



## GREATER MANCHESTER MEDICINES MANAGEMENT GROUP

### INTERFACE PRESCRIBING SUBGROUP

### TERMS OF REFERENCE

#### BACKGROUND

In 2013 it was agreed that the functions of the previous GM Interface Prescribing and New Therapies Prescribing Subgroup should be separated into two new subgroups: an Interface Prescribing Group and a New Therapies Sub-Group.

The new Interface Prescribing Sub-group (IPS) will bring together medical and pharmaceutical representation from relevant CCGs and Trusts with independent secretarial support from the Regional Drug and Therapeutics Centre (RDTC) to consider all aspects of Shared Care relating to prescribing and to make recommendations to the parent GMMMG and local Drug and Therapeutics Committees of Greater Manchester NHS organisations.

#### RESPONSIBILITIES

1. To make decisions on the most appropriate place for prescribing of named drugs (the Red/Amber/Green list) using set criteria and ensuring that decisions made are based solely on safety and monitoring of the drug and or disease.
2. To make decisions on the most appropriate place for prescribing of medical devices that are prescribable on FP10 prescriptions and have been reviewed by the New Therapies and/or Formulary Subgroups.
3. To facilitate the production of Shared Care Protocols across Greater Manchester, ensuring a fair balance of workload between hospital Trusts. A template for Shared Care Guidelines has been produced for use across GM and the group encourages Trusts to use this. <http://gmmmg.nhs.uk/docs/ip/SCG%20template%20updated.doc>. The template is based on standard criteria that the GP will require if they are to take over prescribing of the drug. If a shared care guideline is not available or information incomplete then the GP may refuse to prescribe the drug and the drug would default to a red status
4. To oversee the production and availability of Shared Care Protocols for all drugs designated “amber”.
5. The Group’s recommendations are advisory, and the appearance of a medicine on the Red/Amber/Green list does not imply endorsement of use, but rather a recommendation on prescribing responsibilities and whether or not the supply of a medicine should be organised through the hospital or primary care pharmacy network. Its primary function relates to patient safety and enhancement of services for patients prescribed specialist medicines. Where necessary, secondary and primary care prescribers should discuss the appropriate management of individual patients personally. These guidelines are expected to cover the majority of occasions but in exceptional circumstances both parties may agree to work outside of this guidance. In addition where appropriate pathways are in place, some CCGs may have a variation to this list.

6. The Group will consult with commissioners via CCGs Locality Leads/Trust Chief Pharmacists on the commissioning implications of its decisions and advise GMMMG accordingly, particularly for newly considered drugs and existing drugs whose RAG status is changed.
7. Shared Care Protocols will be hosted on the GMMMG website
8. To liaise with the New Therapies and Formulary Subgroups as necessary.
9. To highlight and support the development of specific treatment pathways to complement the joint formulary.
10. When appropriate, to be cognisant of relevant NICE guidance and recommendations therein.

### **Principles:**

NHS Policy EL(91)127 (Responsibility for prescribing between hospitals and GPs) and EL(94)72 (Purchasing and Prescribing) made it clear that where prescribers accept prescribing responsibility they should have all the information and support that they need to prescribe and monitor their patients and, as a consequence, shared care agreements include a prescribing treatment protocol. The shared care arrangement should identify the areas of care for which each partner to the arrangement has responsibility including initiation of treatment and then, throughout ongoing care, stating clearly who has the responsibility and authority to adjust and stop treatment and who is responsible for acting upon side effects. Any training required by GPs, other primary care prescribers, and their staff should be identified and provided to a satisfactory standard by the specialist department seeking the shared care arrangement. Agreed channels of communication should also include contact details for use when a primary care prescriber needs advice.

A primary care prescriber's responsibilities would usually include replying to the request for shared care, prescribing and following the specialist advice on any changes in treatment. The primary care prescriber would also refer back to the specialist in the event of deteriorating clinical condition and report any adverse events. They would also be responsible for discontinuing treatment if necessary on the advice of the specialist. A patient's role would include reporting any adverse side effects of the treatment to the specialist, GP, or other prescriber; sharing any concerns and letting them know if he or she does not have a clear understanding of the treatment.

