Our reference: MLX 356

Date: 5 December 2008

PROPOSAL FOR AMENDMENTS TO MEDICINES LEGISLATION TO ALLOW MIXING OF MEDICINES IN PALLIATIVE CARE

Dear Sir/Madam

Introduction

1. I am writing to consult you in accordance with section 129(6) of the Medicines Act 1968 about proposals to regularise the legal position of those mixing and administering medicines in palliative care. This would be achieved by amendments to the Medicines Act 1968 and the Misuse of Drugs Regulations 2001.

2. The proposals are intended to ensure that nurse and pharmacist independent prescribers and others administering mixtures of medicines in palliative care are acting within the law. In this consultation letter "palliative care" means the care of patients (children, adolescents and adults) with advanced progressive life-limiting disease which is not responsive to curative treatment.

Application to Wales, Scotland and Northern Ireland.

3. This consultation has been produced jointly with the Home Office and is being made available in Wales, Scotland and Northern Ireland. Northern Ireland has its own misuse of drugs regulations and the Department of Health, Social Services and Public Safety will be considering similar changes to those regulations. For non-controlled drugs, medicines control is not an excepted or reserved matter as far as NI is concerned and NI's Health Minister will be a co-signatory to amendments to the Medicines Act 1968.

Current Legal Position - Medicines Legislation

4. Section 132 of the Medicines Act 1968 defines manufacture. The section provides:

" "manufacture", in relation to a medicinal product, includes any process carried out in the course of making the product, but does not include dissolving or dispersing the product in, or diluting or mixing it with, some other substance used as a vehicle for the purpose of administering it."

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This definition allows a tablet to be crushed or a capsule opened and mixed with a solution to make it easier for the patient to swallow. It would also enable mixing substances with, for example, water for injection prior to parenteral administration. However, mixing two licensed medicines where one is not a vehicle for the administration of the other, falls within the definition of manufacture and results in a new, unlicensed product being administered. In addition, as a new product is being manufactured, a manufacturer's licence would be required.

5. There are exemptions in medicines legislation to allow for the manufacture, supply or administration of unlicensed medicinal products. The law in this area is complex and the exemptions apply to different categories of product depending on whether they are subject to EC legislation or not. In brief, the exemptions apply to the following:

1 products supplied in response to a bona fide unsolicited order, formulated in accordance with the specification of a doctor, dentist or supplementary prescriber (within the scope of a Clinical Management Plan) and for use by his individual patients on his direct personal responsibility in order to fulfil the special needs of those patients. These products are known as "specials".
2 products prepared by a pharmacist in accordance with a medical prescription ("magistral formula") or in accordance with the specification or monograph of a pharmacopoeia ("officinal formula"). These products are sometimes referred to as "extemporaneously prepared" medicines.
3 products "specially prepared" by a doctor or dentist or to his/her order for administration to patients under section 9 of the Medicines Act 1968.

6. However, currently, there are no provisions in medicines legislation for Nurse and Pharmacist Independent Prescribers to prepare unlicensed medicines or give directions for others to do so. Similarly, there are also restrictions on doctors giving directions in these circumstances (paragraph 11 refers). Recognising this, the Agency has since acted and issued a statement - see paragraph 13 below.

Controlled Drugs

7. A number of medicines used within palliative care are subject to the additional controls contained in the Misuse of Drugs Regulations (MDR) which are the responsibility of the Home Office. The MDR has a similar concept relating to the mixing of drugs which is referred to as "manufacturing" or "compounding". Under the MDR only practitioners (doctors, dentists and vets) or pharmacists have the authority to manufacture or compound. Nurses do not have any such authority.

Background

8. Initially, the Agency was asked for advice on the legalities of physiotherapists mixing two licensed medicines in a syringe prior to administration under a Patient Group Direction (PGD). The legal framework for PGDs excludes unlicensed medicines. As neither medicine was a vehicle for the administration of the other, the Agency therefore took the view that a new unlicensed product was being manufactured. The Agency subsequently contributed to a position paper published by the Chartered Society of Physiotherapists (CSP) which set out the legal position.

9. Following publication of the CSP statement, the Agency established from enquiries and discussions with palliative care interests, that it is long standing accepted practice in this field to prescribe a mixture of licensed medicines for administration to patients usually via a syringe driver. There is also a body of evidence supported by many years of clinical experience that mixing certain medicines in a syringe driver is effective and safe.

