MEDICINES MANAGEMENT GUIDE TO PRESCRIBING

Foreword
This document aims to support the PCT’s Medicines Management Team in the delivery of consistent prescribing advice to practitioners prescribing on behalf of NHS Surrey with a purpose of:

- Improving the quality and consistency of patient care
- Improving patient access to healthcare services
- Utilising limited resources as effectively as possible
- Patients being fully informed of the reasons why a medicine has or has not been prescribed
- Achieving good patient concordance or compliance with their prescribed treatment
- Increasing the appropriateness and cost-effectiveness of prescribed treatments
- Improving care between the primary, secondary and tertiary care interface.

The document was approved for use by the Medicines Commissioning Group in 2012.

The intention is that the document is updated as and when required to provide up-to-date information on changes to advice or legislation. It is also available to support the development of NHS Surrey employees who should be working under the organisation’s Medicines Policy.

Implementation and Monitoring
The information in this guide is advisory in nature and should be regarded as good practice. Prescribing in NHS Surrey is monitored routinely through analysis of ePACT.net data, clinical audits within GP practices and the analysis of acceptance/rejection of ScriptSwitch recommendations (ScriptSwitch is a piece of software that links with GP clinical systems). Information messages in ScriptSwitch are set up to support the advice and recommendations contained within this document. All GP practices in Surrey have allocated pharmacy support on a regular basis.

Instances where a practitioner acts outside their terms of service or in contravention of legislation are addressed through appropriate channels within the organisation.

Training
Many aspects of this document are self-explanatory and require little or no additional training. When requested, the Medicines Management team are able to offer one to one support or group sessions.

Kevin Solomons
Head of Medicines Management

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<td>British National Formulary</td>
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1. **SCOPE**
This guidance is offered to all practitioners working for or on behalf of Surrey Primary Care Trust (PCT) including:
- General medical Practitioners
- General dental Practitioners
- Independent and Supplementary prescribers

2. **DOCUMENT PURPOSE**
This document aims to support the PCT Medicines Management Team in the delivery of consistent prescribing advice to practitioners prescribing on behalf of NHS Surrey with a purpose of:
- Improving the quality and consistency of patient care
- Improving patient access to healthcare services
- Utilising limited resources as effectively as possible
- Patients being fully informed of the reasons why a medicine has or has not been prescribed
- Achieving good patient concordance with their prescribed treatment
- Increasing the appropriateness and cost-effectiveness of prescribed treatments
- Improving care between the primary, secondary and tertiary care interface

It is anticipated that this document will be under regular review and updated to reflect changes relating to medicines management both nationally and within NHS Surrey.

The Medicines Management Team structure and a full list of contact details are available on [http://nww.intranet.surreypct.nhs.uk/sites/PublicHealth/MedMan/Shared%20Documents/Medicines%20Management%20Team%20contact%20details%20April%20202012%20(Rochelle).doc](http://nww.intranet.surreypct.nhs.uk/sites/PublicHealth/MedMan/Shared%20Documents/Medicines%20Management%20Team%20contact%20details%20April%20202012%20(Rochelle).doc)

**GUIDANCE**

3. **PRESCRIBING RESPONSIBILITIES: PRIMARY/SECONDARY CARE INTERFACE**
NHS Surrey interface with the following Acute Trusts:
- Ashford & St Peters NHS Trust
- Frimley Park Hospital NHS Trust
- Royal Surrey County Hospital NHS Trust
- Surrey & Sussex Hospitals NHS Trust
- Epsom & St Helier University Hospitals NHS Trust
- Surrey & Borders Partnership NHS Mental Health Trust
- Kingston Hospital NHS Trust

The Medicines Management team interface with these Trusts at the following forums:
- Surrey Prescribing Clinical Network (PCN)
- Ashford & St Peters - Drugs & Therapeutics Committee (D&TC)
- Frimley Park Hospital – D&TC and Primary/Secondary care Interface Prescribing Forum
- Royal Surrey County Hospital – D&TC
- Surrey & Sussex Hospitals – Area Prescribing Committee (APC)
- Epsom & St Helier University Hospitals - New Drug Appraisal & Interface Group (NDAIG)
- Surrey & Borders Partnership – Medicines Management Committee
- Kingston Hospital NHS Trust – D&TC and Interface Group
3.1 General points to consider

The GMC’s Good Medical Practice guidelines state that you must:

- Make the care of your patient your first concern
- Recognise and work within the limits of your professional competence

The doctor who has clinical responsibility for the patient should undertake the prescribing (EL(91)127)

Prescribing at the primary/secondary care interface presents a number of potential difficulties:

- The medicine may be outside of the GP’s current experience
- The GP may have been given inadequate information about the medication and its management
- The GP may not be in control of the monitoring and/or does not receive results of such
- The treatment may be outside of the licensed indications
- The dosage may be outside of the licensed range
- Local Policy and/or the BNF recommends specialist supervision
- The treatment may not be obtainable from community pharmacy

Formal “Shared Care” arrangements may be an appropriate way of overcoming some of these issues

3.2 Traffic Light System

The Acute Trusts within Surrey and those that interface with us have developed drug formularies for use within their Trusts and traffic light systems that provide guidance on the use/prescribing of medicines across the interface.

The traffic light system provides a framework for defining where clinical and therefore prescribing responsibility should lie through categorisation of individual drugs.

For details of the traffic light status for the individual drugs and where applicable the relevant amber shared care protocol or amber* information sheet please access the Prescribing Advisory Database (PAD).

http://www.app.surreyhealth.nhs.uk/gpview/default.html

The system is only advisory but is intended to clarify expectations of prescribing responsibility.

- RED DRUGS / HOSPITAL ONLY DRUGS: for specialist use in secondary/tertiary care on the grounds of one or more of the following:
  1. Only available in hospital
  2. New classes of drugs (usually a minimum of 6 months since its launch) and new indications for older drugs: where clinical experience is limited in general practice
  3. Clinical trial drugs that are being used in the hospital
  4. Complex monitoring requirements and specialist drugs
  5. Drugs being used outside licensed indications that are not in common usage and / or doses
  6. Unlicensed drugs in certain situations
  7. Medicines that require preparation by the hospital pharmacy: unless an acceptable procedure for supply through a community pharmacy can be arranged.
AMBER DRUGS: prescribing initiated in secondary care with the potential to transfer to primary care when:
1. An individual GP has agreed to accept clinical responsibility for an individual patient
2. Agreed shared care arrangements have been established and the GP is willing to take over shared care
3. The patient’s condition and/or treatment has been stabilised
4. In one off situations, a specific GP can agree to enter into a ‘shared arrangement’ without a formal shared care guideline providing a letter is sent to the GP giving appropriate advice and guidance
5. The GP is provided with information and given the opportunity to accept prescribing responsibility before the transfer takes place
6. Under a shared care arrangement the prescriber must be able to: receive monitoring results promptly and be able to interpret them, have consultant/specialist support, ensure that the local pharmacy can dispense the drug to ensure continuity of supply

AMBER * DRUGS: due to widespread GP experience these amber drugs are often prescribed in Primary Care following specialist advice and initiation in secondary care, without the need for formal shared care
If the GP feels unable to accept prescribing responsibility for a drug in the amber category then clinical responsibility for prescribing that drug rests with the initiating clinician

GREEN DRUGS: can be initiated and continued in primary, secondary or tertiary care
If the GP has any concerns on either the treatment or the indication for use then it is suggested they contact a member of the PCT Pharmacy Team for clarification.
Where a shared-care protocol has been developed and agreed it will be made available on the Prescribing Advisory Database (PAD)
http://www.app.surreyhealth.nhs.uk/gpview/default.html
See section 9.1 for more details.

3.3 Requests for GPs to prescribe Red/hospital only drugs
GPs should not be asked to accept prescribing responsibility for Red/Hospital Only drugs from our local Acute Trusts. If this occurs, the GP should contact a member of the Specialist Commissioning Pharmacy team:
Linda Honey – Lead Specialist Commissioning Pharmacist 01372 201811
Victoria Overland - Specialist Commissioning Pharmacist 01372 201714
Clare Johns – Senior Pharmacy Technician 01372 201812
Abby Mabil - Team Administrator 01372 201750
There may be some occasions where requests from tertiary centres are in conflict with the local Traffic Light System. In these instances the GP should:
- Consider whether they have the confidence and knowledge/experience to accept the clinical responsibility associated with prescribing the drug
- Decide whether they have been given sufficient information from the tertiary centre or if there is a shared care protocol available from the tertiary centre
- Contact a member of the PCT Pharmacy team for further advice if necessary
If a GP is unwilling to accept responsibility, it should be possible for prescriptions to be issued by a hospital doctor and posted to a patient who lives at a distance from the hospital.

3.4 Payment by Results (PbR) excluded drugs and devices / funding requests to the PCT from acute Trusts for high cost drugs

A number of high cost drugs, devices, procedures and products have been excluded for the scope of the national tariff of PbR. PbR excluded drugs are not included within the national tariff prices that are paid for routine packages of care.


NHS Surrey has agreed specific commissioning arrangements for PbR excluded drugs with the providers from which it commissions services. The commissioning intentions document details NHS Surrey’s criteria and specific funding arrangements for each of the PbR excluded drugs; it cannot be assumed that NHS Surrey will automatically fund these drugs.


This process considers funding requests for PbR excluded drugs and other high cost drugs that require continued prescribing by the acute Trusts (e.g. Red drugs and a small number of Amber drugs in NHS Surrey’s traffic light system).

Although the majority of the PbR excluded drugs are Red drugs on NHS Surrey’s traffic light system (prescribing to be retained in secondary / tertiary care) detailed guidance on the use /prescribing of these drugs across the interface can be found in NHS Surrey’s traffic light system (section 3.2)

NB: Where a Red drug is prescribed by a practice there will not usually be any allocation made from the contingency fund to cover the cost of prescribing.