CCGs will want to see good controls assurance for patients involved in shared care. For example, they may wish to be assured or see evidence of individual patient management plans in line with the shared care treatment protocol, the dates of biochemical and physiological test results, any episodes requiring hospital admission and any adverse events caused by the specialist drugs, and show how patient defaults are followed up. CCGs may also wish to look at outcomes including unusual incidents which would also be reported to the CCG at the time of any significant incident.

### **MEMBERSHIP**

IPS is a clinical decision making group and therefore members will need to have delegated responsibility from their locality. The success of the group will depend strongly upon members working voluntarily together and ensuring two way communications between the Subgroup and localities.

The Subgroup will draw membership from all 12 GM CCGs and support will be provided by the RDTG (Wolfson Unit) and the GM CSU. It is intended that those localities that don't attend will feedback any local issues to either CCG representatives or GM CSU.

Membership to include (up to):

- 3 General Practitioners (one to Chair)
- 2 Secondary Care Doctors (one as deputy chair)
- 12 Pharmacists:  
(five senior CCG prescribing advisers and seven chief pharmacists, or their nominated deputies/specialist pharmacists, including a representative from a Mental Health Trust)
- 1 RDTC representative
- 1 Greater Manchester Shared Services (part of North West CSU) representative

In total there are 8 x primary care representatives and 9 x secondary care representatives on the group.

Each member of the group is nominated by the relevant professional or management group with the understanding that those nominated should be recognised by their peers as representing their views.

### **Responsibilities of Individual Members:**

- Accept ownership of IPS decisions.
- Undertake work as necessary between meetings.
- Promote communication between IPS and relevant NHS colleagues / organisations.
- Take specific views, from IPS back to localities for comment, and then to feed back the responses back to IPS as appropriate.
- Commit to regular attendance of IPS meetings to ensure continuity and balance of input into decision-making.
- Be an enthusiastic, motivated and an active participant in the committee.

Members should send a representative with appropriate authority and experience wherever possible, if they are unable to attend.

Appointments will be reviewed every year. Members must complete a 'declarations of interest' form on joining the group and adhere to the GMMMMG DOI policy. In addition members are required to declare any relevant interests relating to the agenda at each meeting. Members may be excluded from decision making (to be judged by the Chair) where appropriate.

### **IN ATTENDANCE:**

Clinical staff from localities may be invited to attend the meeting for the purpose of providing advice and/or clarification to the Group.

### **QUORUM**

For the group to be quorate there should be a total of **seven** members present including the following that must attend each meeting;

- Chair (or deputy)
- 2 CCG representatives
- 2 Secondary Care representatives
- 1 Pharmacist
- 1 GP

A primary and secondary care representative must be included in the above list.

**If the group is not quorate then agreement (via email) from group members not present must be sought on any decisions made.**

## **MEETING FREQUENCY**

The group will meet every alternate month. Copies of the work plans will be available on the website and will be updated on a regular basis following each meeting.

## **COMMUNICATION**

Draft minutes will be circulated after the meeting to the members and confirmed in the subsequent meeting. Once confirmed and signed off by the main GMMMG group they will be made available on the GMMMG website. The majority of communication will be via the website and through membership to their locality.

Following approval of a new or change in RAG status OR a Shared Care Protocol by the GMMMG, Commissioners will be alerted to a change by the CSU and/or CCGs. The RAG list and/or Shared Care Protocol will also be updated on the GMMMG website.

## **DECISION MAKING**

If a meeting does not have a quorum all decisions/recommendations taken at that meeting must be ratified by the absent members prior to implementation via email.

Participating organisations will need to ensure that they have appropriate corporate governance processes in place to ensure that the recommendations made by the GMMMG are considered in the correct manner and endorsed as appropriate.

