Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Harrogate and Rural District Clinical Commissioning Group

Scarborough and Ryedale Clinical Commissioning Group

Policy on

BRAND AND GENERIC PRESCRIBING OF MEDICINES

		Date
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The on-line version of this policy is the only version that is maintained. Any printed copies should therefore be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

Version number	By	Nature	Approved by	Approval date	Internet updated

To request this document in a different language or in a different format, please contact the CCG at:

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CONTENTS

1. INTRODUCTION

1.1 The Clinical Commissioning Group (CCG) wants to commission best value treatment for local patients and wants the right clinician to have responsibility for those treatments. We want patients to have access to medicines which improve the quality of their care, that have demonstrated cost effectiveness and are safe.

1.2 The CCG wants to ensure that only treatments that are clinically effective and provide a clear health benefit to patients are prescribed on NHS prescriptions. This will help ensure that NHS resources are used most effectively to provide interventions with a proven health gain for the population. The CCG prioritises the use of these resources based on the value of treatments or interventions, using the following features and evidence to assist: comparative clinical effectiveness and health outcomes; safety data; cost effectiveness; patient acceptability.

1.3 The CCG identified there are potential savings within current NHS prescribing patterns by prescribing some drugs by their generic (recommended International Non-propriety (rINN)) name and further savings by prescribing other drugs by a brand name.

1.4 The policy aims to provide clarity on the CCG position on the prescribing of drugs by generic or brand; aiming to ensure clinical standards are maintained, do not conflict with GMC guidance or contractual requirements, and provide best value for limited NHS and public resources.

2. POLICY STATEMENT

2.1 The CCG aspires to the highest standards of corporate behaviour and responsibility. It is the role of the CCG to manage the local medicines bill, to ensure the most clinically appropriate, cost effective and safest use of medicines across the locality. This policy represents best practice and supports the requirement of the NHS to make best use of NHS resources.

3. IMPACT ANALYSES AND SCOPE

3.1 Quality and equality - As a result of performing a screening analysis, the policy does not appear to have any adverse effects on quality or on people who share protected characteristics and no further actions are recommended at this stage. The results of the screening tool can be viewed in appendix 1.

3.2 Sustainability - A Sustainability Impact Assessment identified no negative and one positive impact. See appendix 2. During consultation, Community Pharmacy West Yorkshire (CPWY) stated that "*the prescribing of branded generics has a negative impact on community pharmacy funding*". However, aims of the policy are to keep generic prescribing rates as high as possible and to only recommend the use of brands or branded generics where considerable and unnecessary additional NHS costs are incurred by CCG commissioners due to the:

- use of expensive brands (when non-generic prescribing is standard practice)
- national generic pricing model is considered by the CCGs to be too slow in reducing NHS Drug Tariff prices for generics; this should be very rare.

3.3 Privacy - As a result of performing a screening analysis, the policy does not appear to have any adverse risk on the privacy or confidentiality of any individual. The results of the screening can be viewed in appendix 3.

Scope

3.4 This policy applies to all prescribers (including non-medical prescribers) within providers of primary care services in the CCG. The CCG expects all prescribers, be they GP partners, salaried staff or locums, within GP practices or services such as Out of Hours, to comply with the arrangements outlined in this policy. While the policy does not extend to secondary care providers, recommendations and decisions on individual drugs should both consider and influence the position of relative secondary care providers to support consistency.

3.5 The content of this policy is considered to be best practice and supports the use of the requirement of the NHS to make the best use of NHS resources. It should avoid any conflict with GMC guidance or GP practice NHS contractual requirements.

3.6 The scope of this document is to establish a policy for prescribers on the rationale for generic and branded prescribing within the CCG area and to detail the basis on which exceptions are considered appropriate.

4. POLICY PURPOSE AND AIMS

4.1 The CCG wants to ensure that only treatments that are clinically effective and provide a clear health benefit to patients are prescribed on NHS prescriptions. This is to ensure that CCG resources provide interventions with a proven health gain for the population. The CCG prioritises the use of these resources based on the value of treatments or interventions, using the following features and evidence to assist: comparative clinical effectiveness and health outcomes; safety data; cost effectiveness; patient acceptability.

4.2 All other treatments should be considered as less suitable for prescribing on NHS prescription.

4.3 This supports the following GMC guidance: ‘You must make good use of the resources available to you’. Variance from this position will limit the resources available for the provision of healthcare to other members of our population.

