patients may be encouraged to provide their own analgesics when this need can be met from common, over the counter (OTC) preparations. There should be an expectation that the GP will not prescribe these OTC preparations and other analgesia will be provided by the Trust.

Admissions over 48 hours duration

Inpatients, on discharge shall receive a minimum of 28 days' treatment unless otherwise indicated clinically or in line with a 'dispensing for discharge' policy when the minimum shall be 14 days treatment. An original pack will usually be supplied for inhalers, creams etc. unless this is clearly insufficient for a 14-day supply. If the patient has a sufficient supply of their own medicines (minimum 14 days), this can be utilised at discharge. End of Life Care patients will receive 7 – 14 days' supply on discharge (based on clinical judgement of appropriate duration of supply).

On discharge, patients will be provided with a copy of the TTO outlining their medicine regime. Appendix B lists exceptions to the supply standards.

Medicines Information on Discharge

The GP practice will be supplied with the following required information on discharge (as applicable):

- Newly commenced medicines: indication, monitoring required, plan for any dose titration beyond 28 days (titration within the first 28 days remains the responsibility of the hospital specialist)
- Dose alterations: rationale, monitoring required, any further actions anticipated
- Discontinued medicines: rationale, conditions to be met to enable medicine to be restarted

For any item marked for review there will be clarity regarding who will undertake the review and timescales for this.

For admissions of less than 48 hours duration, addition of 'no changes to existing medicines' to the discharge letter will be sufficient to communicate that all medicines should continue to be prescribed as per drug history held by the GP. Any new medicines or medicines changes will be detailed in full.

The accuracy of medicines information on discharge may be audited in GP practices using a sample of discharge letters. Inclusion criteria will be agreed with the Trusts and results will be fed back via Trust Chief Pharmacists and Medicines Safety Officers.

Medication Compliance Aids (MCA)

Patients being discharged using a Sealed MCA

If a compliance aid is required on discharge, the Trust will liaise with the GP and Community Pharmacist in time for supplies to be ready for the patient's discharge. If there is a risk of the patient's discharge being delayed due to these arrangements not being in place, then the Trust will supply the patient with medicines in conventional containers and provide a list of medicines and/or a copy of the discharge prescription.

Exceptions: If a patient is:

- being discharged home, and
- they are using, or require a Sealed MCA, and
- there is no domiciliary care in place, and
- there is a risk of their discharge being delayed because arrangements have not been made for the GP / Community Pharmacist to provide the Sealed MCA in time for their discharge, then

the Trust will supply the patient with two weeks supply of medicines in a disposable, sealed MCA and provide a list of medicines and/or a copy of the discharge prescription.

Supply standards for outpatients

GMC guidance on out-patient prescribing and advising should be followed. Where a hospital clinician recommends that a patient goes to their GP for commencement of treatment, 28 days' notice will be given from the date of the out-patient appointment for the GP to receive and action written information prior to the patient attending the practice. Procedures will be in place to communicate this to the patient at the outpatient appointment.

In accordance with System agreement via the Integrated Medicines Optimisation Committee (IMOC), GP advice forms (commonly known as chitties) will not be used as a communication mechanism across Northamptonshire.

Patients with self-limiting illness and those suitable for self-care will be advised to purchase over the counter medicines as appropriate in accordance with NHSE guidance.

Urgent medicines i.e. those required within 28 days of appointment will be supplied by the hospital and 28 days will be supplied unless a shorter course of treatment is indicated.

Any investigations related to medicines prescribed, that are required within 28-days will be ordered and reviewed by the prescribing clinician or their team.

Medication information is by generic name, except where use of a brand name is clinically indicated.

Trusts will ensure that whenever possible clinicians recommend a specific medicine in accordance with current formularies or offer GPs a choice within a therapeutic class.

Appendix B lists the exceptions to the supply standards.

Admission / referral

The GP / referrer must provide or ensure availability of:

- Details of any allergies or intolerances with each referral or admission including a description of the type and severity, where that data is available.
- An up to date, comprehensive and accurate list of all current repeat medicines and any relevant acute medicines related to the present condition. This should include details of name, form, dose, strength, and frequency.
- Information if a patient has compliance difficulties and / or uses a Medication Compliance Aid (MCA) including the patient's supplying Community Pharmacist, if known.

For elective admissions these data must come in advance or with the patient. For non-elective admissions the details should come with the patient (GP referral) or be made available immediately on request from the hospital (non-GP referral) by the patient's GP practice, or on the next working day if the admission is out of hours.

Primary care teams should encourage patients to take all their medicines into hospital with them; this will ensure accurate reconciliation, aid in the detection of problems and ensure that the patient's medicines are immediately available for continuing care.