Following approval of a new or change in RAG status OR a Shared Care Protocol by the GMMMG stakeholders may need time to considering implementing the recommendation, particularly in the case of RAG decisions/Share Care Protocols with major commissioning implications. Those RAG recommendations and Shared Care Protocols with major commissioning implications will not be implemented until the commissioning arrangements are resolved. Commissioners will be alerted to a change by the CSU and/or CCGs. The RAG list and/or Shared Care Protocol will also be updated on the GMMMG website.

### **Voting**

It is recognised that there are very few occasions when recommendations are not unanimous and therefore the requirement for the group to vote may not be necessary. If there are conflicting opinions within the group, the recommendation will be put to a majority vote.

A 'one member, one vote' system will operate, taking into account declarations of interest.

If there is an equal split this will be communicated to the GMMMG who will be asked to make the final decision.

Any dissent against a decision will be noted.

Members should agree to abide by the outcome of such votes.

If the decision is not unanimous due to different commissioned pathways then agreement can be made to allow for local variation or in the case of shared care protocols to have a common core with local appendices.

### **Interface RAG list**

The primary function of the RAG list is to consider patient safety issues and the enhancement of services for patients prescribed specialist medicines. This list does not take

into account of the cost implications of use of a particular medicine or indeed the evidence for use, however this is considered in new therapies recommendations and the two where possible will be linked. A list of general principles have been developed to aid the group in their decision making and to ensure consistency of all medicines discussed, regardless of specialty. This document can be found on the website. <http://gmmmg.nhs.uk/docs/ip/RAG%20list%20General%20Principles%200312.pdf>

The group may review and update this document. It may also consider how to deal with drugs which are now commissioned by NHS England and maybe required to liaise with NHSE about such drugs as NHSE still sees a role for shared care.

Please note all Subgroup Recommendations apply to NEW initiations. Existing patients should be reviewed at their next routine appointment and the decision about whether to continue a medicine should be made after discussion of alternatives with the patient. For changes to RAG status: stable patients who are being adequately monitored and reviewed should not have their supply disrupted. Discussions between primary and secondary care must take place within localities prior to passing over of prescribing responsibilities.

The list provides a framework for defining where clinical and therefore prescribing responsibility should lie through categorisation of individual drugs. The criteria used for defining status is based on the specialist nature of the drug, the complexity of the assessment and monitoring arrangements required for the care of the patient, clinical responsibility and competency associated with the prescribing of a medicine and is not based on the cost of a medication. Note that drugs appear individually alphabetically and are not grouped by class (unless indicated). If an indication is not stated then the designated status relates to licensed indications only.

Unlicensed treatments and indications are automatically classified as red unless designated otherwise on the list below. This includes unlicensed treatments for use in paediatrics however for off-label paediatric use of licensed products please consult the children's BNF in addition to the list below. However where there is a strong body of evidence supporting their use or/and use is likely to apply to an identifiable patient cohort then an application can be made for GMMMG to assess or re-assess the RAG status. Certain unlicensed indications are listed where the Interface Subgroup has been specifically asked to consider these.

### **Shared Care Protocols**

The core of a shared care protocol should be standard i.e. monitoring requirements and this would be expected to be included within a GM-wide SCP, but that there is some scope for variation within organisations depending on local commissioning arrangements, which can be included within an appendix.

A Shared Care Protocol Template is available to ensure consistency in production of SCP's.

## **APPEALS**

Applicants who wish to appeal against the decision of the subgroup will be required to present substantial new evidence as to the merits of a medicine with regard to shared care.

It is however, important to note that all GMMMG IPG recommendations or decisions are **advisory** to GM CCGs and Trusts and as such it is up to the individual organisations involved as to how these are implemented. Therefore, any appeals regarding a policy decision taken by a CCG to adopt GMMMG advice must be addressed to the CCG in question.

Grounds for appeal are as follows:

- Significant new clinical evidence or national guidance (e.g. NICE, MHRA Drug Safety Update) available to support application not considered as part of original application.
- Decision appears to be based on inaccurate or incomplete information.

- GMMMG process for producing RAG recommendations and/or shared care protocols has not been followed.

