Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Prescribing Framework 2025-2026

Contents

General

This Prescribing Framework will be applicable and should be delivered in full by any provider, commissioned to provide NHS services to patients within Cambridgeshire and Peterborough.

Provision of NHS services commissioned by Cambridgeshire and Peterborough Integrated Care Board should be accordance with the NHS Cambridgeshire and Peterborough Medicine Standards.

All health care professionals in Cambridgeshire and Peterborough should align with both our system wide formulary (C&P netFormulary) and local, regional, or national treatment pathways. These have been endorsed for use across the Integrated Care System (ICS) by the Cambridgeshire & Peterborough Joint Prescribing Group (CPJPG), or with respect to clinical policies, the C & P Clinical Policies Forum (CPF). Any deviation from these must be clearly documented in the individual patient's medical record providing clear, robust evidence-based rationale for the decision made.

The range of healthcare professionals now authorised to prescribe medicines has broadened and continues to expand. This Prescribing Framework relates to all those professionals with responsibility for prescribing.

In addition to this Prescribing Framework, all health care professionals should also adhere to the Cambridgeshire and Peterborough system agreed 'Working Together Guiding Principles':

1. Keep the Person at the Centre of Decisions.
2. Considerate, Good Quality and Timely Communications with Local People and Colleagues.
3. Respect Clinical and Professional Accountability and Responsibility.

For this Prescribing Framework, a prescribable product refers to any medication, appliance, dressing, reagent or nutritional product which can be prescribed via a prescription in primary or secondary care. This includes items which are procured through the NHS Supply Chain, or direct from suppliers in provider Trusts, but are eligible to be prescribed on a prescription in primary care.

Formulary Adherence

The Cambridgeshire and Peterborough system wide formulary (C&P netFormulary) is agreed jointly by both primary and secondary care clinicians in line with the Cambridgeshire & Peterborough Joint Prescribing Group Terms of Reference.

All providers within Cambridgeshire and Peterborough should adhere to the system wide formulary and ensure that it is published and readily available to the providers clinicians

Clinicians who do not adhere to the formulary, including the wound, continence, stoma and nutrition formulary subsections, and prescribe medications, dressings, devices or nutritional feeds which are deemed non-formulary, will be requested to justify their prescribing unless it is clear in the patient's clinical records or on transfer between providers why this decision has been made. Unless it is deemed clinically appropriate to continue to use a non-formulary medicine, an alternative formulary product will be expected to be prescribed. Non-compliance with the formulary should be clearly documented in the patient's medical notes with the rationale for prescribing.

Where a non-formulary product is agreed to be implemented as a system to mitigate against a shortage this will be agreed through the System Wide Medicines Shortage Group and communicated through the system formulary and the ICS Medicines Supply Information webpage.

Any medication deemed 'Restricted - Hospital only, not to be prescribed in primary care (Red)', as listed in the system wide formulary, must not be prescribed in primary care. Consultants or specialists who wish to use this medication will be expected to maintain the supply and accept the clinical responsibility including prescribing and any relevant monitoring unless agreed differently through the Cambridgeshire and Peterborough Joint Prescribing Group. They will also be required to accept financial responsibility, unless considered excluded within the National Payment Scheme and in line with agreed commissioning criteria. Patients who are on hospital only medication should not be discharged from the care of the prescribing clinician.

Organisations are expected to monitor compliance to the formulary and have a mechanism in place to challenge non-formulary prescribing.

Where non-formulary prescribable items are initiated and there is no clear rationale in the individual patients' record, and a formulary item would have been clinically acceptable, the prescribing should be reviewed either by the prescriber or where this has been on the recommendation of another clinician, that original clinician.

Generic Prescribing

Generic prescribing can help mitigate medicine shortages by allowing pharmacists to dispense any suitable generic or branded product when a specific product is unavailable. This flexibility can reduce delays in supplying medicines to patients and ensure access to treatment.