Discharge Information

Patients in an inpatient setting must be provided with information about how to take prescribed medication to include confirmation of which medicines have been stopped, changed, and started.

It is the responsibility of the prescriber to inform pharmacy teams supplying medicines of specific needs of patients with a disability.

The General Practice must receive an electronic discharge summary within 24 hours. The discharge summary must be clear and include the following details regarding the medication regimen:

- proposed treatment plan (including name, strength, formulation dose, time, frequency, and duration).
- reason for initiation for any new medication started during the patient's hospital stay including when treatment should be stopped (where applicable).
- number of days' supply provided.
- discontinued medication and the reasons for discontinuation.
- any changes to existing medication and the reasons for those changes.
- Any new drug allergies or sensitivities to a medication during admission and full details of any allergy delabelling.
- If a further review of the prescription is required, detail when and by who.

A written summary of changes to medication must also be provided to the patient.

Patients should be encouraged to give consent for discharge medication information to be sent to their regular community pharmacist via Discharge Medicines Service (DMS).

Pharmacy staff are responsible for ensuring that the exact number of days supplied of discharge medication is recorded. If no member of pharmacy staff is involved in the production of a discharge letter, the responsibility lies with the prescriber.

Shared Care (Amber medicines)

Clinical responsibility for prescribing should sit with those professionals who are in the best position and appropriately skilled to deliver care which meets the needs of the patient. This means increasingly, patients with continuing specialist clinical needs can be cared for at home or in the community receiving medicines prescribed by primary care prescribers so long as sufficient support, review criteria and information are shared between the specialist team, primary care prescriber and, most importantly, patients themselves.

Shared care should be undertaken in accordance with the following guidance:

Responsibility for prescribing between primary and secondary/tertiary care (NHSE).

Good practice in prescribing and managing medicines and devices (GMC)

Shared Care for Medicines Guidance – A Standard Approach, which details the characteristics of medicines suitable for shared care and contains a national list of medicines that when prescribed in primary care should be provided via a shared care arrangement. A suite of

standard Shared Care Protocols (SCPs) are available nationally to provide a suitable SCP template for local adoption and implementation.

For medicines requiring shared care, the supply of medicines by secondary care must be continued until the care has been shared with the GP using the process described.

In the transfer of management and prescribing responsibilities to the GP under shared care, it is essential that:

- The patient's condition fits any criteria stated in the Shared Care Protocol, where this exists.
- Dissemination of sufficient information to the GP and other carers has occurred using agreed shared care protocols and/or letters as appropriate.
- A GP must advise the consultant if they are NOT happy to take over the prescribing and monitoring responsibility, clearly stating the reason for this and copy the letter to the ICB Medicines Optimisation team.
- The GP can monitor treatment and adjust the dose if necessary.
- The medicine has received approval by NPAG and has been designated as Shared Care.

Where a dose adjustment of existing treatment under shared care is required by a specialist, a supply will only be provided within secondary care if the adjustment will result in the patient having less than 14 days' supply or the specialist considers that there is an exceptional need to supply. NOTE: a new shared care is not required for changes in dose or formulation of the said medicine already agreed under shared care.

Shared Care Prescribing Arrangements

Shared care protocols must be developed in line with NHS England guidance regarding the principles for shared care.

Northamptonshire shared care protocols are being aligned with the national templates.

All healthcare professionals involved in shared care are expected to follow the shared care protocols. Exceptions to this should be managed on an individual basis.

The Pharmacy teams in all settings will facilitate the appropriate development and use of shared care protocols, led by UHN and NHFT as appropriate. Exceptions and declines should be managed on an individual basis.

If a medicine is covered by a shared care protocol, the shared care protocol request form or template letter must be sent by the secondary care clinician to the GP. Acceptance of shared care is assumed unless a refusal to share care letter is returned within 28 days.

Shared care protocols can be accessed via the Primary Care Portal under Traffic Light Drugs.

Patients should be consulted about shared care treatment and agree prior to initiating.

Specialist only (Red) medicines

For specialist only medicines, prescribing will be retained within secondary care in all circumstances. This applies to medicines that are classified as red according to the local traffic light system and to those requiring shared care until the care is shared with the GP using the process described. The prescribing specialist, alongside the hospital pharmacy department, will ensure suitable arrangements are in place for the administration of medicines within and outside the hospital setting.

Patients own medicines

Patients are permitted to use Patients Own Medicines during inpatient stay, where applicable.

Patients' own medicines brought into hospital remain the property of the patient and will be returned to the patient if they are to be continued.

In the inpatient setting storage will be as per the hospital trust patients own medicines policy.

If there is a change of medication regimen and with the permission of the patient, medicines no longer required will be disposed of.

Transfer of medicines

The green bag system can be used to transfer the patients' medication between primary and secondary care.