Any appeals on decisions made by any subgroups should be submitted to the subgroup in question first, and a recommendation should be made by that subgroup, which should then be reported into GMMMG. GMMMG will then approve or reject the subgroup recommendation and inform the applicants.

There are no time limits on making an appeal.

An intention to appeal should be made in writing to the professional secretary.

An application to appeal an Interface Subgroup recommendation will be considered at the next available Interface Subgroup meeting to decide if there are grounds for an appeal.

Appeals granted grounds for appeal will be heard at an Interface Subgroup meeting once a quarter (March, June, September, and December) where a total of thirty minutes will be allowed to hear the appeal. This would normally comprise a brief presentation by the appellant of any new information not previously considered, or the reason the applicant feels the original decision making process was flawed, followed by questions by the committee. The appellant has no voting rights.

If there are conflicting opinions within the group regarding the appeal, the decision will be put to a majority vote.

The appellant will be informed of the outcome of the appeal by the professional secretary within one week of the meeting.

## REPORTING

Minutes of the meeting will be available for all members of the group, the GMMMG and Greater Manchester D&T Committees and Medicines Management Groups via the GMMMG website. *Please note there may be a delay in the minutes appearing on the website due to the time lag in approval.*

Final decisions will also be made available following consideration by the group on the website (<http://gmmmg.nhs.uk/>).

IPS is a subgroup of GMMMG and therefore all Shared Care Protocols and RAG status decisions must be signed off by GMMMG prior to becoming final.

The current work plan of the group will be updated regularly and will be available on the website so interested parties are able to submit papers for consideration on specific products.

## SUPPORT

Professional secretarial support is provided by the Regional Drug and Therapeutics Centre, Wolfson Unit, Newcastle upon Tyne.

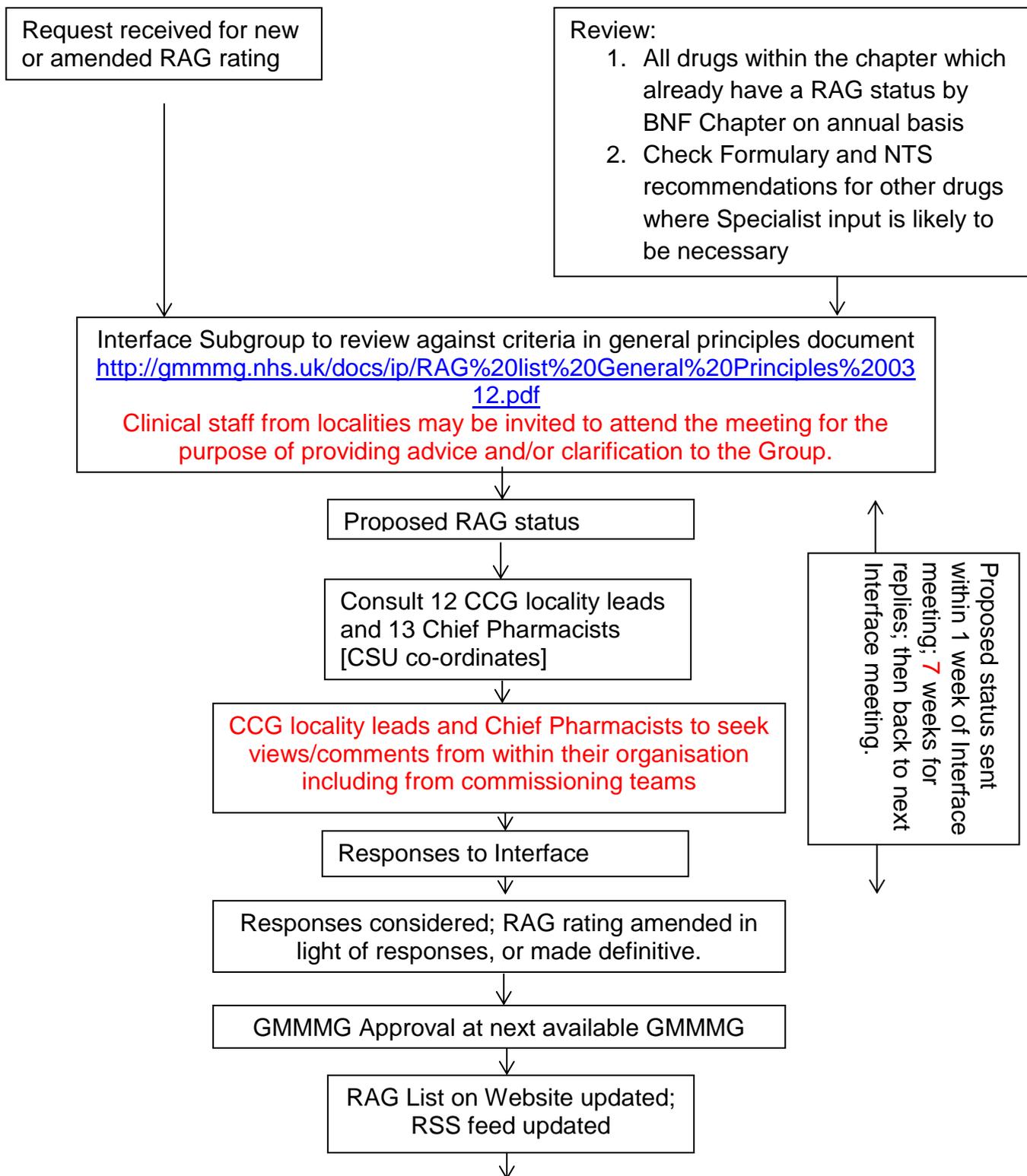
### **Responsibilities of Greater Manchester Shared Services (part of North West CSU) and RDTC staff:**