In line with 14.9 of the Standard General Medical Services Contract, all prescribers across Cambridgeshire and Peterborough should prescribe generically in accordance with the Generic and Branded Medicine Prescribing Policy unless there are national recommendations which advise brand prescribing is required or the patient has a confirmed allergy to a specific excipient which is documented in the patient's clinical record.

Biosimilar Prescribing

In line with the NHS Standard Contract Service Condition 39.11, 14.9 of the Standard General Medical Services Contract, the 2025/26 Priorities and Operational Planning guidance, and Commissioning framework for biological medicines providers must improve prescribing by ensuring that patients are prescribed the best value biological medicine where a biosimilar medicine is available.

The best value biological medicine will be that which is agreed through the Cambridgeshire & Peterborough Joint Prescribing Group.

Where a national reference price has been agreed for biological medicines, this will be paid by the Commissioner. The national reference price will include costs for the delivery of additional clinical capacity required to facilitate a switch should this be required.

Where a biosimilar medicine is available which is considered excluded within the National Payment Scheme and a national reference price is not available, and the timescales for implementation as included in the Biosimilar Service Development Improvement Plan (SDIP) are not met by a Provider, the Integrated Care Board will default to payment in line with the best value biological medicine, as detailed in the NHS Standard Contract Service Conditions 39.4. The only exceptions will be individual patient cases (which the ICB have been notified of in advance), or circumstances outside of the Providers control (for example stock shortages).

Prescribing of Unlicensed Medicines, Licensed Medicines for Unlicensed Indications and 'Specials'

In line with Regulation 167 of the Human Medicines Regulations 2012 an unlicensed medicine should only be supplied when there is no licensed available medicine that can meets the clinical needs of an individual patient.

Health care professionals within Primary Care across Cambridgeshire and Peterborough should prescribe and dispense in accordance with the Recommendations to Prescribers on the use of

Unlicensed Medicines and Licensed Medicines for Unlicensed indications in Primary Care.

NHS Trusts and other secondary care providers should have internal policy regarding the use of unlicensed medicines and licensed medicines for unlicensed indications which should be followed.

The Neonatal and Paediatric Pharmacy Group (NPPG) and the Royal College of Paediatrics and Child Health (RCPCH) strongly recommend that when children require liquid medications, they should receive the RCPCH and NPPG recommended concentrations, where one exists. All health care professionals in Cambridgeshire and Peterborough are expected to adhere to these recommendations.

Where an individual patient requires an unlicensed medicine which are also known as 'specials' (products which have been specially manufactured or imported for the treatment of an individual patient, or provision of a unlicensed supplement), this should be prescribed in line with Part VIIIB of the Drug Tariff where clinically acceptable. Part VIIIB - Arrangements for payment for Specials and Imported Unlicensed Medicines Where more than one formulation within Part VIIIB of the Drug Tariff would be clinically acceptable for the individual patient, the lowest cost formulation should be prescribed unless an alternative formulation is listed in the system agreed formulary.

Where the clinical needs of an individual patient require a special to be prescribed outside of Part VIIIB, the most cost-effective supply route should be agreed. Where the initiating prescriber is outside of General Practice, for example in secondary care, secondary care organisation should retain prescribing of the unlicensed product where this is the most cost-effective supply option.

Where a cost-effective supply can be obtained in the community and General Practice has the expertise to prescribe, the Provider Trust will provide the patient, GP and patient's chosen community pharmacist where possible, with the details of the supplier and the lead time needed to obtain the medication. With the patient's agreement a referral through the Discharge Medicines Service should be considered to the patients nominated Community Pharmacy, to support with continuity of care.

Wound Care Prescribing

General Practice, nursing homes and community-based services (where the ICB directly funds wound care prescribing), must obtain dressings through the NHS supply chain in line with the system-wide formulary and Wound Care Formulary Guidelines. This will also allow dressings to be available to clinicians at the point of patient care.