4  PRESCRIBING NEW PRODUCTS

The principles outlined in this section of the document apply equally to the prescribing of medicines, dressings, stoma and continence products.

If the GP does not feel confident to prescribe a new treatment they should discuss the implications with the PCT Medicines Management Team or their Defence Organisation before prescribing.

Some new medicines may offer distinct advantages over current therapies. However there is often a lack of good quality demonstrable evidence at the time of launch to be able to define their place in therapy. In addition the safety profile of a new drug cannot be fully assessed as only a few thousand patients may have been exposed to it by the time it is licensed.

Drugs that are newly licensed and are being monitored intensively by the Medicines & Healthcare products Regulatory Agency (MHRA) can be identified in the BNF by the black triangle symbol ▼

In order to avoid exposing patients to an unknown risk of adverse events, GPs need to have a careful, critical approach to the use of new drugs in order to ensure their use is
appropriate. Extreme vigilance is needed to detect and report possible adverse effects; thereby ensuring patients are not exposed to unnecessary risks. An adverse drug reaction (ADR) can be reported online using the Yellow Card Scheme at

http://yellowcard.mhra.gov.uk/_assets/files/Healthcare%20professional%20Yellow%20Card%20reporting%20form_2.pdf

Additional information about the Yellow Card Scheme and the reporting of ADRs can be found at www.mhra.gov.uk

Before prescribing any new innovative treatments, it is suggested that the GPs discuss this with a member of the PCT Medicines Management team to make sure that they have access to all available evidence on safety and effectiveness.

The transfer of prescribing for new drugs, initiated by hospital consultants, should only be considered in cases where the drug has been added to the hospital formulary through due process, i.e. ratification by the Drugs and Therapeutics Committee. Consultants should not refer the prescribing of these drugs to primary care as a means of bypassing their approved hospital formulary.

The Surrey Prescribing Clinical Network (PCN) and the Medicines Commissioning Group (MCG) will keep abreast of developments nationally and locally e.g. NICE, NSFs, good practice guidelines, local priorities, Trust DTC decisions and identified problem areas. In doing this they will consider the implications of, and make recommendations for the managed entry of new drugs (Further information about the role of the PCN / MCG can be found in section 13 and Appendix 1).

**Before prescribing a new drug/product, there are a few things to consider:**
- Is it a truly new medicine, or merely an attempt at patent extension e.g. a novel formulation or isomer of a former medicine?
- Does this medicine provide evidence-based, demonstrable benefits to patients?
- Can pharmaceutical company claims be substantiated?
- When should this medicine be used in preference to current treatment decisions and will it give better outcomes?
- What are the licensed indications?
- Is it a specialist treatment?
- Are there any published comparative safety data and has it been widely used?
- Are there any monitoring requirements?
- Are there any clinically important drug interactions?
- Are there particular groups of patients in which this medicine should not be used or used with care?
- Is there any independent guidance from the PCT Pharmacy team, the NHS Surrey PCN / Medicines Commissioning Group or the South East Coast (SEC) Policy Recommendation Committee?
- Is there good quality, demonstrable evidence that it is more cost-effective than existing treatments?
- What impact would prescribing this medicine have on the whole health economy?

**5. UNLICENSED MEDICINES**

Medicines should be licensed for the indication for which they are intended.
When a GP chooses to prescribe a product outside the terms of its licensing agreement, the product liability passes to the GP.

Before prescribing outside the licensed indications the GP should be confident that a reasonable body of medical opinion would support the use of the product in that way (Bolam principle). However, recent court judgements and Human Rights legislation may mean that the ‘Bolam test’ may not always be a suitable defence. If in doubt, prescribers are advised to seek guidance from the PCT Pharmacy team or their defence organisation, if appropriate.

All GPs are advised not to prescribe an unlicensed product if requested to do so by secondary care unless they have full clinical knowledge and understanding of the product’s efficacy and safety and are prepared to accept clinical responsibility for the use of the product in each patient. Under these circumstances a shared care agreement may be appropriate.

For specific shared care information please access the Prescribing Advisory Database http://www.app.surreyhealth.nhs.uk/gpview/default.html.

Many medicines initiated by the paediatricians in secondary care are unlicensed but their use is medically accepted practice. Providing that the drug, indication and dose is included in the Children’s BNF then a shared care protocol is not required in order for the transfer across to primary care to take place. GPs are advised to seek advice from the PCT Pharmacy team and their medical defence organisation (on each occasion), as appropriate.

6.1 Private Referral

- The responsibility for prescribing rests with the doctor who has clinical responsibility for a particular aspect of the patient’s care (EL(91)127).

- Where an NHS GP refers a patient (privately or otherwise) to a Consultant for advice but retains clinical responsibility for the patient, then the GP should issue the necessary prescriptions at NHS expense.

- In the situation where the Consultant retains clinical responsibility, for example, where he continues to administer any treatment or the treatment is recognised to be specialist in nature, then, it is the Consultant who should issue the prescriptions.

- Where patients opt to be referred privately (i.e. outside of the NHS) then they would be expected to pay the full cost of any treatment they receive in relation to the referral, including that of any drugs and appliances until the Consultant has discharged the patient and the GP has accepted Clinical Responsibility. There are certain circumstances where this does not apply, as highlighted within “Guidance on NHS patients who wish to pay for additional private care” (March 2009) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096576.pdf

- Policies for Cancer “top-ups” for local acute trusts can be found at Link tbc
In cases where the Consultant continues to have clinical responsibility for treating a particular condition, the consultant should continue to prescribe privately.

Following a private consultation, there is no obligation for the GP to prescribe the recommended treatment if the GP does not feel clinically competent to do this and it is contrary to his/her normal clinical practice.

For further information see:
“Prescribing of NHS Medication recommended during or after a private Episode of Care”

6.2 Infertility Treatment
NHS Surrey Assisted Conception Commissioning Policy, Criteria for Access to Treatment and the NICE Pathway for Fertility Treatment can be found at

Further information can be found at on the NICE website:

IVF and other similar assisted conception methods are specialist services and access will normally be on the recommendation of a local NHS Consultant Gynaecologist and on some occasions from local NHS Consultant Urologist.

NHS Surrey believes that such treatment should not be undertaken in primary care and have alternative funded arrangements in place.

Drug treatments are included in the cost of the package and will not be funded as separate elements by Primary Care clinicians.

In essence, we would advise that you do not prescribe fertility drugs, not only due to clinical concerns but also to prevent inequalities across the PCT.

Where a patient wishes to change from private to NHS status, the following principles apply:

- A patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation
- Any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient
- Any patient changing their status after having been provided with private services should not receive an unfair advantage over other patients

As a matter of principle a patient must never be treated on a different basis to another NHS patient simply because they previously held private status.

6.3 Private Service for travel vaccination
Immunisations for conditions for which there are no reimbursement arrangements (e.g. Hepatitis B, Rabies), GPs may levy a charge directly to the patient under Schedule 5 Fees and Charges of The National Health Service (General Medical Services Contracts) Regulations 2004 – see appendix 2 for additional information.

Patients can be charged directly for some vaccinations but note:
You CANNOT charge for advice
You CANNOT charge if the service is available on the NHS
You CANNOT mix NHS and non-NHS
You can write a private prescription or charge patients for the stock and the administration
The level of charge is for the practice to determine. It is advisable for practices to develop a protocol which is available to patients or included in the practice leaflet.

6.4  Malaria Prophylaxis

Anti-malarial drugs, for the prophylaxis of malaria, may not be prescribed on the NHS.

The Department of Health issued guidance in 1995 (FHSL(95)7) suggesting that medication for malaria prophylaxis should be provided on a private prescription. This was supported by a change in the GMS Regulations to permit GPs to charge for such prescribing. However the guidance does not apply to the treatment of malaria or the use of the treatments specified below for any other indications.

For the prevention of malaria doxycycline, proguanil with atovaquone (Malarone®), pyrimethamine with sulfadoxine (Fansidar®) and mefloquine (Lariam®) may be prescribed on private prescription as they are Prescription Only Medicines.

Other medicines for the prevention of malaria are available for purchase “over the counter” at community pharmacies.

Advice in relation to recommended malaria prophylaxis can be accessed on the NaTHNaC website www.nathnac.org and the TRAVAX website www.travax.nhs.uk

TRAVAX is paid for annually by the PCT for use by our practices and is accessed by Log-in and password (available from the Pharmacy Team).

Other useful advice can be found by clicking the links to the Health Protection Agency website and the Department of Health website below.

http://www.hpa.org.uk/publications/PublicationDisplay.asp?PublicationID=87
www.dh.gov.uk/PolicyAndGuidance/HealthAdviceForTravellers/fs/en

Patients should be advised to purchase sufficient prophylactic medicines to cover the period of their travel, please refer to up-to-date information in the BNF.

Please note that due to the side effects with Mefloquine, patients should be advised to commence therapy two and a half weeks prior to travel in case of adverse reactions. The importance of prevention, e.g. through the use of mosquito nets, suitable clothing and insect repellents to protect against being bitten, should be stressed.

Remember the four steps (ABCD) to prevent suffering from malaria in UK travellers

- Awareness: know about the risk of malaria
- Bites by mosquitoes: prevent or avoid
- Compliance with appropriate chemoprophylaxis
- Diagnose breakthrough malaria swiftly and obtain treatment promptly

6.5  Emergency travel kits

Emergency travel kits are available in two forms:

- The “basic kit” contains items such as disposable needles and syringes, IV cannulae, sutures and dressings
● The “POM” kit contains additional items such as plasma substitutes and medicines. A private prescription is required for the latter. Neither kit is available on the NHS but the kits are available through community pharmacies on demand, due to expiry dates.