5. PRINCIPAL REASONING FOR GENERIC PRESCRIBING

5.1 The use of generic drug names is the preferred option in most cases. Major factors in favour of this position are:

- For the vast majority of NHS prescriptions, using the generic drug name attracts a lower cost to the NHS than using a brand name.
- Dispensing options are broader if an item is prescribed generically, allowing any branded or generic version that meets the specification on the prescription to be dispensed. This is particularly beneficial when there are shortages or

delays in the supply of medicines. Prescribing by brand restricts primary care dispensing contractors to supplying that brand only.

- Procedures for the licensing of drugs for the UK and European markets require each drug to satisfy rigorous initial and ongoing tests to ensure appropriate equivalence (bioavailability and release profiles) to products already licensed. While the 'non-drug' ingredients can vary between different manufacturers, the effectiveness of the drug should not be affected. Exceptions to this are identified in section 6 of this policy 'Principal Reasoning for Branded Prescribing'. But in most cases, generic versions offer an alternative means of prescribing without affecting the clinical care of the individual. There is little robust evidence that switching between different manufacturers of a generic product is clinically significant.
- Improved familiarity with drug names reduces the risk of confusion by patients, carers and clinicians, especially those in wider access services like Accident and Emergency or Out of Hours. Familiarity with drug names assists patients' compliance with their medicines regimes and assist carers and clinicians to make the best clinical decision for the patient. It is difficult to remember the names of the many frequently used generic drugs; the use of various brand or branded generic names increases this problem, risking error and confusion. Where clinically appropriate to do so, using the generic name is the most assured option to longer term consistency. Overuse of brand names can increase confusion and uncertainty around patients' drug regimes.
- Initiating generic prescribing from the outset removes the need for future review of repeats. When the patent for a brand subsequently expires then the financial benefits of lower cost generics can be realised faster.

5.2 To support the case for generic prescribing, there are also reasons why branded or branded generic prescribing is not (or is less) appropriate:

- Branded (or branded generic) prescribing can undermine the competitive market, which the NHS relies on to keep drug costs low. Drugs in 'category M' of the NHS Drug Tariff account for the majority of items prescribed on the NHS and their prices are greatly affected by this. Prescribing by brand removes these lower cost products from the review and control of category M prices.
- The low price of a brand or branded generic can be short-term, therefore sustaining maximum financial benefit for the NHS requires ongoing review and potentially further changes to drug names. Keeping patients on the same drug while changing the name (to generic, branded-generic or brand) can also be confusing for patients (and clinicians not fully versed in the change). Where clinically appropriate to do so, using the generic name is the most assured option to longer term consistency.
- When generic prescribing is more cost effective than branded or branded generic prescribing, in the better interests of CCGs' NHS commissioning budgets and our wider population, prescribers should NOT prescribe using brand or branded generic names. The expected default position of the GP would be to prescribe generically but also see 9.1. Exceptions to this are identified in section 6. Although a CCG cannot formally prevent GPs from prescribing a drug that is not on the NHS Prescription of Drug Regulations

"Banned and Restricted Drugs List", it can guide practices to do so if there is good reason. It is for NHS England to decide if there is any breach to GMS Contract Regulations that provide that a contractor must not prescribe products the cost or quantity of which is in excess of that which was reasonably necessary for the proper treatment of the patient.

6. PRINCIPAL REASONING FOR BRANDED PRESCRIBING

6.1 This section applies to branded or branded generic prescribing.

6.2 A branded generic is the brand name given to a generic drug from a specific manufacturer that is not an original brand. Branded generics and generics are effectively bioequivalent to the original (innovator) brand, but once the original brand name has come off patent it can be marketed under another company's brand name or under its generic name.