FP10 prescribing is not supported unless a Tissue Viability Nurse or clinician with expertise in wound care confirms that a formulary dressing does not meet the clinical needs of an individual patient, and this is documented in the patient's clinical record.

Non-Prescribable (not in drug tariff) Medical Devices

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

Where a medical device and associated consumables can be prescribed on a FP10 and have been recommended through Cambridgeshire and Peterborough Joint Prescribing Group or the East of England Priorities Advisory Committee as suitable for prescribing in Primary Care, the principles above, as defined for medication, apply for medical devices and the associated consumables.

General Practice are unable to prescribe medical devices or appliances which are not listed in the Drug Tariff.

Where a non-prescribable medical device is issued by the Trust, all subsequent costs for replacement of the device or consumables used with the device (if not prescribable), and any associated maintenance or servicing will be the responsibility of the initiating Trust, unless considered excluded within the National Payment Scheme and in line with agreed commissioning criteria.

Formulary review participation

All provider Trusts are expected to contribute to the maintenance/review of the system -wide formulary through Formulary Subgroup attendance. Stakeholder input will be in line with the Formulary Subgroup Terms of Reference.

Organisations, or their nominated representatives, must submit their feedback on proposed formulary changes, updates, or removals by the specified deadline. The review timeline and deadlines will be clearly communicated to all required stakeholders and will allow at least 3 weeks to feedback, unless there is an urgency to amend the formulary due to medication shortages or a clinical / safety concern. If a stakeholder fails to provide feedback by the stated deadline, it will be assumed that they agree with the proposed changes.

Any formulary decisions, for prescribable products, which will impact other organisations including Primary Care, must be reviewed through the Cambridgeshire & Peterborough Joint Prescribing Group, before being agreed and implemented.

Implementation of formulary decisions agreed through the Cambridgeshire & Peterborough Joint Prescribing Group

All health care professionals in Cambridgeshire and Peterborough must adhere to the system wide formulary and implement the recommendations of the Cambridgeshire and Peterborough Joint Prescribing Group within 3 months of decision approval, or sooner where the decision relates to

patient safety. This is with the exception to any NICE Technology Appraisal where the timeframe for implementation is directed by the Secretary of State.

A programme for ongoing training of healthcare professionals including locum/bank staff to ensure awareness of the local formulary and how this can be accessed must be in place across all ICS providers to ensure implementation of formulary decisions within timescales agreed.

Pharmaceutical Company Funded Roles

NHS trusts or commissioned organisations with posts funded by the pharmaceutical industry must have formal governance measures in place to ensure that prescribing decisions are based solely on clinical need, and free from pharmaceutical influence.

Organisations across both primary and secondary care using pharmaceutical funded workforce must be able to provide assurance that prescribing is impartial and complies with local formularies.

Shared Care

A number of formal shared care arrangements between primary and secondary care have been endorsed by the Cambridgeshire and Peterborough Joint Prescribing Group and are available through the system wide formulary or ICB website Shared Care Guidance | CPICS Website.

If a primary care clinician is uncertain about their competence to take responsibility for the patient's continuing care, they should seek further information or advice from the clinician with whom the patient's care is shared or from another experienced colleague within their practice.

If the primary care clinician feels that the request for shared care is clinically inappropriate for an individual patient, with respect to medication safety or complexity of condition, then the primary care clinician is entitled to refer the patient back to the initiating provider and decline shared care. The management of that patient will need to be retained by the Provider Trust including the supply of medication and any required monitoring.

To support patient choice, where a patient is seen by an NHS commissioned provider outside of Cambridgeshire and Peterborough (this would under Right to Choose who hold a qualifying contract with an NHS commissioner), these principles also apply to any shared care agreement which has been approved through those providers Integrated Care Board or equivalent NHS committee (it should be clear on the shared care agreement who the commissioner of the service is and their ratification process).

Self-Care

Over the counter (OTC) medicines and nutritional supplements can be purchased from a pharmacy, any general store or online. People should be supported to manage their own care.