Oral nutritional supplements (ONS)

Oral nutritional supplements are only prescribed or recommended for patients on discharge when the use is clinically indicated. Clear advice from the Dietitian will be provided to primary care about the treatment plan for patients for on-going use of oral nutritional supplements following discharge from hospital.

A 3-day supply of oral nutritional supplements (ONS) will be provided on discharge. This may be increased by the discharging Dietitian in the event of a specific issue e.g. bank holiday up to 7 days.

A 7-day supply of enteral tube feeds and associated supplementary equipment e.g. giving sets and syringes are provided on discharge from the ward to support with the administration of feeds and medicines. This may be increased by the discharging Dietitian in the event of a specific issue e.g. bank holiday up to 10 days. When an ONS is used for bolus enteral tube feeding the 7- or 10-day supply rule applies.

Dressings & Appliances

A 5-day supply of required dressings will be provided on discharge and dressings supplied will be in line with the local dressings' formulary.

A 7-day supply of required appliances will be provided on discharge.

Non-Prescribable (not in drug tariff) Medical Devices

Not all devices used or recommended by Provider Trusts are prescribable on an FP10 prescription form in primary care. Only appliances which are listed in the Drug Tariff can be supplied against a FP10.

Where a non-prescribable medical device is issued by the Trust, subsequent costs for replacement of the device or consumables used with the device (if not prescribable) will be the responsibility of the Trust.

Where a medical device and associated consumables can be prescribed on an FP10 and have been recommended through NPAG as suitable for prescribing in Primary Care, the principles above, as defined for medication, apply for medical devices.

Care Homes

Compliance aids containing patient medication should not be sent into hospital in the green bag as the hospital trust cannot use them.

All other medication must have a pharmacy label e.g. inhalers, creams and eye drops should be sent in the green bag with a copy of the Medication Administration Record (MAR) chart.

The discharging team will liaise with carers and provide medication when there is no supply for the patient at the care home or when there is a medication change. This will avoid sending medication when there is a further supply at the care home and will reduce waste.

Controlled entry for new medicines and treatments

All organisations support the Northamptonshire traffic light classification system for medicines and expect all prescribers to practice in line with the classification system.

The classifications are as follows:

Red	Responsibility for prescribing these items remains with a hospital consultant or specialist.
Amber	These items require shared care between the specialist and the GP i.e. the patient must remain under the care of the specialist for monitoring of the medicine. If a Shared Care Protocol exists, then this must be followed. All Amber medicines must be initiated or recommended by a specialist, they will be classed accordingly as Specialist Initiated (SI) or Specialist Recommended (SR).
Green	Can be prescribed routinely. For certain items, prescribing in primary care should only be commenced if it has been initiated or recommended by a specialist, they will be classed accordingly as Green Specialist Initiated (SI) or Green Recommended (SR). If 'Prescribing Guidance for the GP' exists for a Green (SI) or Green (SR) medicine, then this should be followed.
Double Red (PA)	not usually recommended. In situations where other treatments are not suitable a request for a double red drug may be made by completing a Prior Approval form and submitting it to northantsicb.priorapproval@nhs.net. There will be a response within a week*
Double Red (IFR)	not routinely commissioned. Any requests would only be considered via the Individual Funding Request process.*
Grey	This is a holding category for drugs not yet formally assessed by NPAG. Prescribers should refrain from prescribing and contact the ICB medicines optimisation team for more information

*Any prior approval or IFR should be completed and submitted by the clinician recommending the double red drug

For information on the Traffic Light System see: Medicines optimisation | Integrated Care Northamptonshire (icnorthamptonshire.org.uk).

Further guidance on medicines initiated or recommended by out of area clinicians can be found on the Primary Care Portal.

Formulary and Prescribing Guidelines

Medicine choices will consider differentials in the cost of medicines between primary and secondary care and reflect sound cost benefit analysis.

All prescribing (and recommendations to prescribe) should be for the generic product unless there is recognised reason to prescribe by brand (as per Specialist Pharmacy Service guidance).

System partners will follow locally agreed guidelines where applicable.

If a biosimilar medicine is available, choice of product will be considered and agreed following best value principles. The ICB will be notified of and involved in any decision to deviate from use of the best value product.

Individual Funding Requests

Where an exceptional need exists for a medicine in a situation which is not likely to be commonly encountered, an application for funding may be made via the Individual Funding Request (IFR) process.

Referrals to the IFR Panel should only be for patients whose circumstances are exceptional in accordance with the definition contained within the ICB Policy.

Responses to IFR requests will be in accordance with the ICB policy. The IFR should be completed and submitted by the clinician recommending the medicine in question.

Retrospective IFRs will be considered in clinically urgent situations. Individual funding requests | Integrated Care Northamptonshire

The IFR process should not be used for introduction of new licensed medicines or where a cohort of patients (however small) exists.