6.6 Clinical Trials / research

All trials of medicines within NHS Surrey should have gained Research Ethics approval and meet research governance criteria where appropriate.

NHS staff should have evidence that the research protocol has the ethical and regulatory approval it needs.

Research governance for NHS Surrey is managed by Sussex Research Consortium contact details are below:

Mrs. Helen Vaughan
Senior Research Governance Officer
Sussex NHS Research Consortium

Research Department
Worthing Hospital
Lyndhurst Road
Worthing, West Sussex, BN11 2DH
Tel: 01903 285222 ext 4190
Fax: 01903 209884
E-mail: helen.vaughan@wsht.nhs.uk

For more detailed information on Research Governance please refer to the NHS Surrey Research Policy or contact Glynis John Quality & Clinical Governance Facilitator, glynis.john@surreypct.nhs.uk Tel: 07775 560105

7 VACCINES

Guidance for GPs on risk assessment for travellers, advised vaccinations, antimalarials and other appropriate advice is available by logging on to the TRAVAX website www.travax.nhs.uk

TRAVAX is paid for annually by the PCT for use by our practices and is accessed by Login and password (available from the Pharmacy Team).

TRAVAX aims to give 'evidence based' and practical information and to this end undertakes continual monitoring of travel related health risks and the available preventive measures. Quality is also regulated by the clinical governance procedures in place in Health Protection Scotland. TRAVAX carry out literature searches and specific research as required guided by the TRAVAX Advisory Board.

7.1 Global sum vaccinations

A number of vaccinations are available on the NHS for specific indications/circumstances – see Appendix 2 for the list.

No charge can be made to patients for these vaccines and immunisations.

The vaccine can be obtained in bulk by the practice and charged to the PPA on FP10 (or FP34D for specific vaccines).
The payment for the administration service provided by practices is paid for from the Global Sum (GMS) or built into the baseline funding for PMS practices.

Vaccines – both Influenza and HPV have a DES. The DES payment is £7.64 and pays the administration costs. The cost of purchasing the vaccine is claimed back using the FP34D form. HPV and mainly vaccines for children cannot be claimed on FP34D as they are supplied free of charge to practices.


8 PRESCRIBING ISSUES

8.1 Quantities

8.1.1 Acute Prescriptions

Prescriptions for medicines which have never been supplied to the patient before should be the minimum quantity necessary to assess the response and for no longer than the next review date (to a maximum of 28 days). It is worth remembering that most acute side effects occur within the first 7 to 14 days.

Quantities of medicines which are ‘when required’ should reflect the anticipated need of this course of treatment or review period.

8.1.2 Repeat Prescriptions

The decision to delegate a medicine as suitable for inclusion on the repeat medication list should be taken in accordance with the practice repeat prescribing policy.

The Department of Health takes the view that prescribing intervals should be in line with the medically appropriate needs of the patient, taking into account the need to safeguard NHS resources, patient convenience, and the dangers of excess drugs in the home.

NHS Surrey would suggest that if a medicine is to be issued as a repeat item, the quantity should usually be for 28 days (with the exception of HRT, oral contraceptives, levothyroxine and preparations supplied in original packs that cannot be broken down, e.g. certain creams, Didronel PMO® etc).

A maximum of 28 day supply is particularly recommended for medicines such as:

- Benzodiazepines & other hypnotic agents (based on CSM advice)
- Anti-depressants (particularly where there is potential for overdose)
- High cost drugs i.e. those costing £2,500 per patient per annum
- New drugs (whilst you establish benefit versus adverse effects)

It is estimated that between 5-10% of all prescription medicines are wasted (£8 -£15 million across NHS Surrey based on 2009-10 spend. The majority of wastage is due to changes in medication resulting in destruction of previously dispensed medicines. Consideration of quantities prescribed will have a beneficial effect on this level of wastage.

Special consideration should be given when prescribing for patients over 60 years of age. This age group is more vulnerable to the adverse effects of medicines and their general health varies greatly. This increases the likelihood that prescriptions will alter more frequently. Consequently, longer supplies often equate to more waste.

If a longer period is prescribed, consideration should be given to the likelihood of any adverse events, which may go unnoticed or alterations in therapy which will result in
wastage. All repeat medicines should be reviewed regularly to assess effectiveness and side-effects.

Up to 80% of people do not pay for their prescriptions but for those who do, a pre-payment certificate may be a cost effective option where they regularly have 4 or more prescription items in 3 months or 14 items in 12 months. These can be paid by direct debit – see PPA website for details [http://www.nhsbsa.nhs.uk/1127.aspx](http://www.nhsbsa.nhs.uk/1127.aspx)

There are 3 ways to apply for a pre payment certificate:

- Over the internet at [www.ppa.org.uk](http://www.ppa.org.uk)
- Over the telephone on 0845 850 0030
- Send an application form (Available from GP surgeries and community pharmacies (form FP95) by post to:
  
  *Prescription Pricing Authority*
  
  *PPC Issue Office*
  
  *PO Box 854*
  
  *Newcastle Upon Tyne,*
  
  *NE99 2DE*

With the development of repeat dispensing and Electronic Transfer of Prescriptions, it is likely that prescription intervals of 28 days will become the norm – see below for further information about Repeat Dispensing and the Electronic Prescription Service.

### 8.1.3 Excessive and Inappropriate Prescribing

This policy has been produced to support best prescribing practice and is intended to inform all prescribers in relation to prescribing behaviour that could be considered excessive or inappropriate. This policy refers to Annex 8 of the GMS contract but the principles will be applied to any prescriber working for or on behalf of a practice. [http://www.portal.surreypct.nhs.uk/DocLibraries/Policies%20Procedures%20and%20Guidelines/POLICY%20excessive%20inappropriate%20prescribing%20updated%20April%202012.pdf](http://www.portal.surreypct.nhs.uk/DocLibraries/Policies%20Procedures%20and%20Guidelines/POLICY%20excessive%20inappropriate%20prescribing%20updated%20April%202012.pdf)

### 8.2 Repeat Dispensing

Repeat dispensing is the process by which patients can obtain supplies of their repeat medicines over a defined period of time, without the need to contact their GP practice on each occasion a new supply is required.

Under the repeat dispensing system, the prescriber produces a ‘repeatable’ prescription on a standard FP10 prescription form for the patient’s repeat medicines. This must be annotated to distinguish it from a standard prescription form.

A series of accompanying ‘batch issues’ (also printed on FP10 forms) enable the pharmacist to continue to dispense the medicines by instalments for the duration of the original repeatable prescription. This can be up to 12 months.

Repeat Dispensing makes it easier for patients to obtain repeat supplies of their medication in instalments at the community pharmacy, speeding up services and relieving pressure on GP surgeries.

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1 QoF indicator - Medicines 5 and 9
Repeat Dispensing offers an opportunity to streamline the process, improve services for patients, reduce wastage and enhance the role of community pharmacists.

**Practices must** notify the PCT of their intention to provide repeat dispensing services. This notification should:
- Provide the names of the GPs who will be providing services
- Specify a start date. This should provide at least one week’s notice to allow the PCT to amend the list of doctors providing repeat dispensing services.

Repeat dispensing is specified as an essential service under the new Community Pharmacy Contractual Framework. As of 1st October 2005 therefore, all pharmacies must be in a position to dispense a repeatable prescription if presented with one.

There is a requirement for community pharmacists to undertake appropriate training before providing repeat dispensing services. Training requirements are set out in paragraph 4.2 of part VIA of the drug tariff.

Prior to each dispensing episode the pharmacist will ensure that the patient is taking or using, and is likely to continue to take or use, the medicines or appliances appropriately, and that the patient is not suffering any side effects from the treatment which may suggest the need for a review of treatment. The pharmacist will also check whether the patient’s medication regimen has been altered since the prescriber authorised the repeatable medication and whether there have been any other changes in the patient’s health since that time, which may indicate that the treatment needs to be reviewed by the prescriber.

The selection of appropriate patients is vital for the success of the repeat dispensing process. For more information about this and other elements of Repeat Dispensing please contact a member of the Medicines Management Team.

### 8.3 Electronic Prescription Service (EPS)

The Electronic Prescription Service (EPS) is being developed and implemented by the Electronic Transmission of Prescriptions (ETP) programme.

Additional information and regular updates can be found on the Connecting for Health website at [www.cfh.nhs.uk/eps](http://www.cfh.nhs.uk/eps)

EPS will bring gains in both efficiency and safety for both patients and health professionals. Once fully operational, EPS will:
- Reduce unclear or illegible prescriptions which may lead to the wrong items being dispensed, thereby increasing patient safety
- Allow the instant cancellation of prescriptions thought no longer clinically appropriate
- Prevent the loss of prescription forms
- Reduce the number of fraudulent prescriptions
- Allow preparation of prescriptions in advance of their collection, saving patient time at the dispensary, and making it easier for pharmacists to manage workflow and stock control
- Relieve patients or their representatives of the need to collect prescriptions from the prescriber
- Eliminate the need for pharmacists to re-enter prescription information, thereby saving time and increasing dispensing accuracy

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2 The National Health Service (General Medical Services Contracts) Regulations 2004
3 Service Specification ES2 (version 1 10-10-04)
• Allow faster and more accurate processing of prescriptions by the BSA (Business Services Authority)

Each GP surgery and pharmacy will go through two main stages of implementation, based upon two software upgrades which are known as "Release1" and "Release 2".

Release 1 will lay the technical foundations required to operate the Electronic Prescription Service. Patients themselves will not notice much change when their GP surgery has implemented Release 1. They will still receive a paper prescription, which will be almost identical to the current FP10 paper prescription form except that it will have a barcode on it which represents a unique code to identify the prescription.