- Coordinate agenda, minutes and actions
- Prepare papers and evidence for consideration by the meeting
- Facilitate the agreed work programme and the production of GM wide shared care protocols.

**Membership**

<b>Name</b>	<b>Job Title</b>	<b>Organisation</b>	<b>Voting Rights</b>
Dr Richard Darling (Chair)	General Practitioner	Heywood, Middleton and Rochdale CCG	Y
Jole Hannan	Interface Pharmacist	Bolton CCG	Y
Dr Jane Bradford	GP Prescribing lead	Bolton CCG	Y
Jeanette Tilstone	Medicines Management Lead	Bury CCG	Y
Claire Foster	Medicines Management Pharmacist	South Manchester CCG	Y
Jason Farrow	Medicines Management Lead	Salford CCG	Y
Dr Tom Leckie	Consultant in Emergency Medicine	Pennine Acute Hospital Trust	Y
Rob Elsey	Specialist Pharmacist	Pennine Acute Hospital Trust	Y
Robert Hirst	Senior Pharmacist	Tameside Foundation Trust	Y
Robert Hallworth	Lead Pharmacist – Medicines Management – Provider Services Specialist Cancer Pharmacist – CWW LAT, NHS England	Pennine Care NHS Foundation Trust	Y
Lesley Smith/ Sarah Harris	Chief Pharmacist (Mental Health)	Pennine Care NHS Foundation Trust	Y
Dr Simon Darvill	Consultant Psychiatrist	Pennine Care NHS Foundation Trust	Y
Gary Masterman	Deputy Chief Pharmacist	Wigan, Wrightington and Leigh Foundation Trust	Y
Anna Swift	Medicines Management Pharmacist	Wigan CCG	Y
Roisin McCanney	Senior Pharmacist (mental health)	Manchester Mental Health and Social Care Trust	Y
Vanessa Reid	Lead Pharmacist	CMFT	Y
Bernadette Bennie	Shared Care Pharmacist	Greater Manchester West Mental Health Trust	Y
Andrew Martin	Strategic Medicines Optimisation Pharmacist	Greater Manchester Shared Services (part of North West CSU)	N (support)
Gavin Mankin	Principal Pharmacist Medicines Management	Regional Drug & Therapeutics Centre, Newcastle	N (support)

### Process for RAG rating reviews



## Process for Shared Care Protocol reviews