6.3 The use of generic drug names is the preferred CCG option in most cases. However, major factors in favour of the use of brand names are:

- Proven and true clinical hypersensitivity to any of the excipients in other generic or branded versions of that same drug (same strength, release rate and dosage form). Such cases tend to be rare and should not have a significant impact on generic prescribing rates but in practical terms will have to be a decision made, ideally collectively by the practice's GPs.
- To overcome difficulties in adherence, for example consider those with autism.
- Drugs with a 'narrow therapeutic index/window', where there is a fine line between a drug being effective and causing toxicity. Examples include phenytoin and carbamazepine for epilepsy and lithium.
- Certain modified or extended release products where there are proven differences in release profiles of the drug that lead to clinically significant differences in disease management. Examples include mesalazine SR, diltiazem MR (over 60mg), nifedipine MR and MR opiates.
- When there are relevant formulation differences between different brands for the same generic medicines and a patient's routine use would mean they are nor interchangeable. Examples include transdermal opioids of fentanyl patches (matrix can be cut but reservoir cannot), or different brands of buprenorphine patches that last for either three or four days.
- Certain administration devices that vary in how they operate and/or deliver the drug. Examples include inhalers for asthma.
- Products with the same drug and strength but have different bioavailability profiles that are significant and relevant to disease management and side effect profiles. Examples include Qvar® v Clenil® beclometasone inhalers.
- Multiple ingredient products where the full descriptive name and strength can be confusing and increase risk of error. Examples include combined oral contraceptives, hormone replacement therapy and emollients.
- Different products of the same drug that have different licensed indications that cannot be easily distinguished from other details on the prescription. Examples include duloxetine as Cymbalta® or Yentreve®.

- Biological rather than chemical medicines. Examples include erythropoietin and insulin glargine.

6.4 Prescribing some items using their brand name can reduce immediate costs to the CCG's drugs bill. If there is no clear and outstanding clinical case to prescribe by brand and the sole reason is financial, then a case must be presented by the Medicines Management Team (MMT) for the CCG to debate and determine its support or rejection of this option. The MMT will firstly screen and consider the appropriateness of the recommendation as well as a recommended brand before approval. This recommendation will incorporate the general features described below (section 6.5) and allow the CCG to review these and consider the impact specific to it and its practices, including workload and available resources to deliver change. The CCG decision can be delegated to an appropriately empowered sub-committee, such as an Area Prescribing Committee that has appropriate GP and pharmacist representation from the CCGs affected by the decision. Such decisions will be formally recorded.

6.5 Major factors to consider are as follows:

- where there is expected to be significant longer-term (minimum of three years) financial benefit to the CCG, the CCG should consider the financial value on a case by case basis. A high predicted value is not an immediate qualifier and any value should be considered worthwhile when compared against the workload, any disruption and safety implications. Consideration needs to anticipate the likely change in market, such as other competitive products and price changes in the NHS Drug Tariff.
- whether the NHS will incur additional expense through claims from dispensing contractors for ‘out of pocket expenses’.
- the clinical risks and disruption to individual patients is agreed as being minimal
- exceptionality can apply and should be considered in individual patients
- the workload involved with change is heavily outweighed by the financial benefit to the CCG
- features of the branded alternative, which will be summarised in the MMT’s options recommendation in each case, including:
  - equivalence in bioavailability and release profile
  - licensing for the relevant clinical indications
  - significant variance in excipients between the formulations
  - sufficient information on the product is readily available for clinicians
  - the product is listed on prescribers’ clinical systems
  - there is sufficient guarantee from the manufacturer of the immediate and long-term supply chain and its availability to all local dispensing contractors
  - the (generic) product is not in Category M of the NHS Drug Tariff
  - the recommendation can be added to the CCG’s active profile of its clinical decision support software (currently OptimiseRx)
  - the implementation of the change is or will be included in an approved switch protocol

- the product (and its generic name) will be added to the CCG's active list of recommended branded products to assist practice and dispensary staff.

- the impact on local dispensing contractors

A positive decision will be highlighted to GP practices as the recommended brand to prescribe and dispense, but this is not a requirement to change, or to change to that specific brand. Any alternative selected by a practice should be of equivalent actual cost to the NHS and CCGs drugs bill.

7. OVERALL POSITION UNDER GMS CONTRACT

7.1 It is CCG policy that all prescriptions should be prescribed generically unless the exceptions described within the policy are applicable to the drug or the individual concerned. The CCG does not support the addition of a brand name within the generic prescription.

7.2 Prescribers should avoid referencing a specific salt within the prescription unless this of clinical relevance. Doing so can lead to a requirement for a brand to be dispensed rather than generic.

7.3 Should legitimate clinical needs require a specific brand then the brand should be provided on the NHS. Prescribers should be sure that the clinical needs are legitimate. Where there are affirmed reports of a specific preparation unexpectedly being ineffective or causing unexpected adverse effects, these should be reported to the MHRA.