In line with section 14Z51 of the NHS Act 2006 all organisations, including Provider Trusts, within Cambridgeshire and Peterborough should have a self-care policy which aligns to the ICS Self Care Policy and NHS England Policy on Conditions for which over the counter items should not be routinely prescribed in Primary Care.

Where patients are seen in either an outpatient or inpatient setting communication to both the patient and the patients General Practice should be clear that medicines which are suitable for self-care should be purchased in line with the ICS Self Care Policy and not recommended for prescribing in primary care.

Organisations are expected to monitor compliance to their policy and have a mechanism in place to address prescribing which does not align. Compliance can be monitored through ePACT2 (Oracle Analytics Interactive Dashboards - OTC Prescribing).

Items which should not be routinely prescribed

In line with section 14Z51 of the NHS Act 2006 all organisations, including Provider Trusts, within Cambridgeshire and Peterborough should adhere in full to the recommendations of NHS England in relation to items which should not be prescribed in primary care because they are unsafe, ineffective for some or all patients, or are not cost-effective.

Organisations are expected to monitor compliance to their policy. Compliance will be monitored through OpenPrescribing and ePACT2 (Oracle Analytics Interactive Dashboards - Items not for Routine Prescribing).

Where prescribing in General Practice is identified outside of this policy as directed by secondary care, prescribing and any associated monitoring will be repatriated to the initiating organisation where the medication will be deprescribed or prescribing and associated monitoring retained by the initiating clinician.

Antimicrobial Stewardship (AMS)

All Primary and Secondary care organisations must have processes in place to monitor prescribing of antimicrobials across all services, in line with Criterion 3 in the Health and Social Care Act 2008- Code of Practice on the prevention and control of infections, NHS Standard Contract SC21, Network Contract DES, NICE NG 15 AMS guidance and formulary.

This would typically include a programme of regular audit, access and use of current evidence-based guidance and ongoing training of healthcare professionals, including locum/bank staff.

All NHS commissioned organisations will align prescribing so as to achieve national targets based on the National Action Plan for 2024-29, in order to optimise patient safety and help decrease the spread of antimicrobial resistance which will also decrease patient morbidity and mortality.

Transfer of Care Prescribing Responsibilities

Outpatient / Emergency Department / Urgent Treatment Centre / Pre-assessment Clinics

In accordance with the NHS Standard Contract Service Conditions 11.9, it is the responsibility of the outpatient clinic (including pre-assessment clinics), emergency department (ED), or urgent treatment centre (UTC), where there is an immediate clinical need (agreed locally as within the next 14 days) for the patient to receive a prescribable product or where the formulary classification is specialist initiation, shared care, or hospital only, to supply the required medication.

Either a hospital prescription, a FP10HP, FP10, pre-pack, or the prescription medication sent through the post, for an appropriate amount of the prescribable product for example, a defined course of antibiotics or steroids, an original pack of medication, or at least two weeks wound care (where clinically needed), stoma or continence consumables.

In instances where the outpatient clinic, ED, or UTC prescriber diagnoses the patient as requiring acute medicines i.e. a defined short course of antibiotics or steroids, the entire course will be supplied through the prescriber's organisation, even where this is deemed not clinically urgent.

When a course of treatment, for example eye drops are supplied, and patient administration technique may be a concern, sufficient supply should be made by the prescribing clinician to cover any potential wastage through patient administration error. The patients primary care clinician should be notified of this.

Where a new prescribable product is started or there is a change to existing medication, this will be communicated to the practice within 7 days to allow for the patient's primary care record to be updated.

Where a new or change of prescribable product (suitable for prescribing in Primary Care (Green or Specialist Advice)) is deemed appropriate but there is no immediate clinical need for the prescribable product to be started or changed (not needing to occur within at least the next 14 days), the outpatient clinic, ED or UTC prescriber can request that the patients GP consider prescribing. This can be via a letter or electronic transfer. The decision to prescribe rests with the GP and the prescription will be generated in the usual manner according to the local GP practice protocols. The provider trust

must have processes in place to ensure that patients are advised in writing of this and requested not to contact their GP practice until at least 14 days post their outpatient clinic, ED or UTC attendance, to allow the provider Trust communication to be received and reviewed. Where a GP disagrees with the recommendations, or the prescribable product being recommended is non-formulary, a discussion should be held between both health care professionals to resolve.