10. Prescribing in palliative care is not only undertaken by doctors but also by Nurse Independent Prescribers and, increasingly, Pharmacist Independent Prescribers. The mixing and administration may be undertaken by the prescriber but is more usually carried out by a nurse who is not an independent prescriber but is competent to prepare and set up a syringe driver. (It is good practice for one practitioner to avoid prescribing, dispensing and administering in a single patient episode). Decisions on the specific combinations or mixtures of drugs prescribed for the patients are made at the discretion of the independent prescriber who has an existing relationship with the palliative care patient that enables him/her to understand their individual clinical requirements. The range of drugs prescribed in this scenario is limited and the drugs and combinations are described in all palliative care guidelines and textbooks. As clinical needs are liable to change without warning it is best practice for independent prescribers to give written directions for variable doses and combinations of medicines for administration via a syringe driver (within limits). This can then allow nurses attending patients day to day to alter dosage according to the clinical needs that present.

11. The outcome of the Agency's clarification of the law in relation to "manufacture" was that a number of NHS bodies advised palliative care practitioners that mixing should not continue without specific directions of a doctor or, if included in a patient's Clinical Management Plan, under Supplementary

Prescribing arrangements. However, further legal clarification obtained by the Agency confirms that under the current legal provisions a doctor cannot effectively instruct the practitioner to mix because the latter would require a manufacturer's licence. A Clinical Management Plan is not appropriate either because it only enables the supplementary prescriber to order the unlicensed product. Therefore, as the law currently stands there are actually no circumstances in which practitioners can legally mix medicines. Unless medicines legislation is amended, this will have an adverse impact on patient care.

12. In addition to the impact on current arrangements for palliative care services, the Government has recently published its End of Life Care Strategy to help patients continue to be cared for and die in their own homes. There is therefore likely to be a growing demand for experienced and specialist palliative care practitioners, not necessarily independent prescribers, who can respond directly to the needs of patients as and when those needs change. However, unless Nurse Independent Prescribers and Pharmacist Independent Prescribers can mix medicines or instruct others to do so, they will be effectively unable to care for patients in their homes (or indeed any other settings such as hospices).

13. The Agency has recognised that the present legal position has the potential to obstruct the provision of effective pain relief to patients receiving palliative care. We have therefore issued a statement which makes clear that the MHRA would not consider taking enforcement action for breaches of medicines legislation by doctors, Nurse or Pharmacist Independent Prescribers engaging in the long standing accepted practice of prescribing and administering (and providing directions to others to administer) a mixture of licensed medication via a single injection or a syringe driver unless it would be in the public interest to do so. This also applies to those mixing and administering medicines in accordance with the directions of the prescriber. Each case would be considered individually. A copy of the statement is attached at **Annex A**.

Proposals

14. The proposals have been developed by the Agency with input from palliative care interests, the RPSGB and the Home Office. The views of the NMC were also sought. The proposals are aimed at relaxing the legal requirements to enable mixing of licensed medicines for administration in palliative care in circumstances where a manufacturer's licence is not required and where safe and effective practice can be supported by evidence. The proposals recognise that enabling Nurse and Pharmacist Independent Prescribers to prepare or instruct others to prepare combinations of medicines will benefit patients and carers by

reducing potential delays in access to treatment. The proposals are also strongly supported by the Department of Health.

15. The Agency identified four options for changes to medicines legislation to support palliative care:

A. Do nothing.
The Agency does not recommend this option. Having to cease the mixing of appropriate medicines could lead to delays to patient care at a time of particular stress. It could also mask inappropriate practice as there may be other mixing scenarios which have yet to come to light.

B. Amend the definition of "manufacture" in the Medicines Act.
This option is also not recommended. Any relaxation of the actual definition could inadvertently provide a "loophole" for the mixing of medicines without a manufacturer's licence where such a licence is necessary to protect patient health

C. Develop a formulary for mixing in palliative care.
This is a possibility but not necessarily desirable. The Agency takes the view from past experience with nurse prescribing that developing formularies are time-consuming to review and the process itself is not responsive to changing practice and best patient care.