7.4 If a patient requests a particular branded product, despite local NHS policy to prescribe generically, the prescriber can only offer an NHS prescription, and cannot offer a private prescription.

8. ULTIMATE CLINICAL DECISION

8.1 Prescribers should use the information within this policy to reinforce a stance on generic prescribing with patients who demand a branded option. The decision about which product to prescribe is the prescriber's alone and must not be dictated by the CCG or a patient, although the views of both may be taken into account by the prescriber.

8.3 It should be noted that the NHS prescription form remains the property of the NHS throughout its lifetime, and is never the property of the patient.

9. ACTIONS, INSTRUCTION AND ADVICE FOR IMPLEMENTATION

9.1 Prescribers should not provide patients with two prescriptions (both a private prescription for a brand and a NHS prescription for the generic). This is a breach of GMS contract and also potential unsafe practice.

9.2 Practices should recognise the CCG's request that generic prescribing is normal practice with variance only supported in circumstances described within this policy.

9.3 Practices are encouraged to support the use of clinical decision support software that is funded by the CCG to assist on drug choices, e.g. OptimiseRx.

9.4 Practices should advise local dispensing contractors 28 days in advance of a planned change to a branded product. Advice can be obtained from the CCG MMT if a newly recommended brand is not available through regular wholesalers.

9.5 Using practice level prescribing data (from NHS Business Services Authority Information Services Portal and the CCG), GP Practices should review their prescribing of branded drugs and consider opportunities to reduce NHS costs.

9.6 The CCG will monitor practice prescribing activity to assist GP practices in recognising opportunities to improve value from limited NHS resources.

9.7 The MMT will be responsible for updating the policy through relevant review processes.

9.8 The MMT will be responsible for circulating, promoting and publishing the policy as well as any amendments and supporting documentation. Any queries of recommendations relating to this policy should be directed to the Lead Pharmacist within the CCG's MMT.

10. POLICY REVIEW

This policy will be reviewed by a period of no longer than three years as stated or in response to any relevant changes in local and / or national policies and guidance, whichever is sooner.

11. REFERENCES

Medicines and Healthcare Products Regulatory Agency https://www.gov.uk/report-problem-medicine-medical-device

Specialist Pharmacy Service (2017-11): Which medicines should be considered for brand-name prescribing in primary care? https://www.sps.nhs.uk/wp-content/uploads/2017/12/UKMi_QA_Brand-name_prescribing_Update_Nov2017.pdf

PrescQIPP (2016-05) – Branded generic drugs briefing 2.1

GMC (2013-02) – Good practice in prescribing and managing medicines and devices: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices

PSNC (2017-06) - The community pharmacy: A guide for general practitioners and practice staff: http://psnc.org.uk

Electronic Medicines Compendium: https://www.medicines.org.uk/emc/

12. CONTACT DETAILS

Each CCG's embedded Medicines Management Team.

APPENDIX 1:

QUALITY AND EQUALITY IMPACT ANALYSIS SCREENING TOOL

Title of Project or proposed pathway change: Brand and Generic Prescribing Policy

Brief summary of project (please include a link to project plan document):

The CCG wants to ensure that all prescribing is clinically appropriate and effective and applied in a way that delivers greatest value to the care of all patients within NHS budgets. While generic prescribing is often seen as the most economical way to prescribe, it can be that some branded products are more economical or need to be used for genuine clinical reasons. This policy aims to clarify a standard generic prescribing position, but includes defined exceptions for branded prescribing. These are where detailed and considered review has been given to the financial benefits of prescribing by brand OR where it is clinically appropriate to do so, even if there is no financial benefit to the CCG budgets. While the CCG will work to define and identify where exception applies, there will be individual cases where the patient's GP is best placed to discuss with the patient and determine the need to prescribe by brand.

The following screening tool is to undertake an initial assessment of a policy decision by the CCG and the impact this might have on quality.

Should the screening flag up a red or amber status overall, a more detailed Quality Impact Analysis should be undertaken.

The screening below assesses the impact on quality on CCG-commissioned service providers and internally within the CCG's policy decision on the CCG's standing/reputation.

An assessment of the outcome of the screening tool is below.