For any medication deemed 'Restricted - Hospital only, not to be prescribed in primary care (Red)', Specialist Initiated or Shared Care, as listed in the system wide formulary, the prescribing clinician must follow the principles within this Prescribing Framework for those formulary categories.

Discharge Prescribing

Patients admitted to hospital should ideally bring all current medications with them to hospital. All Provider Trusts operate a Patient Own Drug policy (POD). This ensures that where appropriate patient's own medication is used while they are in hospital, which aids medicines reconciliation and avoids undue waste.

Trusts will not ask patients to request their repeat prescriptions early to cover their stay in hospital. The cost of medications provided to patients when in hospital is in the Trust's baseline unless excluded within the National Payment Scheme.

Inpatient stay of less than 120 hours

Patients who are admitted and stay within the Trust for less than 120 hours from the decision to admit, including short stay surgical patients, will only be supplied with new or changed medication. This should be reflected in the discharge summary.

Responsibility for continued supply of all other medication, medical devices or appliances remains as prior to the short stay admission.

Where a patient's medication, medical devices or appliances are changed during inpatient or day case stay, the Trust will ensure that the patient is provided at discharge with a minimum of 14 day's supply or sufficient to finish a treatment course with the exception of the following:

- Patients requiring pain medication post an acute intervention – a suitable quantity, normally up to a maximum of 14 days or a sufficient quantity as deemed suitable for the individual patient, should be provided to cover the patient until the point where the patients pain can be managed with over-the-counter treatments in discussion with their local pharmacist. This should be clear on the discharge summary. Primary Care should not be requested to prescribe pain medication for symptom management of an acute intervention.
- In instances where the Provider Trust are supplying acute medicines e. g. a defined course of antibiotics, refeeding vitamins & minerals, steroids and low molecular weight heparin (LMWH)

the Provider Trust will supply the entire course unless agreed with the patient and GP in advance or where it would be clinically inappropriate or unsafe to do so.

- Where a course of medication is longer than 14 days, the duration of the course must be made explicit on the discharge summary if clearly defined / known at the time e.g. Folic acid prescription for 4 months. Continuation of prescribing will be in line with the formulary status of that medication.
- If there are clinical concerns for individual patients e.g., risk of overdose then, in liaison with the patient's GP, less than 14 days may be supplied.
- Where medicines have been prescribed during the admission which would be suitable for self-care, communication to both the patient and the patients General Practice should be clear that in line with the ICS Self Care Policy they are not recommended for continued prescribing in primary care, where the patient is willing and able.

Inpatient stay of 120 hours or longer

When a patient's own medication, medical devices or appliances have been used in hospital and the patient has a length of stay of 120 hours or more, the Provider Trust will ensure that the patient either has an adequate supply at home (minimum of 14 days) or is provided at discharge with a minimum of 14 days' supply or sufficient supplies to finish a treatment course.

Where a patient's medication, medical devices or appliances are changed during an inpatient stay, the Trust will ensure that the patient is provided at discharge with a minimum of 14 day's supply or sufficient to finish a treatment course, noting any exceptions as above (inpatient stays of 120 hours or less).

Discharge Medicines Service

In accordance with the NHS Standard Contract Service Conditions 11.13, all NHS Trusts must use all reasonable endeavours to refer Service Users, on discharge from inpatient care and where clinically appropriate, into the NHS Discharge Medicines Service, in accordance with the NHS Discharge Medicines Service Toolkit (as stipulated in the providers Service Development Improvement Plan) and in accordance with NHS guidelines to increase medication safety for patients and to ensure seamless transfer on discharge from hospital.