When a dispenser, who has also implemented Release 1 of the software, receives a paper prescription which has a barcode on it, scanning the barcode will retrieve the electronic copy of the information onto the dispenser's computer. There will be no need to retype the information onto the dispenser's system as there is currently, which will also help to improve accuracy.

On implementation of Release 2, the prescriber will be able to apply an electronic signature to the electronic message. Smartcards, which control access to the Electronic Prescription Service, will also control who is allowed to electronically sign a prescription. Release 2 will also allow a patient's prescription to be sent electronically from their GP to a pharmacy.

Regulatory changes were required in order to allow the use of an electronic signature for ETP. The Medicines for Human Use (Prescribing) Order 2005 amended the Prescription Only Medicines (Human Use) Order 1997 to allow a prescription to be signed by an advanced electronic signature. However, current NHS legislation states that PCTs must be authorised by the Secretary of State before contractors in their area operating under an NHS contract can use EPS. This will allow the controlled rollout of electronic prescribing to the NHS. Initially, EPS will not use electronic signatures. A paper prescription, issued in parallel with the EPS message, will remain the legal prescription.

8.4 Patients travelling or moving abroad

Under NHS legislation, the NHS ceases to have responsibility for people when they leave the U.K. However, to ensure good patient care the following guidance is offered:

People travelling to a European Economic Area (EEA) country or Switzerland should make sure they obtain a European Health Insurance Card (EHIC) as well as private health insurance. The card entitles you to reduced cost, sometimes free, medical treatment in most European countries.

The EHIC is issued by the Prescription Pricing Authority (PPA) and is free of charge.

You can apply for an EHIC for your spouse/partner and any children up to the age of 16 (or 19 if they are in full-time education) at the same time as applying for your own. If you are a foster parent or guardian (including boarding school teaching staff), you can apply on behalf of any children you are looking after. You must be over 16 to apply as a main applicant.

• Apply for an EHIC online at www.ehic.org.uk  The card will be delivered within 7 days.
• Apply by phone on 0845 606 2030. The card will be delivered within 10 days.
• Apply by post by picking up a form from the Post Office. The card will be delivered within 21 days.

Patients travelling abroad should always have clear information about any existing medical conditions & medications and should keep a written record. This may be required in order
to export their medication or to bring it back into the UK. The generic names, as well as the trade names, may be required in order to accurately identify any medicines.

Medication required for a pre-existing condition should be provided in sufficient quantity to cover the journey. If the patient is returning within the timescale of a normal prescription then this should be issued.

For longer visits abroad, the patient should be advised to register with a local doctor for continuing medication (this may need to be paid for by the patient). NB. It is wise to check with the manufacturer that medicines required are available in the country being visited.

**Persons who have left the UK, or who are intending to leave the UK for more than 3 months are not normally allowed to continue to be registered with a practice**

GPs are advised not to provide prophylactic treatment on NHS prescriptions for conditions that may arise while travelling e.g. travel sickness, diarrhoea. Patients should be advised to purchase these items prior to travel. Advice is available from community pharmacists if required. Patients should be advised to seek medical attention abroad for conditions that arise at that time and are unresponsive to self medication.

### 8.4.1 Prescribing for Patients travelling abroad/access to free NHS services/visitors to the UK

Entitlement to free NHS services is a complex matter and depends on many factors. The regulations concerning entitlement to NHS treatment in England and additional advice concerning overseas visitors can be found on the Department of Health website [www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors](http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors)

### 8.4.2 NHS funding and healthcare abroad


### 8.5 Temporary Residents / eligibility to free NHS healthcare for visitors to the UK

A GP remains clinically responsible for the duration of the treatment that they prescribe. It is therefore advised that prescribing for Temporary Residents should reflect the time the patient is under the temporary care of the GP. Thus if a patient is registered for 14 days any prescription should be for a very limited period. However, some flexibility may be needed to support patients in seeking further medical advice, e.g. from their own GP on their return home. In general, such prescriptions should not exceed 28 days, and it will often be appropriate for them to be shorter.

#### 8.5.1 Asylum seekers

Asylum seekers and refugees who are given leave to remain in the UK, or who are awaiting the results of an application to remain or an appeal, are entitled to register with a GP practice and receive free NHS primary medical services.

If an asylum seeker loses their claim to asylum and all appeal processes have been exhausted, they become ineligible for routine NHS primary care treatment from the date their asylum claim failed. A practice can then charge the individual concerned as a private
patient for any treatment which it provides, unless the treatment is emergency or immediately necessary – further information and advice can be found on the Department of Health website http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors/index.htm

8.5.2 Emergency or Immediately Necessary treatment

A practice is required to offer free NHS treatment to anyone who requests it if, in the opinion of a clinician, it is immediately necessary.

This is essential treatment, which in the clinical judgement of a healthcare professional cannot be delayed or avoided.

A practice is also required to offer free emergency or immediately necessary treatment to a person who:

- Has been refused acceptance onto the practice list for up to 14 days from the date of refusal or until registered elsewhere (whichever is sooner)
- Has been refused by the practice as a Temporary Resident for up to 14 days from the date of refusal or until accepted elsewhere (whichever is sooner)
- Is in an area for less than 24 hours

A patient might require necessary drugs or dressings following immediately necessary treatment. These are supplied and prescribed in the same was as for UK residents. Prescription charges might also be applicable.

Immediately necessary treatment also includes treatment that, in the clinical judgement of a health care professional, is required to treat a pre-existing condition that has become exacerbated during the period of a person’s stay in the UK.

8.6 Monitored Dosage Systems (MDS) / auxiliary aids

An auxiliary aid may be more appropriate than a Monitored Dosage System (MDS). The decision rests with the pharmacist in conjunction with the patient and others involved in their care.

Under the Disability Discrimination Act (DDA) pharmacies must provide the most appropriate auxiliary aid to disabled customers. Auxiliary aids include:

- Tick charts /medication administration
- Reminder cards
- Wing tops
- Large labels
- Oversized bottles

An MDS should not be used when Social Services care workers (not necessarily the case for other care workers) are in attendance, they can administer from a labelled container.

An MDS is not suitable where medications are “when required”, dispersible, liquid or in a form with limited stability.

Pharmacies can make a charge to cover the cost of providing an auxiliary aid if:

- the patient does not meet the criteria of the DDA, or
- Another adjustment is deemed more appropriate, but the patient or their carer insists on a particular auxiliary aid.

Where the intention is to dispense a 28-day supply, pharmacies can not request 7-day prescriptions.

The following statement summarises the agreement between our LMC and LPC:
• Community pharmacists will not directly request 7 day prescriptions from any GP
• If as a result of a DDA assessment, or by other means, a patient is identified as needing an MDS unit, this will be initially discussed with the pharmacist: this may be with the patient, relative, community nursing staff, or carer
• If the pharmacist agrees that they are willing to dispense via MDS, and other issues (such as how the prescription is received and collected/delivered) are resolved, then the patient or their representative will contact the GP to explain the above
• The final decision as to the prescribing interval used is for the GP to make, bearing in mind such issues as the patient’s clinical needs, safeguarding NHS resources, patient convenience, and the dangers of excess drugs in the home, need to be taken into account – these examples are all drawn from BMA advice.

8.7 Prescribing for Nursing & Residential Homes

8.7.1 Homely remedies

By law an appropriately trained nurse can administer any P or GSL medication to a patient in their care without the need for a prescription. However, it is strongly recommended by the Nursing & Midwifery Council (NMC) that a robust protocol is in place with their employing organisation.

A “homely remedy” protocol can be agreed between the care home and the GP providing the prescribing service, which allows nursing staff to administer specific non-emergency, non-prescription medicines that would otherwise require the GP or out-of-hours provider to be called, or the patient going without the medicine until the GP is able to visit.

Examples of typical homely remedies include:
• Gaviscon liquid
• Paracetamol tablets
• Senna tablets
• Lactulose
• Aqueous cream

The medicines included in the homely remedy protocol can be obtained in one of two ways:
• The care home can purchase these medicines to keep as stock
• The GP can write a bulk prescription on an FP10 – however, this is not always possible (see below)

A bulk FP10 prescription can be written4:
• For any P or GSL medicines that is prescribable on FP10
• For any 2 or more patients
• Where the care home has at least 20 residents and the GP issuing the bulk prescription is responsible for at least 10 or more of those residents

The prescription should bear the name of the institution and there are no charges for bulk prescriptions.

4 Drug Tariff March 2008; Part VIII paragraph 9
9 Prescribing decision aids, tools and information

9.1 Prescribing Advisory Database (PAD)
The PAD contains information and guidance in relation to the prescribing of medicines in Surrey:

- All decisions, policy statements and submission papers are available from the on Surrey Prescribing Clinical Network and the Medicines Commissioning Group. It is intended all key decisions made by Surrey Acute Trust Drugs and Therapeutic Committees or equivalent will be added.
- The Traffic Light Status for the individual drugs are displayed and where applicable the relevant amber shared care protocol or amber* information sheet. It is intended that the traffic light system will provide guidance on the use of medicines across the interface between primary and secondary care. It provides a framework for defining where clinical and therefore prescribing responsibility should lie through categorisation of individual drugs. The system is only advisory but is intended to clarify expectations of prescribing responsibility.
- All agreed drug pathways and Surrey decision making tools in relation to prescribing are available on the PAD

http://www.app.surreyhealth.nhs.uk/gpview/default.html

For comments or suggestions regarding the PAD please email sur-pct.SurreyPAD@nhs.net

9.2 Prescribing for the Management of Anxiety Spectrum Disorders and Depression – The Mood Hive
The Mood Hive is a web-based tool to help health care professionals recognise and manage depression and anxiety spectrum disorders. The tool has been developed with NHS Surrey and Surrey and Borders Partnership NHS Trust. It has been designed to help with diagnosis of depression and anxiety, treatment choices and management of lack of efficacy and / or tolerability issues and appropriateness of referrals to secondary care.

http://www.sabp.nhs.uk/moodhive

9.3 ScriptSwitch®
ScriptSwitch® is a software solution which works alongside practice clinical IT systems to offer up-to-date prescribing recommendations at the point of prescribing.