D. Enable Nurse and Pharmacist Independent Prescribers to specially prepare products for their individual patients and direct nurses and pharmacists who are not prescribers to mix drugs prior to administration. At the same time, enable doctors to direct nurses and pharmacists to mix on a similar basis.
The MHRA believes this is the best solution. The proposal is based on the understanding that all concerned are experienced in palliative care, that they would take full professional and clinical responsibility for their actions and their employers develop or make available appropriate guidance to ensure patient safety.

Commission on Human Medicines
16. Provisional views were sought from the Commission on Human Medicine (CHM) on the options outlined in paragraph 14. The Commission were, in principle, broadly supportive of Option D and will consider the issues further following completion of the consultation. **We are therefore proposing** that Option D is the most suitable way forward. **We welcome views on this proposal.**

Controlled drugs

17. The Advisory Council on the Misuse of Drugs (ACMD) is an independent expert advisory body to the government on controlled drug related issues. Pursuant to Option D and having secured the agreement of the ACMD, the Home Office intend to extend the current authority for practitioners and pharmacists to compound controlled drugs to Nurse Independent Prescribers. Compounding is not defined in the MDR and is consequently given its everyday meaning of combining two or more ingredients so as to form a whole. This would be included in agreed forthcoming amendments to the Misuse of Drugs Regulations 2001 which will allow both Nurse and Pharmacist Independent Prescribers to prescribe any controlled drugs within their competence. The changes will have the effect of placing Nurse Independent Prescribers on the same footing as doctors and pharmacists in respect of compounding a controlled drug. It is not intended that the extension of this authority is limited to certain controlled drugs or to certain conditions which is consistent with the forthcoming changes in respect of independent prescribing.

18. These changes do not however, extend to those nurses who will often be undertaking mixing of medicines in palliative care but are not Nurse Independent Prescribers. **The Home Office propose** to further extend the authority to compound controlled drugs to nurses with the supporting authority for a nurse to possess a controlled drug for this purpose. This would be subject to the requirement that the compounding would only be in accordance with the independent prescriber's directions for the purpose of immediate administration of medicines to the patient. The proposal is based on the understanding that all concerned are competent, that they would take full professional and clinical responsibility for their actions and their employers develop or make available appropriate guidance to ensure patient safety. **We welcome views on this proposal.**

Implications for other areas of practice.

19. Although this consultation letter focuses on palliative care, we should be interested to know of other specific examples of clinical care which are affected by the definition of manufacture. For example, we understand this may impact on Total Parenteral Nutrition Services. In particular, **we should welcome information about the detail underpinning these practices**, who is engaged in them, the extent to which they are used and the overarching governance regimes. This will enable the CHM to consider these issues and to recommend to Ministers whether any further legislative changes would be appropriate. The MHRA does

not at this stage, intend to undertake further consultation exercises on other areas of practice which have been brought to our and CHM's attention.

Impact Assessment
20. An Impact Assessment is not required for these proposals because they will not impose a cost compliance on business, charities or the voluntary sector or result in a cost saving. Nor do we believe that the proposals impact in any way on equality issues. **We welcome comments on these views**.

Comments
21. You are invited to comment on the proposed changes to legislation set out in paragraphs 14 and 16 and to provide information sought in paragraphs 17 and 18.

Circulation of proposals
22. This consultation letter is being brought to the attention of those organisations listed. Copies of the consultation are also available from our website - www.mhra.gov.uk and replies are welcome from all interested parties. A form is attached for your reply. Comments should be addressed to Mr Roy Drepaul, MHRA, 16-139, Market Towers, 1, Nine Elms Lane, London SW8 5NQ (or e-mail to: Part3@mhra.gsi.gov.uk" to arrive no later than 27 February 2009. Comments received after this date will not be taken into account. The MHRA will not enter into any correspondence concerning these proposals.

23. This consultation follows the Cabinet Office Code of Practice on Consultation - the criteria for which are set out at **Annex B**.

24. The Commission on Human Medicines will be asked to consider the proposals in the light of comments received and their advice will be conveyed to Ministers. Subject to the agreement of Ministers, we plan to implement the changes by Statutory Instrument. Statutory Instruments are available from the Stationary Office and may also be viewed on their website: www.opsi.gov.uk

Making copies of the replies available to the public
25. To help informed debate on the issues raised by this consultation, and within the terms of the Freedom of Information Act 2000, the Agency intends to make publicly available copies of comments that it receives. Copies will be made available as soon as possible after the public consultation has ended. Furthermore, information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes. These are primarily the Freedom of Information

Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004.