The Discharge Medicines Service is an essential service under the Community Pharmacy Contractual Framework which should be implemented in full for all referrals received.

The majority of the referrals are expected to be from high-risk cohorts, including but not limited to:

- Patients on high-risk medications (e.g. anticoagulants, opioids, insulin).
- Patients with complex polypharmacy.

- Patients with a history of medication-related hospital admissions.
- Older adults or those with frailty who may require additional support.
- Patients who are prescribed a 'special' (i.e. an unlicensed medicine which is made specifically for a patient from a third-party provider).
- Patients with significant medication changes during their hospital stay.
- Patients discharged from virtual wards.
- Patients who need nutritional support which requires continuation in the community.
- Vulnerable patients.

Medication Compliance Aids

Use of original packs of medication, along with appropriate support (e.g. medication reminder charts) is the preferred option for most patients as there is limited evidence that medicines compliance aids improve compliance with medicines. This approach is endorsed by The Royal Pharmaceutical Society, NICE and the Care Quality Commission.

In line with the Care Quality Commission recommendations, when there is a requirement for medicines support to continue to remain independent, a medication review should be undertaken to simplify the medicines regimen where clinically possible NICE guidance (NG67) states: "*Consider using a monitored dosage system only when an assessment by a health professional (for example, a pharmacist) has been carried out, in line with the Equality Act 2010, and a specific need has been identified to support medicines adherence".*

In Primary Care, where a medicines compliance aid is agreed as the most appropriate and safe method of dispensing for an individual patient aligned to the Equality Act 2010, seven-day prescriptions are only needed if a joint decision has been made by the prescriber and pharmacist, on clinical grounds, that medication should be issued to the patient on a weekly basis. If a 28-day prescription is issued, where weekly medicines compliance aids are filled, all four will be issued at once.

Where a patient is discharged from a Trust into the Community and the patient continues to require a medicines compliance aids,7 days' supply of medication will be provided. Unless the patient declines consent, a referral through the Discharge Medicines Service must be made to the patients nominated Community Pharmacy.

Where a patient requiring a medicines compliance aid declines consent for a referral through the Discharge Medicines Service, 14 days' supply of medication will be made to allow the patient to obtain further supplies in Primary Care post discharge.

Virtual Ward Prescribing

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. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital.

Responsibility for the supply and funding of medicines (unless excluded within the National Payment Scheme) and all other prescribable medical devices, nutrition products and consumables to patients whilst admitted to virtual wards remains with the provider. Upon discharge from virtual wards providers will ensure patients are supplied with at least 14 days' worth of medication or enough to complete the course. Exceptions to 14 days' supply are as described above.

Aligned to the virtual wards operational framework and Guidance on Pharmacy Services and Medicines Use within Virtual Wards, on discharge relevant information about changes to a patient's medicines should be shared with the patient's GP and Community Pharmacy. Reasonable endeavours to make a referral to the Discharge Medicines Service should be made if clinically appropriate.

Palliative Care Prescribing

Where palliative care medications are needed in the Community, they should be prescribed in appropriate quantities to meet the clinical needs of the individual patient (whole packs where clinically acceptable), being mindful of pack sizes. Injectable medications usually come in packs of 5 or 10 and should not be split.

All settings in the Integrated Care System (ICS) where palliative care medicines are administered by continuous subcutaneous infusion (CSCI) via a syringe pump to adults by suitably trained practitioners, including patient's homes, residential homes, community hospitals, hospices and other clinical areas, should align with the Syringe Pump Policy for End-of-Life Continuous Subcutaneous Infusions (Adults) This policy aims to establish safe and consistent practice in the use of syringe pumps in line with national guidance, evidence and best practice, to reduce risk, minimise errors and maintain the safety of patients.

The prescribing of anticipatory medication should be discussed as part of the advanced care planning discussion, and the patient's decision should be documented and coded appropriately, so they can be identified by clinical searches for medication reviews.