The advice offered by ScriptSwitch® is tailored by the PCT Pharmacy team to reflect local and national prescribing recommendations and offer both clinical and cost-effective prescribing advice.

The prescriber is able to accept or reject the advice at the click of a button.

Feedback on any ScriptSwitch® recommendations should be directed towards the PCT Medicines Management Team on surrey.scriptswitch@nhs.net

9.3.1 ScriptSwitch® Reports
Both the PCT and the practices are able to access ScriptSwitch® reports at http://reporting.scriptswitch.com

Should you experience any difficulties in doing this, the Technical Support number at ScriptSwitch® is 02476 430 064

Practices are able to access their own reports to review the number of times each prescriber accepts or rejects the ScriptSwitch® advice. This will allow practices to identify
internal variation in prescribing practice. The extent to which practices use this data is entirely up to them.

The PCT Pharmacy team are able to access reports of the number of times each practice accepts or rejects the advice and the potential financial benefit for the PCT and practice. This information is used to refine the messages and identify key areas of change and to evaluate the cost effectiveness of the system.

9.3.2 Summary of advantages

ScriptSwitch® provides advice which:
- Is up to date and relevant to local prescribing issues
- Supports practices in achieving financial balance
- Supports achievement against national and local targets e.g. QoF action points, medicines management local enhanced service, QIPP.

ScriptSwitch® delivers advice simply, quickly and safely for every prescriber at the point of prescribing.

ScriptSwitch® allows the prescriber to make quick changes to patients' prescriptions with no extra effort.

9.4 Prescribing of Borderline substances

In certain conditions some foods and toilet preparations have characteristics of drugs.

The Advisory Committee on Borderline Substances (ACBS) advises as to the circumstances when such substances may be regarded as drugs and can be prescribed on the NHS.

When prescribed under these circumstances the prescription should be endorsed “ACBS”.

Doctors should satisfy themselves that the products can safely be prescribed, that patients are adequately monitored and that, where necessary, expert hospital supervision is available.”

A list of these preparations and the specific conditions that they can be used to treat are listed in part XV of the Drug Tariff.

Although this is a non-mandatory list, Nurse and Pharmacist Independent Prescribers should normally restrict their prescribing of borderline substances to items on the ACBS approved list. They should also work within the guidance of their employing organisation.

GPs may use their clinical judgement and take full responsibility when they choose to make exceptions to the approved list.

This may occur following recommendations from a dietician or for a medical condition requiring nutritional support for a defined period of time. For example a patient discharged from hospital having had a wired jaw and requiring nutritional support for 6-8 weeks post-operation.

The PCT will support any doctor wishing to refuse prescriptions of dietary products for patients (or nursing or residential homes) not complying with the above uses and using them as a convenience rather than liquidizing/purchasing appropriate food.

GPs are often requested by patients to prescribe dietary supplements or herbal remedies that might have medical value. Examples include St. John’s Wort and co-enzyme Q10. As
these are all currently unlicensed, it is recommended that these are not prescribed and that the patient is directed to purchase them from an appropriate outlet. Of course, if an illness such as depression is diagnosed, then licensed medicines should be prescribed as appropriate. Please consult a member of the Pharmacy team for further advice when necessary.

9.4.1 Drugs requiring “SLS” endorsement

The following drugs are only prescribable on the NHS for specific groups of patients with specific conditions - see Part XVIIIB of the Drug Tariff for list. Prescriptions should be endorsed with the reference “SLS”:

- Clobazam
- Cyanocobalamin tablets
- Locabiotal aerosol
- Niferex elixir 30ml paediatric dropper bottle
- Nizoral cream
- Oseltamivir (Tamiflu)
- Zanamivir (Relenza)

The following drugs for erectile dysfunction:

- Alprostadil (Caverject, MUSE, Viridal)
- Apomorphine hydrochloride (Uprima)
- Moxisylyte hydrochloride (Erecnos)
- *Sildenafil (Viagra)
- *Tadalafil (Cialis)
- Thymoxamine hydrochloride (Erecnos)
- Vardenafil (Lевитра)

*Note*: there have been prescriptions for Sildenafil and Tadalafil, prescribed for pulmonary hypertension with an SLS endorsement. This is against the GP terms of service. GPs should contact the medicines management team if asked to prescribe these drugs for any indication other than erectile dysfunction.

*Note*: prescribing of these drugs for severe distress should only be carried out in specialist centres using FP10(HP)s and endorsed SLS if they are to be dispensed in the community.

9.5 Prescribing gluten-free foods

To achieve a balanced diet, it is essential that patients include naturally gluten free carbohydrates in their diet. These include rice, potatoes, corn (maize), soy, buckwheat, millet, lentils, quinoa and amaranth.

GPs can aid patient adherence to a gluten free diet by prescribing up to a maximum of eight items of long life bread or flour per patient, per month. Since March 2011 NHS Surrey have recommended a restriction of gluten free foods to ensure the cost effective use of NHS resources and the equity of the supply of dietary products.

Table 1 provides the list of long life bread, flour and bread mix agreed for funding by NHS Surrey.
Ener-G gluten-free brown rice bread 474g
Ener-G gluten-free tapioca bread sliced 480g
Ener-G gluten-free white rice bread sliced 456g
Glutafin gluten-free wheat-free fibre loaf sliced 400g
Glutafin gluten-free wheat-free white loaf sliced 400g
Glutafin Select gluten-free fibre loaf sliced 400g
Glutafin Select gluten-free seeded loaf sliced 400g
Glutafin Select gluten-free white loaf sliced 400g
Juvela gluten-free fibre loaf sliced 400g
Juvela gluten-free fibre loaf unsliced 400g
Juvela gluten-free white loaf sliced 400g
Juvela gluten-free loaf white unsliced 400g

Flour products that are available:
Innovative Solutions Pure Xanthan
Innovative Solutions Pure Gluten-Free Blended Flour
Innovative Solutions Pure White Rice Flour
Innovative Solutions Pure Brown Rice Flour
Innovative Solutions Pure Potato Starch Flour
Innovative Solutions Pure Tapioca Starch Flour
Innovative Solutions Pure White Teff flour
Innovative Solutions Pure Brown Teff flour
Orgran self-raising flour

Bread Mix that is available:
Orgran Bread Mix

10 Home Oxygen
The New Home Oxygen contract started on 26th March 2012 and the supplier for NHS Surrey patients has changed from Air Liquide to Dolby Vivisol. The aim of the new contract is to improve patient access to a wider range of technologies, introduce a robust assessment process reflecting the Department of Health Home Oxygen Good Practice Guide for Assessment and Review (available from: http://www.pcc.nhs.uk/home-oxygen-service-good-practice-guide-for-assessment-and-review) for Long Term Oxygen Therapy (LTOT) and ambulatory oxygen. One of the major changes to the new contract is that the prescriber chooses the equipment rather than the supplier.

Home Oxygen Consent form
A consent form must be completed for all patients receiving home oxygen for the first time, available here: http://www.pcc.nhs.uk/home-oxygen-consent-form

The Home Oxygen Consent Form (HOCF):
- Must be signed by the patient to indicate that they agree to the sharing of their information with Dolby Vivisol
- Should be completed in the presence of the patient
- Should be completed at the same time as the HOOF
- Should be copied (front page only) and filed in the patient’s notes; copy given to the patient

Note: Once a patient has completed a consent form, they will not be required to complete another, even if a new HOOF form is completed.
Prescribing Home Oxygen

Prescribing of home oxygen is done via the HOOF (Home Oxygen Order Form) – since the introduction of the new contract, there are 2 types of HOOFs:

**HOOF Part A**: The HOOF Part A should be used where the request is made via non-specialist Healthcare Professionals, or for temporary supply pending a specialist review. Static concentrators (usually for LTOT) and static cylinders for short burst oxygen therapy (SBOT) can be ordered using this form.

The HOOF part A is available here: [http://www.pcc.nhs.uk/home-oxygen-order-form](http://www.pcc.nhs.uk/home-oxygen-order-form)

**HOOF Part B**: The HOOF Part B is for specialist Healthcare Professionals trained in assessing and reviewing patient’s home oxygen needs (e.g. respiratory specialist practitioners). The HOOF Part B gives access to a wider range of treatment modalities, including several options for ambulatory oxygen.

Prescribing of oxygen should only routinely be done by respiratory specialists (exceptions include palliative care) oxygen for patients suffering from cluster headaches and paediatric patients should only be initiated under the recommendation of the relevant specialist.

All HOOFs and consent forms should be faxed to Dolby Vivisol on: 0800 781 4610

- A copy of the completed HOOF should be:
  - Filed in the patient’s notes (original form)
  -Copied to the patient’s GP (if you are not the GP!)

On receipt of the HOOF Dolby Vivisol will:
- confirm by automatic fax back that they have received the form
- Fax a copy to the Commissioning Pharmacist/Oxygen Lead at Cedar Court (the patient signs a consent form (HOCF) for the sharing of this information to enable the PCT to check payments to the supplier)
- activate the request and arrange delivery of the oxygen as specified
- undertake any necessary installation and provide all the necessary equipment to the patient
- ensure that the patient is trained in its use before informing the specialist team that the order has been completed
- maintain regular contact with the patient to ensure that they have the necessary supplies and that their equipment is regularly maintained
- It is extremely important that ALL section of the HOOF are completed for PCT records and auditing purposes – particularly Section 3.1 Clinical Code(s) on the HOOF Part A.