The screening assessment impact can be identified below as that in green highlight, including any statement that applies to this screening assessment:

Screening Tool

1 - Costs & Savings	Negative Impact	Minimum Impact	Positive Impact
(a) Type of savings	No savings or minimal anticipated	Cash-releasing saving and/or potential for improved productivity	Both cash savings and improved productivity is expected
(b) Cost of change. Likelihood that costs will not be a barrier to implementation	Change requires significant non-recurrent resources such as capital costs for adapting buildings. Change will incur significant extra costs.	Change requires additional resources, but resources are non-recurrent resources that are less than one year's savings. Change will incur extra costs.	Change can be achieved with minimal or no additional resources. Change will create efficiency savings
2 – Quality			
(a) Impact on clinical quality	Significant reduction in clinical quality	Minimal impact anticipated to have any impact (favourable or adverse) on quality of care delivered to patients	Clinical quality will be improved resulting in better outcomes anticipated for patients
(b) Impact on patient and staff safety	Increased risk to patient safety	Minimal impact anticipated to have any impact on patient safety	Improved patient safety, such as reducing the risk of adverse events is anticipated
(c) Impact on patient and carer experience	Significant reduction in patient and carer	Minimal impact anticipated on patient and carer	Improved patient and carer experience

	experience	experience	anticipated
(d) Impact on operational effectiveness	Significant adverse impact on operational performance	May have adverse impact on operational performance or minimum impact anticipated	Improvements on operational performance expected
(e) Impact on CCG reputation with patients, staff and other stakeholders	May have significant adverse impact on CCG reputation	May have minimal adverse impact on CCG reputation	An improved positive impact on CCG reputation is expected
3 - Ease of implementation			
(a) Likely speed of implementation	Will take longer than 3 years	Can be achieved between 1 - 3 years	Can be achieved within 1 year
(b) Ease of organising the change	Affects multiple organisations	Affects multiple departments within the an organisation.	Affects a small number of services or a number of teams within an organisation
(c) Degree and complexity of support and commitment required	Likely to be significant resistance from most stakeholders	Likely to get some resistance from some stakeholders.	Likely to achieve good engagement from stakeholders
4 – Equality			
Human Rights	May have significant impact on recognising and meeting Peoples Human Rights	May have some impact on recognising and meeting Peoples Human Rights	No impact on recognising and meeting Peoples Human Rights
Health Inequalities	May significantly increase health inequalities	May have some impact on increasing health inequalities	No impact on increasing inequalities
Age	Significant impact on some age groups	Some impact on age groups	No impact on age
Disability	Significant on an identified group	Some impact on an identified group	No impact on an identified group
Carers	Significant impact on carers	Some impact on carers	No impact on carers
Sex, Sexual orientation or Gender reassignment	Significant impact	Some Impact	No impact
Ethnicity	Significant impact	Some Impact	No impact
Pregnancy or Maternity	Significant impact	Some impact	No impact

Brief analysis of screening

The screening shows that the decision to implement the initiative would have a positive impact on quality and safety based on the highlighted areas of green.

This screening assessment has an overall rating of Positive impact therefore a more detailed quality impact assessment is not required.

Date completed: **27/11/18**
Completed by: **Ken Latta, Head of Medicines Management**

APPENDIX 2: SUSTAINABILITY IMPACT ASSESSMENT

Staff preparing a policy, board report, committee report, service plan or project are required to complete a Sustainability Impact Assessment. Sustainability is one of the CCG's key priorities and the CCG has made a corporate commitment to address the environmental effects of activities across CCG services. The purpose of this SIA is to record any positive or negative impacts that this activity is likely to have on each of the CCG's Sustainability Themes. For assistance with completing the SIA, please refer to the Equality and SIA guidance.