When prescribing anticipatory medication, a copy of the Cambridgeshire and Peterborough End of Life Care Medicine Administration Record (EOLC MAR) Chart should be completed manually or electronically, and a physical copy should be provided alongside the Anticipatory Medicines Patient Information Leaflet, where the key contact details should be recorded for the patient.

If a completed EOLC MAR chart cannot be supplied at discharge, a duplicate inpatient chart or an after-visit summary/discharge summary should be provided with the discharge prescription and labelled medication for community nurses to use.

For further information, please refer to the ICS Anticipatory Prescribing Policy.

Nutrition Products

Oral Nutrition Supplements (ONS)

The prescribing of oral nutritional support (ONS) by clinicians across Cambridgeshire and Peterborough should be in line with Local Pathways and Guidelines | CPICS Website (Nutrition section)

As included in the NHS Standard Contract Service Conditions SC19, all Provider Trusts must comply with the National Standard for Healthcare Food and Drink.

Patients requiring ONS on discharge should be provided with advice on 'Food First' and homemade supplements, even if they have been receiving ONS whilst as an inpatient.

Where patients have been receiving ONS in the hospital or inpatient setting, but there is no clinical need for this to be continued post discharge, the trust must have in place a process to ensure that this does not appear on the discharge summary or on the MAR chart.

Where ONS is clinically indicated and the patient is likely to need ongoing nutritional support, a minimum of 14 days ONS should be provided on discharge by the Provider Trust.

To ensure appropriate referrals and improve system waiting times for patients, Provider Trusts should ensure that patients who continue to require nutritional support receive a follow-up phone call, prior to the ongoing request for ONS prescriptions from General Practice, or referral to community dietetics.

Should ongoing dietetic input be required after this assessment, prescribing of oral nutrition supplements **should not** be considered 1st line. Local Pathways and Guidelines | CPICS Website (Nutrition section).

If community criteria for requesting ONS are met, ongoing supply must be in line with the system wide formulary choices, which will necessitate a change of product.

Specialist Infant Products including those for Cows Milk Protein Allergy (CMPA)

All relevant provider trusts must be participants in the Baby Friendly Initiatives (BFI) and either have started the process or are awaiting review of their accreditation. All policies and clinical recommendations for infant formula/ infant feeding should be in line with the BFI standards.

Clinician should not request/advise or prescribe infant formulas which recommend reconstitution with water below 70°C (e.g. room temperature or cooled boiled water). These products do not follow WHO guidelines on safe infant formula reconstitution and increase the risk of illness related to bacterial contamination.

In line with BFI Clinicians should ensure that families are supported to breastfeed for the management of cow's milk protein allergy (CMPA) where this is clinically appropriate.

CMPA Products which contain Probiotics/ Syn-biotics/GOS/FOS are legally prohibited from making health claims related to this (pursuant to Regulation 2016/127.) Clinicians should not prescribe/request/endorse these products as the DHSC has deemed the evidence insufficient.

The prescribing of infant formula for the management of CMPA by clinicians across Cambridgeshire and Peterborough should be in line with Cow's Milk Allergy Pathway including formulary choices and prescription volumes. At 12 months infants should be transitioned onto an appropriate plant alternative milk drink and prescription of infant allergy formula should be stopped. Please see local guidance for further support on this transition.

All extensively hydrolysed formulary (EHF) and amino acid formulas (AAF) have the same clinical efficacity in managing CMPA. An extensively hydrolysed formula (EHF) can control symptoms in 90% of CMPA, including mild-moderate IgE-mediated allergies, and considered 1st line. In less than 10% of cases, for severe CMPA, amino acid formulas (AAF) can be used. ALL children using an amino acid formula (AAF) should be known to a dietitian due to regular monitoring of micronutrients required in long term AAF patients.

Where cow's milk protein allergy is diagnosed in hospital or in an outpatient clinic, patients should be given a supply of an appropriate formula prior to GP prescription issue. Patients should be advised that an alternative equivalent brand formula may be supplied in their local area.