A HOOF remains valid and Dolby Vivisol will continue to provide oxygen supplies until you either notify them of a change in the patient’s requirements by completing a new HOOF, or if you terminate the supply by notifying them. It is recommended that patients should be reviewed regularly to determine whether they still require oxygen or whether their oxygen requirements have changed. **If a patient dies or no longer requires Oxygen, Dolby Vivisol and the PCT must be notified, so their Oxygen account can be closed, otherwise NHS Surrey will continue to be billed.**
Oxygen Therapies

- **Short burst (SBOT)** - Where oxygen therapy is only required on an as required basis for short periods of time. Patients may require assessment for long term oxygen and need specialist referral.

- **Long-term (LTOT)** - Where a patient requires continuous oxygen for several hours a day and/or night (including where this is part of palliative care for patients being cared for at home) - this is usually delivered via a concentrator. Respiratory patients must be clinically stable for 5-6 weeks before assessment (including blood gases) for LTOT can be conducted – during this time they may be prescribed a trial of SBOT.

- **Ambulatory** - Where, following specialist assessment, it is considered that a patient has a clinical need (e.g. desaturation on exertion) or is on LTOT and requires the greater mobility provided by the use for portable or ambulatory oxygen (e.g. to continue to attend school or work).

- **Emergency oxygen** - Where a GP or out of hours service decides oxygen is needed urgently in the home but the patient does not require hospital admission. Dolby Vivisol will deliver within four hours of receipt. Patients should then be referred to the relevant specialist team for assessment of ongoing need.

Additional Emergency supplies

**Holiday provision**

- If patients require oxygen away from home using the same equipment they have at home, a Holiday HOOF is no longer required under the new contract. Instead, the patient can call the Dolby Vivisol Customer Contact Centre on 0500 823 773 (Freephone) and arrange their oxygen-away-from-home supply **at least 3 weeks** before departure.

- If a patient needs different or additional equipment (for instance portable oxygen) to travel within the UK, they need to advise their Healthcare Professional. Please allow enough time for a new holiday order form (holiday HOOF) to be processed - **at least 3 weeks** before required. Details, such as arrival and departure dates, contact details at the destination and the address where the oxygen will be required should be completed on the HOOF.

This HOOF should then be faxed to Dolby Vivisol in the normal way and they will arrange the supply to the holiday address.

**Emergency provision** - Complete the HOOF in the normal way, identifying that this is an URGENT request (Box 10.3 on the HOOF Part A). Oxygen will be provided within 4 hours of receipt of the HOOF. Patients should then be referred the relevant specialist team for assessment of ongoing need. Note there is an additional cost for urgent delivery.

**Specialist Assessment**

Clinical good practice guidelines recommend that patients requiring LTOT or ambulatory oxygen should be referred to a respiratory consultant/specialist practitioner for assessment. Specialist teams will assess the patient and order oxygen if appropriate when:

- a GP has referred a patient for specialist assessment
- a patient is discharged from hospital
- a patient’s needs are re-assessed as part of clinical follow up and review services
After assessment, many patients will remain under the care of the specialist who should liaise directly with Dolby Vivisol whilst also keeping the GP informed.

**Hospital discharge**
Dolby Vivisol operates a dedicated advice service for clinical staff who may wish to discuss their patient’s needs and will also provide an office hours advice and support service for patients and carers on the use and maintenance of equipment and a 24-hour emergency service for patients experiencing problems with their equipment (see Dolby Vivisol contact details below).

Dolby Vivisol will provide oxygen services to a patient’s home within 24 hours of notification of the patient’s discharge (provided box 10.2 on the HOOF Part A is ticked to indicate next day delivery is required). The cut off point is 5pm on the day of order.

**Nursing/Residential Homes requesting oxygen**
Oxygen is a drug and should only be prescribed for patients following individual assessment (preferably by a specialist team with the exception of palliative care) or used by emergency services. Use of oxygen by an untrained person can have disastrous consequences.

The private supply of oxygen to nursing/residential homes is not supported by NHS Surrey and nursing/residential homes using oxygen in this manner do so at their own risk.

Homes should be reminded that Dolby Vivisol can deliver emergency oxygen within 4 hours of receipt of a HOOF from a GP.

Where oxygen is needed more urgently than this the ambulance service should be called.

**Managing Oxygen Costs – Prescribing Advice**
The tariff charged for oxygen was agreed nationally by the Department of Health and the suppliers. Unlike the previous contract where the PCT was charged a daily tariff for oxygen regardless of actual use, the PCT is now charged per delivery and per refill, resulting in potential cost savings provided the cost of oxygen is not driven up by large numbers of refills or deliveries. It is important that prescribers therefore order the right amount and type of equipment – if assistance with this is required, contact the Dolby Vivisol dedicated clinician support line (see below).

Where a GP feels it is appropriate for him/her to prescribe oxygen, patients should then be referred to specialist teams as soon as possible for further assessment. Patients requiring ambulatory oxygen should be referred for specialist assessment and considered for Pulmonary Rehabilitation.

Dolby Vivisol Contact Information:
Dedicated Clinician support line: 0844 381 4402
- Free phone patient number, 24 hrs, 7 days a week: 0500823773
- Healthcare professional’s email: cliniciansupport@dolbyvivisol.com (should you need to send patient identifiable data please use DMHRC.prescribers@nhs.net
- Website: www.dolbyvivisol.com/england

11 **Non- Medical Practitioners**
Non medical prescribing is a generic term that covers independent and supplementary prescribing.
11.1 Independent Prescribing

Independent prescribing was introduced in May 2006 and is prescribing by a practitioner responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.

Independent prescribing allows a suitable practitioner to prescribe any licensed medicine for any medical condition within their own level of experience and competence.

11.1.1 Who can be an independent prescriber?

The following healthcare professionals are able to act as independent prescribers following successful completion of programmes approved by their professional body:

- Registered nurses (first level)
- Registered specialist Community Public Health Nurses
- Registered midwives
- Registered pharmacists
- Registered optometrists

The DH Guide to Implementation and the NMC Standards of Proficiency for nurse and midwife prescribers state that nurses put forward for prescribing training must have at least three years post-registration experience. Pharmacists should have at least two years experience following their post-registration year.

11.1.2 What can they prescribe?

Nurse and pharmacist independent prescribers can prescribe any licensed medicine (i.e. products with a valid marketing authorisation/licence in the UK) in the British National Formulary, including schedule 2-5 controlled drugs, for any condition within their clinical competence. This does not apply to the prescribing of cocaine, diamorphine or dipipanone for the treatment of addiction (this is restricted to Home Office licensed doctors).

Nurse and Pharmacist Independent Prescribers are permitted to prescribe unlicensed medicines (medicines without a UK marketing authorisation) and licensed medicines for uses outside their licensed indications/UK marketing authorisation (so called ‘off-licence’ or ‘off-label’). They must however, accept professional, clinical and legal responsibility for that prescribing, and should only prescribe ‘off-label’ where it is accepted clinical practice.

Optometrist independent prescribers are able to prescribe any licensed medicine for ocular conditions affecting the eye, and the tissue surrounding the eye, within their recognised area of expertise and competence, except for controlled drugs or medicines for parenteral administration. Optometrist independent prescribers are not permitted to prescribe unlicensed medicines.

Independent prescribers should also work within the guidance of their employing organisation and take into account local formulary policies and the implications for primary care.

Further guidance on independent prescribing can be found in the Department of Health document 'Improving patients' access to medicines: A guide to implementing nurse and pharmacist independent prescribing within the NHS in England'.
11.1.3 What training is required?

Higher education institutions (HEIs) provide a specific programme of preparation and training for independent prescribing. These programmes are approved by the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain (RPSGB).

Pharmacists and nurses must register their prescribing qualification with their professional body [http://www.pharmacyregulation.org/](http://www.pharmacyregulation.org/) and [www.nmc-uk.org](http://www.nmc-uk.org) respectively.

The training for nurses and pharmacists is spread over a period of six months, and consists of at least 26 days training and 12 days learning in practice.

All participants must pass the end of course assessments.

A designated medical practitioner (DMP) is required to supervise the student during the in-practice learning and provide support. The DMP has a critical and highly responsible role in educating and assessing the non-medical prescriber and assuring competence in prescribing.

Guidance entitled ‘Training non-medical prescribers in practice – A guide to help doctors prepare for and carry out the role of designated medical practitioner’ is available on the National Prescribing Centre website at [www.npc.co.uk](http://www.npc.co.uk).

11.2 Supplementary Prescribing

Supplementary prescribing is a voluntary prescribing partnership between the independent prescriber (who must be a doctor or dentist) and supplementary prescriber, to implement an agreed patient-specific clinical management plan (CMP), with the patient’s agreement.

This mechanism of prescribing is helpful for nurse and pharmacist prescribers when they are newly qualified. It will also be appropriate in specific situations, for instance:

- When working within a team where a doctor is accessible
- For specific long-term conditions
- For mental health and
- For situations involving Controlled Drugs

11.2.1 Who can be a supplementary prescriber?

Supplementary prescribing was introduced for nurses and pharmacists, and has been extended to include physiotherapists, chiropodists/podiatrists, radiographers and optometrists.

11.2.2 What can they prescribe?

The CMP (written or electronic) must:

- be in place before supplementary prescribing can occur
- be specific to a named patient/client and to that patient/client’s specific condition(s) to be managed by the supplementary prescriber
- include details of the illness or conditions that may be treated, the class or description of medical products that can be prescribed or administered, and the circumstances in which the supplementary prescriber should refer to, or seek advice from, the doctor/dentist

Supplementary prescribers must have access to the same patient/client health records as the doctor/dentist.
Following agreement of the CMP, the supplementary prescriber may prescribe any medicine for the patient that is referred to in the plan, until the next review by the independent prescriber.