Policy / Report / Service Plan / Project Title: **Brand & Generic Prescribing Policy (v1.000), 8th June 2018**				
Theme (Potential impacts of the activity)	**Positive Impact**	**Negative Impact**	**No specific impact**	**What will the impact be? If the impact is negative, how can it be mitigated? (action)**
Reduce Carbon Emission from buildings by 12.5% by 2010-11 then 30% by 2020			Nil	
New builds and refurbishments over £2million (capital costs) comply with BREEAM Healthcare requirements.			Nil	
Reduce the risk of pollution and avoid any breaches in legislation.			Nil	
Goods and services are procured more sustainability.			Neutral	Overall preference for generic prescribing will ease procurement and by expanding number of potential suppliers the supply chain will be more assured (use of brands will be restricted). This will minimise complications and improve sustainable provision.
Reduce carbon emissions from road vehicles.			Nil	
Reduce water consumption by 25% by 2020.			Nil	
Ensure legal compliance with waste legislation.			Nil	
Reduce the amount of waste produced by 5% by 2010 and by 25% by 2020			Nil	
Increase the amount of waste being recycled to 40%.			Nil	
Sustainability training and communications for employees.			Nil	
Partnership working with local groups and organisations to support sustainable development.			Nil	
Financial aspects of sustainable development are considered in line with policy requirements and commitments.			Nil	

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group

NHS Harrogate and Rural District Clinical Commissioning Group

NHS Scarborough and Ryedale Clinical Commissioning Group

APPENDIX 3: PRIVACY ASSESSMENT

		Privacy Impact Assessment	Guidance Notes
Please note: if you need assistance in completing the PIA Screening Questions please contact the Information Governance Manager.			For additional guidance please refer to the Privacy Impact Assessment Procedure
Screening Questions	**Yes / No**	**Additional comments**	
Will the project involve the collection of identifiable or potentially identifiable information about individuals?	Policy: NO Application: YES	The policy itself will not. Application of the policy via core/routine medicines management activity (as defined in confidentiality agreements, privacy statements and specific protocols) will result in individual patient identification, access to patient medical records for limite dpurposes and potential contact to deliver effectively and safely.	
Will the project compel individuals to provide information about themselves? i.e. where they will have little awareness or choice. Will the project compel individuals to provide information about themselves?	No		
Will identifiable information about individuals be shared with other organisations or people who have not previously had routine access to the information?	No		
Are you using information about individuals for a purpose it is not currently used for or in a new way? i.e. using data collected to provide care for an evaluation of service development	No		
Where information about individuals is being used, would this be likely to raise privacy concerns or expectations? i.e. will it include health records, criminal records or other information that people would consider to be sensitive and private.	Policy: NO Application: YES	See above	
Will the project require you to contact individuals in ways which they may find intrusive? i.e. telephoning or emailing them without their prior consent.	Policy: NO Application: YES	See above	
Will the project result in you making decisions in ways which can have a significant impact on individuals? i.e. will it affect the care a person receives.	No		
Does the project involve you using new technology which might be perceived as being privacy intrusive? i.e. using biometrics, facial recognition or automated decision making.	No		
Outcome / Next Steps			
Answering 'yes' to any of the screening questions is an indication that a PIA is required. Did you answer yes to any of the screening questions?	No	**The screening questions are not an exhaustive list, therefore in the event of any uncertainty please discuss with the CCG's Information Governance Manager.** **helen.sanderson@nhs.net**	
Screening questionnaire completed by			
Name:	Christopher Ranson		
Job Title:	Senior Pharmacist		
Work Area:	Medicines Management		
Date:	23/05/2018		

Brand and Generic Prescribing Policy – Privacy Assessment Report

Background

The CCG wants to ensure that all prescribing is clinically appropriate and effective and applied in a way that delivers greatest value to the care of all patients within NHS budgets. While generic prescribing is often seen as the most economical way to prescribe, it can be that some branded products are more economical or need to be used for genuine clinical reasons. This policy aims to clarify a standard generic prescribing position, but includes defined exceptions for branded prescribing. These are where detailed and considered review has been given to the financial benefits of prescribing by brand OR where it is clinically appropriate to do so, even if there is no financial benefit to the CCG budgets. While the CCG will work to define and identify where exception applies, there will be individual cases where the patient's GP is best placed to discuss with the patient and determine the need to prescribe by brand.

Work Undertaken

A privacy impact assessment (PIA) has been documented and reviewed and the points noted below in Annex A.

SIRO Summary

It is mentioned that application of the policy via core/routine medicines management activity will result in individual patient identification, access to patient medical records for limited purposes and potential contact to deliver effectively and safely.

However it is noted that this activity will be as defined in existing confidentiality agreements, privacy statements and specific protocols for which a legal basis has been identified.

It is therefore conclude that no addition action is required for this project to be taken forward.

Date of review by Helen Sanderson: 19 June 2018

Signed off by: CCG Senior Information Risk Owner: _____

Date: _____