Tube feeds and metabolic products

A minimum of 14-days' supply should be provided by the hospital at discharge.

Where patients require nutrition products essential to life (e.g. PKU products), or a sudden cessation would result in potentially serious adverse reactions (e.g. patients on a ketogenic diet) and these can

be prescribed on a FP10 (included in Part XV of the Drug Tariff), the initiating Provider Trust should work with General Practice to ensure that there will be continuity of supply in primary care before the patient is discharged.

Probiotics

Clinicians must not request or prescribe probiotics, in line with NHS England policy, as there is insufficient evidence to support their clinical benefit.

Probiotic products have been removed from Part XV of the Drug Tariff and are no longer ACBS endorsed due to the lack of evidence for benefit.

Oxygen

All costs associated with emergency supply of oxygen for patients being discharged by the Provider Trust will be recharged to the Provider Trust unless the patient has been hospitalised for less than 24 hours.

Home Oxygen Therapy patients

The British Thoracic Society has published Quality Standards for acute Non-Invasive Ventilation, following the National Enquiry into Patient Outcome and Death, 'Inspiring Change' which highlighted a mortality rate of over a third for patients receiving NIV. Providers who prescribe home oxygen are expected to comply with these standards.

- It is the responsibility of the initiating service to ensure that all patients started on home oxygen, undertake a holistic risk assessment that includes assessment of smoking status and other fire and falls risks before home oxygen is prescribed.
- It is the responsibility of the initiating service to ensure that all patients started on home oxygen are followed up with a blood gas assessment within 3 months of initiation of therapy where clinically needed; this includes those patients who are discharged home from hospital on oxygen for the first time.
- It is the responsibility of the initiating service to ensure that follow-up visits at 6–12 months post the patients initial 3-month follow-up, and annually (as a minimum) thereafter are undertaken to ensure that oxygen provision continues to be required and meets the patient's clinical needs. This can either be home based or in combination with hospital visits.
- It is the responsibility of the initiating service to ensure that patients who are identified as no longer requiring home oxygen have this withdrawn.

National Medicine Optimisation Opportunities and Best Value Frameworks

In line with the NHS Standard Contract Service Conditions 3.20 and Standard General Medical Services Contract 14.9, providers in both primary and secondary care are expected to have strategies in place to

deliver the national medicine optimisation opportunities and best value frameworks (section 39.3 of the NHS Standard Contract Services Conditions) and be able to demonstrate delivery in these areas.

Organisations are expected to monitor compliance and have a mechanism in place to address unwarranted variation. Compliance will be monitored through ePACT2 Oracle Analytics Interactive Dashboards - National MO Opportunities Dashboard

Sustainability

Medicines account for around 25% of NHS emissions. All organisations should have plans in place to build on progress in reducing "point of use" emissions, while improving patient care and reducing waste.

All organisations in line with the NHS Standard Contract Service Conditions 18.3.2.5 should have processes in place to support high-quality, lower-carbon respiratory care, including supporting patients to choose the most appropriate inhaler(s) in alignment with local clinical guidelines, performing inhaler technique checks with patients and promoting the appropriate disposal of inhalers.

Where a change in inhaler brand is a simple switch (i.e. inhaler device remains the same) for example MDI to MDI containing the same active ingredients, all organisations will align with the formulary for both new and existing patients.

In line with Network Contract DES 8.4.2, Standard General Medical Services Contract 14.9 and NHS Standard Contract Service Conditions 3.20 providers should have processes to address overprescribing and oversupply. Where overprescribing and oversupply of prescriptions items is identified and there is no clear clinical rationale in the individual patients records the prescriber will be responsible for reviewing the patient and deprescribing where medication is no longer needed or aligning to acceptable prescribing quantities. Compliance will be monitored through ePACT2 Oracle Analytics Interactive Dashboards - Oversupply Dashboard.

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