There is no formulary for supplementary prescribing, and no restrictions on the medical conditions that can be managed under these arrangements.

Supplementary Prescribers can prescribe Controlled Drugs and unlicensed medicines in partnership with a doctor, where the doctor agrees within a patient’s CMP.

### 11.2.3 What training is required?

The training for supplementary prescribing is incorporated into Nurse and Pharmacist Independent Prescribing.

Many Higher Education Institutions (HEIs) are offering the supplementary prescribing elements of the course as multi-disciplinary training for nurses, pharmacists, and Allied Health Professionals.

The exception is optometrists, who follow a programme more specific to the eye.

All professional groups must register their supplementary prescribing qualification with their regulatory body before beginning to prescribe.

### 12 Patient Specific directions and Patient Group Directions

#### 12.1 Patient Specific Directions (PSDs)

A Patient Specific Direction is the traditional written instruction, from a doctor, dentist or independent prescriber (i.e. nurse or pharmacist independent prescriber), for medicines to be supplied or administered to a named patient or group of named patients. As it is individually tailored to the needs of patients, it should be used in preference to a Patient Group Direction (PGD) wherever appropriate.

PSDs are used once a patient has been assessed by a prescriber and that prescriber (doctor, dentist or independent prescriber) instructs another healthcare professional in writing to supply or administer a medicine directly to that named patient or to several named patients.

**Examples of a PSD for a single named patient:**

- The usual method for the supply and administration of vaccines in the routine childhood immunisation programme could be via a PSD. The authorisation for this is usually the responsibility of the GP or an independent nurse prescriber at the six to eight-week check and is recorded as an instruction in the Personal Child Health Record (PCHR or Red Book). This agreement allows immunisations to be given in GP surgeries or clinics.

- A prescriber (i.e. GP) could make an electronic written instruction for a patient to be administered a particular vaccine in a patients medical record. This written instruction from the prescriber would constitute a PSD.

**Example of a PSD for a group of named patients**

- As an example, a GP could print off a list of patients’ names off the computer, write an instruction for them all to have a vaccination administered, then add the practice address and date it (the GP signature is also advisable).
Where a PSD exists, there is no need for a PGD.

12.2 **Patient Group Directions**

A Patient Group Direction (PGD) is a written instruction for the supply or administration of a medicine where the patient may not be individually identified before presenting for treatment.

The supply and administration of medicines under PGDs should be reserved for the limited number of situations where this offers an advantage for patient care (without compromising patient safety).

PGDs can only be used by the following registered healthcare professionals, as named individuals:
- nurses
- midwives
- health visitors
- paramedics
- optometrists
- chiropodists/podiatrists
- radiographers
- orthoptists
- physiotherapists
- pharmacists
- dieticians
- occupational therapists
- prosthetists
- orthotists
- speech and language therapists

PGDs are legal documents and must follow the guidance set out in HSC 2000/026. This includes the requirements that:
- The PGD must be signed by a senior doctor and a senior pharmacist, both of whom should have been involved in developing the direction
- The PGD must be authorised by the Primary Care Trust
- PGDs should be drawn up and signed by a multi-disciplinary group involving a doctor, a pharmacist and a representative of any professional group expected to supply medicines under the PGD
- A senior person in each profession should be designated with the responsibility to ensure that only fully competent, qualified and trained professionals operate within directions
- All professions must act within their appropriate Code of Professional Conduct

A PGD can include a flexible dose range so the healthcare professional can select the most appropriate dose for the patient.

Medicines can be used outside the terms of their Summary of Product Characteristics (SPC) so called ‘off-license/off-label’ use, provided such use is supported by best clinical practice. The PGD should state when the product is being used outside the terms of the SPC and why this is necessary. However, unlicensed products which do not have a marketing authorisation in the UK, cannot be authorised under a PGD.

Black triangle (▼) vaccines used in immunisation programmes may be included in PGDs, providing they are used in accordance with the recommendations of the Joint Committee
on Vaccination and Immunisation (JCVI) (Health Service Circular, 2000/026). The PGD should state that a black triangle medicine is being included.

Information which must be included in a PGD is subject to legislation which specifies that each PGD must contain the following information:

- the name of the business to which the direction applies i.e. NHS Surrey
- the date the direction comes into force and the date it expires
- a description of the medicine(s) to which the direction applies
- class of health professional who may supply or administer the medicine
- signature of a doctor or dentist, as appropriate, and a pharmacist
- signature by an appropriate health organisation i.e. clinical governance lead
- signature of a representative of the professional group expected to supply medicines under the PGD
- the clinical condition or situation to which the direction applies
- a description of those patients excluded from treatment under the direction
- a description of the circumstances in which further advice should be sought from a doctor (or dentist, as appropriate) and arrangements for referral
- details of appropriate dosage and maximum total dosage, quantity, pharmaceutical form and strength, route and frequency of administration, and minimum or maximum period over which the medicine should be administered
- relevant warnings, including potential adverse reactions
- details of any necessary follow-up action and the circumstances
- a statement of the records to be kept for audit purposes

13 NHS Surrey Medicines Management Committees

13.1 Medicines Commissioning Group (MCG)

The full Terms of Reference for the MCG can be found on:

[link tbc](#)

Minutes are available under Freedom of Information and will be made available on the PCT intranet [link TBC](#)

The committee’s prime function is to promote a consistent approach with respect to medicines management across Surrey and to work closely with other healthcare organisations both in Surrey and other neighbouring areas to facilitate this.

The **remit** of the committee includes:

- Strategic development for medicines management, prescribing and pharmacy support
- Advising on financial and performance management matters
- Addressing interface issues between primary, secondary and tertiary care
- Promotion of safe, equitable, effective and economic use of medicines
- Supporting the development of robust processes for managing medicines excluded from the National Tariff for Payment by Results (PBR)
- Ratification of key documents relating to the medicines management agenda and ensuring robust implementation and monitoring plans are in place
- Advising on the appropriateness of partnership working with the Pharmaceutical industry
13.2 Prescribing Clinical Network (PCN)

The Purpose of the PCN is to:
- Promote equity of access to medicines across our health community where there is increasing organisational autonomy and multiple care providers
- Promote patient safety:
  - through improving competencies
  - through assisting in the implementation of NPSA programmes
  - encouraging the provision of accurate information on medicines when patients move across boundaries
- Have a consistent approach to value for money and opportunities for investment and disinvestment
- Monitor the impact of its decisions within its member organisations
- Help to ensure that the requirements of healthcare monitoring organisations are met particularly with respect to timeliness and equity of access to new medicines.

This group is represented by:
- Director for Public Health / Medical Director
- Head of Pharmaceutical Commissioning
- Head of Medicines Management
- GP Prescribing Lead from each locality
- Chief Pharmacists from all the acute trusts and Surrey & Borders Partnership
- Medical Directors or Chairs of the Drugs Committee from all the acute trusts and Surrey & Borders Partnership
- Nursing representative
- LMC representative
- LPC representative
- Lay member

The full Terms of Reference for the PCN can be found on:
[http://nww.portal.surreypct.nhs.uk/gps/medicinesmanagement/Documents/Forms/AllItems.aspx?RootFolder=%2fgps%2fmedicinesmanagement%2fDocuments%2fPrescribing%20Clinical%20Network%20Information&FolderCTID=&View=%7b32132990%2d0000%2d413D%2d81FC%2dC1349BA0FF98%7d](http://nww.portal.surreypct.nhs.uk/gps/medicinesmanagement/Documents/Forms/AllItems.aspx?RootFolder=%2fgps%2fmedicinesmanagement%2fDocuments%2fPrescribing%20Clinical%20Network%20Information&FolderCTID=&View=%7b32132990%2d0000%2d413D%2d81FC%2dC1349BA0FF98%7d)

14 Quality and Outcome Framework (QOF) - Medicines Management indicators

The following link will take you to the Connecting for Health website and specifically to further information about the QoF

There are a number of organisational indicators that relate to the management of medicines but 2 of these specifically relate to the medicines management team:

- **Medicines 6 (worth 4 points)** – the practice is required to meet with the PCT prescribing adviser at least annually and agree up to three action points relating to prescribing.
If the PCO prescribing adviser is unable to visit within the year and there has been no contact with another PCO-recognised source of prescribing advice within the year, then the practice is exempt from this indicator. In that circumstance, the practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

- **Medicines 10 (worth 4 points)** – the practice has agreed up to three actions related to prescribing and has subsequently provided evidence of change.

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the PCO prescribing adviser for its reasons for not achieving the areas in question.

15  **Medicinal Waste Management**

Medicinal waste includes expired, unused, spilt, and contaminated pharmaceutical products, drugs, vaccines, and sera that are no longer required and need to be disposed of appropriately. The category also includes discarded items used in the handling of pharmaceuticals, such as packaging contaminated with residues, gloves, masks, connecting tubing, syringe bodies and drug vials.

Medicinal waste is classified into two categories:
- cytotoxic and cytostatic medicines
- Medicines other than those classified as cytotoxic and cytostatic.

Cytotoxic and cytostatic medicines are classified as hazardous waste and it is a legal requirement to segregate cytotoxic and cytostatic medicines from other medicines.

Community Pharmacies are obliged to accept back unwanted medicines from patients. The pharmacy will sort them into solids (including ampoules & vials), liquids and aerosols if required by the waste contractor.

NHS Surrey has an arrangement, via a waste contractor, for the collection and disposal of medicines from community pharmacies at regular intervals.