26. If you want the information that you provide to be treated as confidential, it would be helpful if you could explain why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on us. Confidential responses will be included in any statistical summary of numbers of comments received and summary of views expressed.

27. The Agency's Information Centre at Market Towers will supply copies on request. An administrative charge, to cover the cost of photocopying and postage, may be applied. Alternatively, personal callers can inspect replies at the Information Centre by prior appointment (telephone 0207 084 2351).

Anne Ryan
Direct line 0207 084 2392

ANNEX A

MEDICINES AND HEALTHCARE PRODUCTS REGULATORY AGENCY (MHRA)

STATEMENT ON MEDICAL AND NON-MEDICAL PRESCRIBING AND MIXING MEDICINES IN PALLIATIVE CARE

Background

The MHRA is responsible for the enforcement of the Medicines Act 1968 and related secondary legislation. Initially, the Agency was asked to advise on the legalities of physiotherapists mixing two licensed medicines in a syringe prior to administration under a Patient Group Direction (PGD). The PGD issue was straightforward as the legal framework for PGDs excludes unlicensed drugs. The Agency subsequently contributed to a position paper published by the Chartered Society of Physiotherapists (CSP) which set out the legal position and alternatives to mixing medicines under a PGD.

Section 132 of the Medicines Act 1968 defines manufacture. The section provides:

> " " manufacture ", in relation to a medicinal product, includes any process carried out in the course of making the product, but does not include dissolving or dispersing the product in, or diluting or mixing it with, some other substance used as a vehicle for the purpose of administering it."

This definition would, for example, allow a tablet to be crushed or a capsule opened and mixed with a solution to make it easier for the patient to take. It would also enable mixing substances with, for example, water for injection prior to parenteral administration. However mixing two licensed medicines, where one is not a vehicle for the administration of the other, falls within the definition of manufacture and results in a new, unlicensed product being administered. In addition, as a new product is being manufactured, a manufacturer's licence would be required.

At present there are exemptions in medicines legislation to allow for the manufacture, supply or administration of unlicensed medicinal products (whether or not a particular exemption applies also depends upon whether the product is within the scope of Directive 2001/83/EC). In brief, the exemptions apply to the following:

1 products supplied in response to a bona fide unsolicited order, formulated in accordance with the specification of a doctor, dentist or supplementary prescriber and for use by his individual patients on his direct personal responsibility in order to fulfil the special needs of those patients. These products are known as “specials”.
2 products prepared by a pharmacist in accordance with a medical prescription (“magistral formula”) or in accordance with the specification or monograph of a pharmacopoeia (“officinal formula”). These products are sometimes referred to as “extemporaneously prepared” medicines.
3 products “specially prepared” for individual patients of a doctor or dentist under section 9 of the Medicines Act 1968.

Medical and Non-medical prescribing in palliative care

Following publication of the CSP statement, the Agency received a number of enquiries from palliative care practitioners seeking clarification of the law in relation to non-medical prescribers prescribing two or more medicines for administration via a syringe driver. The Agency’s position is that the advice it had given about mixing of medicines in physiotherapy practice applied equally to the same practice in palliative care. Under medicines legislation independent nurse and pharmacist prescribers are allowed to prescribe any licensed medicine for any medical condition (currently there are certain restrictions on controlled drugs pending forthcoming amendments to the Misuse of Drugs Regulations (MDR)) but Nurse and Pharmacist Independent Prescribers are not authorised to prescribe unlicensed medicines or give directions for others to do so. Further legal clarification recently obtained by the Agency has established that there are also restrictions on doctors giving directions in these circumstances. Under the current legal provisions, a doctor cannot effectively instruct the practitioner to mix because the latter would require a manufacturer’s licence. The use of a Clinical Management Plan under supplementary prescribing arrangements is not appropriate either because it only enables the supplementary prescriber to order the unlicensed product.

The Agency are aware from discussions with palliative care interests that it is long standing accepted practice in this field to prescribe a mixture of licensed medication for administration, usually via a syringe driver. The mixing and administration may be undertaken by the prescriber or by another, usually a nurse, working in accordance with the directions of the prescriber. We understand there is a body of evidence supported by many years of clinical experience that mixing certain medicines in a syringe driver is safe and effective.