Clinical Trials

New medicines provided free of charge for the purpose of approved clinical trials will be managed through formal clinical trials processes.

On cessation of the clinical trial there is no assumption that patients will have access to the medicines used for the trial. Patients must be informed of this on entry to the trial.

In post-marketing trials i.e., trials using existing medicines which may or may not be listed in the formulary and which are not provided free of charge:

- Funding approval must be obtained from the health organisations financially impacted.
- GPs, independent non-medical prescribers, and patients must also be informed that any non-formulary medicines should not usually be continued after the trial ends.

Medicines may sometimes be obtained free of charge on compassionate grounds, but once the medicine is licensed, it is subject to the normal approval process for new medicines entry. This needs to be considered as part of the approval process for each clinical trial and patients informed of this.

Unlicensed Medicines (specials) and Unlicensed Indications

The prescribing of unlicensed ‘special’ formulations should only be considered when licensed products are not available or suitable for the patients’ needs.

If a consultant advises a GP that the use of such a product is in the patient’s best interest, then all the necessary information and advice must be provided. Some unlicensed medicines

MAY be classified as RED under the Traffic Light System, each medicine requires an assessment of clinical risk.

Medicines not Routinely Commissioned

For guidance on medicines not routinely commissioned, see local policy, available on the Primary Care Portal.

Pharmaceutical Company Sponsorship

All organisations involved in this agreement will document details of all clinical staff who are sponsored by an independent company if that company is a significant provider of goods or services to the NHS.

All organisations involved in this agreement should demonstrate that sponsorship has in no way affected prescribing decisions. This is in line with the recommendations outlined in HSG (93)5 "Standards of business conduct for NHS staff" and re-enforced by Commercial Sponsorship – Ethical Standards for the NHS November 2000.

This will be transacted in accordance with the standards of business conduct policy.

Appendix A

Guidance to support the provision of pharmaceutical service

- EL (91) 127 “Responsibility for Prescribing between Hospitals and GPs”
- EL (94) 72 “Purchasing and Prescribing”
- HC (88) 54 “The way Forward for Hospital Pharmaceutical Services”
- EL (95) 5 “Purchasing High-Tech Health Care for Patients at Home”
- HSG (93) 5 “Standards of Business Conduct for NHS Staff”
- The safe and secure handling of medicines: A team approach (a revision of the Duthie Report (1988) led by the Hospital Pharmacists Group of the Royal Pharmaceutical Society) RPSGB March 2005
- HSG (93) 24 “Emergency Planning in the NHS”
- National Service Frameworks
- Guidance issued by the National Institute for Clinical Excellence (NICE)
- Audit Commission Report “A spoonful of sugar” (2001)
- Recommendations produced by the Area Prescribing Committee (APC)
- MHRA Guidance/alerts
- NHS England Responsibility for Prescribing between Primary and Secondary/ Tertiary care 2018
- NHS National Contract 2023/24
- NHS England The interface between primary and secondary care 2017
- NHS England Guidance on the National Health Services (Charges and Pharmaceutical and Local
- Pharmaceutical Services) Regulations 2020

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

Appendix B

Supply exceptions

List of medicines which do not require a minimum of fourteen days’ supply of medication on discharge or 28 days’ supply on outpatient prescriptions:

- Defined courses e.g., prescriptions from the emergency department (A&E), day cases (for supplies from A&E – 14 days or a complete course will be supplied as appropriate).
- Chemotherapy or as specifically required by the prescriber.
- Laxatives
- Analgesia – supplies do vary depending on procedure the patient is having.
- Antimicrobials
- Hypnotics
- When patient has own supply or a further supply at home / or is due a further supply (i.e., has a repeat prescription)
- Specialist only medicines or medicines only available in Hospital – full supply required for patient will be issued
- Supplies of medication from Family Planning Centres - full supply required for patient will be issued
- Sip feeds (3 days on discharge) with consideration of a longer supply if just before or at bank holiday or if it is the sole source of nutrition.
- Dressings (5 days on discharge)

- Medicines where self-care would be more appropriate over the counter considering licensing
- Where there are concerns regarding the risk of suicide or self-harm or the risk of drug misuse
- End of life medicines
- Non-Formulary medicines (supply may be made during the stay but a further supply at discharge is not normally made).
- Existing repeat medicines for planned admissions.
- Anti-inflammatories for acute conditions.
- Eye drops, ear drops, nose drops.
- Medicines in multi-dose packs e.g. creams, ointments, inhalers, insulin vials.

Medicines supplied on discharge for patients on a self-medication scheme, or a one stop dispensing scheme, may be for less than 28-days e.g. where a patient pack is started during the in-patient episode but should not be for less than 14 days.