The MHRA recognise that palliative care requires special consideration and we would not wish to obstruct the provision of effective pain relief to patients. In September therefore, the MHRA will be seeking provisional advice from the Commission on Human Medicines (CHM) on possible options for changes to medicines legislation in advance of the usual public consultation procedures required under the Medicines Act 1968. The CHM will be asked to provide formal recommendations to Ministers following the completion of that public consultation.

In the meantime the MHRA would not consider taking enforcement action for breaches of medicines legislation by a doctor, Nurse or Pharmacist Independent Prescriber engaging in the long standing accepted practice of prescribing and administering (and providing directions to others to administer) a mixture of licensed medication via a single injection or a syringe driver unless it would be in the public interest to do so. This also applies to those mixing and administering medicines in accordance with the directions of the prescriber. Each case would be considered individually.

ANNEX B

The Cabinet Office Code of Practice on Consultation criteria for consultations is set out below:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy

2. Be clear about proposals, who may be affected, what questions are being asked and the timescale for responses.

3. Ensure that consultation is clear, concise and widely accessible.

4. Give feedback regarding the responses received and how the consultation process influenced the policy.

5. Monitor the department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.

6. Ensure the consultation follows better regulation best practice, including carrying out an Impact Assessment if appropriate.

The full code of practice is available at: http://www.cabinet-office.gov.uk/regulation/Consultation

To: Roy Drepaul
MHRA
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LONDON SW8 5NQ

From :_____
_____
_____
_____

CONSULTATION LETTER MLX 356: PROPOSED AMENDMENTS TO MEDICINES LEGISLATION TO ALLOW THE SUPPLY AND ADMINISTRATION OF MEDICINES

* 1. I support the proposals contained in the MLX

* 2. I have no comment to make on the proposals in the MLX

*3. My comments on the proposals in the MLX are below/attached.

* My reply may be made freely available.
* My reply is confidential.
* My reply is partially confidential (indicate clearly in the text any confidential elements)

Signed: _____

* Delete as appropriate

MLX 356: CONSULTATION LIST

NB: this list is not intended to be exhaustive. Copies of the consultation are also available from our website - www.mhra.gov.uk – and replies are welcome from all interested parties.

Advisory Committee on Misuse of Drugs
Ambulance Service Association
Association of British Pharmaceutical Industries
Association of Palliative Medicine
Association of Nurse Prescribing
British Association for A&E Medicine
British Association for Emergency Medicine
British Medical Association
British Mountaineering Council
British Pharmacological Society
Chemist & Druggist
Company Chemists Association
Consumers Association
Doctor Magazine
General Medical Council
General Practitioners Committee
Guild of Healthcare Pharmacists
Health & Safety Executive
Health Development Agency
Health Professions Council
Health Service Commissioner
Health Which?
Help the Hospices
Joint Consultants Committee
Joint Formulary Committee
Joint Royal Colleges Ambulance Service Liaison Committee
Marie Curie Cancer Care
Medical Defence Union

Medical Protection Society Ltd
National Council for Palliative Care
National Palliative Care Nurse Consultant Group
National Patient Safety Agency
National Pharmaceutical Association
National Prescribing Centre
Palliative Care Pharmacists network
Patients Association
Pharmaceutical Journal
Pharmaceutical Society for Northern Ireland
Proprietary Association of Great Britain
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Midwives
Royal College of Midwives (Scottish Board)
Royal College of Midwives (Northern Ireland Board)
Royal College of Nursing
Royal College of Nursing (Northern Ireland)
Royal College of Nursing (Scotland)
Royal College of Nursing (Wales)
Royal College of Physicians (Edinburgh)
Royal College of Physicians (London)
Royal College of Physicians & Surgeons (Glasgow)
Royal College of Surgeons (England)
Royal College of Surgeons (Edinburgh)
Royal Colleges of Physicians: Faculty of Pharmaceutical Medicine
Royal Colleges of Physicians: Faculty of Public Health Medicine
Royal Pharmaceutical Society of Great Britain
Royal Pharmaceutical Society of Great Britain (Scottish Department)
Royal Pharmaceutical Society of Great Britain (Welsh Department)
Royal Society of Chemistry
Royal Society for the Promotion of Health
Scrip Ltd
Social Audit Unit
Society of Pharmaceutical Medicine
UK Clinical Pharmacy Association