No medicines that have been dispensed for a patient can be re-used for another patient and must be appropriately disposed of.

Community pharmacies should not accept waste from Nursing Homes or Dual Registered Homes as this is classified as industrial waste. In order to take waste from a nursing home, the pharmacy would need to obtain a waste management license. Pharmacists contemplating dealing with waste from a nursing home should contact their local Environment Agency for authoritative guidance³  [www.environment-agency.gov.uk](http://www.environment-agency.gov.uk)

15.1  **Controlled Drugs**

Under the Regulations, all Schedule 1 and 2 stock controlled drugs can only be destroyed in the presence of a person authorised under those Regulations to witness destruction.

The Accountable Officer has nominated a number of persons to witness destruction of controlled drugs on behalf of NHS Surrey. The persons in the Pharmacy team who are authorised to do this are:
- The Lead Primary Care Pharmacists
- The Community Pharmacy Development Pharmacists

³ Pharmaceutical Services Negotiating Committee (PSNC); FAQs
● Accountable Officer Support Manager

Please contact the medicines management team administrator on 01372 201805 to arrange a visit.

When a stock controlled drug is destroyed, details of the drug must be entered into the controlled drugs register. This should include:

● the name of the drug;
● its form;
● its strength and quantity;
● the date it was destroyed
● the signature of the authorised person who witnessed the destruction, and the person destroying it (that is, two signatures).

Once issued/dispensed to a patient, the requirements for an authorised witness do not apply, however best practice recommends the use of a separate patients returns log where destruction of patient returns CDs are witnessed.

Ideally, a controlled drug denaturing kit should be used but, in all cases, the guidance issued by the RPSGB should be followed when denaturing controlled drugs – this applies to both stock and returned medicines.


15.2 Sharps Waste

The duty to arrange collection of sharps on request by patients rests with the local authority, and this remains the preferred method of disposal.

Please contact the local borough councils for more details of the sharps collection services.

There is no obligation for a pharmacist to accept sharps for disposal but if they do so, pharmacy contractors should ensure that accepting sharps, storing and arranging for their disposal is undertaken with regard to the need to protect the environment and to protect workers and others who might be affected by these activities.

15.3 Drug donations to other countries

No drugs should be donated that have been issued to patients and then returned to a pharmacy or elsewhere, or were given to health professionals as free samples.

Justification and explanation -

● Patients return unused drugs to a pharmacy to ensure their safe disposal; the same applies to drug samples that have been received by health workers
● In most countries it is not allowed to issue such drugs to other patients, because their quality cannot be guaranteed. For this reason returned drugs should not be donated either
● In addition to quality issues, returned drugs are very difficult to manage at the receiving end because of broken packages and the small quantities involved.

6 World Health Organisation; Guidelines for Drug Donations; Revised 1999
PRESCRIBING BUDGET

16.1 Principles of Budget Setting
The overall aim in setting prescribing budgets for practices is to achieve fair budgets based on objective assessments of need.

Guidance on budget setting was previously produced annually by the Prescribing Support Unit (PSU). This has not been updated for a number of years but the same principles remain.

The actual methodology for setting practice budgets may change each year depending on national budget setting advice and developments. A number of basic principles will apply to ensure that budgets reflect the needs of the population being served:

- Prescribing budgets should move at a reasonable pace of change towards setting ‘fair share’ budgets.
- The ASTRO(09)-PU weighting allows budgets to be adjusted for the number of patients and their age/sex distribution, but other adjustments are also needed.
- The Low Income Scheme Index (LISI) is incorporated into the budget-setting process in line with recommendations from the DH.

Budgets should take into account quality, cost-effectiveness and high-cost patients where possible. There are a number of areas where prescribing can artificially increase or decrease a practice’s prescribing spend, especially where the type and volume of prescribing is not directly in the control of the GP, for example:

- Specialist (High cost) drugs
- High cost feeds
- Tube feeds
- Dressings

Monitoring these elements may explain variations in prescribing outside of a practice’s control (see 16.5 below).

Adjustments for care home patients and list size changes may also be considered.

Any absolute or relative increase in allocation compared to the previous year should not be so great that a practice is unlikely to use it. A “cap” may be applied to prevent this from occurring.

The budget-setting methodology must be open and understandable.

16.2 Historical / capitation split
Cost-based ASTRO-PUs have been used since 1993 in prescribing allocation methodology and as the appropriate denominator when comparing the costs of prescribing between practices or between PCTs.

A 100% weighted capitation budget using ASTRO-PUs may be seen as the best way to “fair share” the budget based on need. However, it is considered that a budget set on just weighted capitation does not take into account prescribing patterns governed by factors such as deprivation, social factors, disease prevalence, ethnicity. In addition, it may not take into account differences in local care pathways, e.g. some practices may be willing to take on shared care for certain drugs thereby adding to their prescribing spend whilst other practices prefer to leave prescribing to secondary care which is likely to impact on their acute contracting spend.
A 100% historical based budget will tend to disadvantage practices that prescribe efficiently and potentially advantage practices that prescribe excessively or inappropriately. This is only likely to be a feasible option in CCGs where there is agreement that all practices have achieved a level of prescribing within a range that is considered to match their needs.

In recent years, Surrey PCT has used the methodology recommended by the Prescribing Support Unit for practice level budget setting which recommends 50% historic spend plus 50% weighted capitation. The principle is intended to move practices towards a median figure, but is somewhat flawed as the baseline of the historical element is reset each year based on outturn. The Medicines Management team would continue to recommend a 50:50 split as a reasonable option; however, CCGs may wish to agree principles within their organisations such that the historical element is not reset each year so that after 3 years even major outliers will have their budgets reduced close to their capitation share.

An example is given below (growth is shown at 5%):

<table>
<thead>
<tr>
<th>Year</th>
<th>Historical*</th>
<th>Capitation</th>
<th>Budget (50:50 split)</th>
<th>Variation from capitation budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>£1,500,000</td>
<td>£1,000,000</td>
<td>£1,250,000</td>
<td>25.0%</td>
</tr>
<tr>
<td>Year 2</td>
<td>£1,312,500</td>
<td>£1,050,000</td>
<td>£1,181,250</td>
<td>12.5%</td>
</tr>
<tr>
<td>Year 3</td>
<td>£1,240,313</td>
<td>£1,102,500</td>
<td>£1,171,406</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

*set on previous year’s budget + growth

16.3 Care Homes

Surrey PCT recognises that patients in a care home setting are often more costly to treat than patients of the same age and sex living outside a care home. In order to ensure equitability between practices, Surrey PCT have considered care home patients, regardless of age or sex, to be worth an additional 16 ASTROs. This is based on research by the Prescribing Support Unit that showed that patients in residential care homes cost twice as much as patients of the same age living in their own homes. For nursing homes costs were three times as much. The figure of 16 arose from taking the average of ASTRO-PU’s (97) for men and women over 65 years (~10.5 ASTRO-PU’s) multiplying by 2.5 (an average of residential and nursing home additional costs) and calculating the difference.

ASTRO-PU’s were recalculated in 2009 but the figure of 16 remained as a number of expensive drugs and dressings which contribute to additional costs were already captured within the “contingency drugs” and within historical spend.

For most care homes the additional allocation is probably fair. However, issues have been raised in relation to costs in certain high dependence homes (particularly for some patients with learning disabilities). CCGs may wish to consider if they wish to allocate different amounts for these homes.

16.4 Deprivation

The Low Income Scheme Index (LISI) was introduced some years ago by the Prescribing Support Unit as a measure of deprivation based on claims for exemption from the prescription charge on the grounds of low income. The figures were collected as part of a 5% sample of prescriptions processed by the PPA. Figures have not been re-issued since
2007-08; CCGs will therefore need to consider if they wish to continue to use them within budget calculations.

16.5 Shared risk fund
A shared risk "fund" may be used to explain variations in prescribing outside of a practice’s control. The rationale behind this fund is to:

- Ensure that practices can prescribe expensive drugs with confidence (providing this is in line with local policy)
- Minimise the potential for practices “cherry picking” patients
- Minimise the financial risk for the smaller practices/localities

CCGs will need to decide annually which drugs, products or other in-year pressures on the primary care prescribing budget may fall into a shared risk fund. This may include:

- Increases in list size
- Increases in expensive drugs and feeds
- Costs resulting from epidemics (e.g. outbreaks of scabies in a nursing home, provision of prophylactic antibiotics during a meningitis outbreak)
- Prescribing costs associated with community nurse prescribing/wound management

Monitoring of these elements will enable CCGs to explain variances from budget for individual practices. The “fund” is somewhat notional as all constituent practices within a CCG will need to take responsibility for the risk if the net impact of adjustments constitutes an overspend.

It is essential that the process for allocating the contingency fund is transparent to avoid any unfair rewards or penalties:

- All practices have equal access to the contingency fund
- The methodology for calculating contingency payments is the same for all practices
- Adjustments are made to practice budgets to account for “windfalls” (e.g. decreases in list size or the amount spent on expensive drugs) where applicable
- Access to the contingency fund is not permitted where a practice has prescribed an expensive drug against local policy

16.6 Budget Monitoring
Practice and PCT performance against allocated prescribing budgets is monitored on a monthly basis by the medicines management team using ePACT data from the Prescription Pricing Division (PPD).

A monthly financial summary is submitted to finance and relevant PCT directors, cluster managers, commissioning leads etc.

Practice budgets are monitored individually and as commissioning clusters and will be sent a financial report on a monthly basis.

It must be noted that any financial data produced in the first six months of the financial year (April to September) is only reliable as an indicator for financial trend e.g. whether prescribing spend is on the increase or decrease. Data in the last six months (from September onward) will provide a more reliable estimated out-turn for both practices and the PCT.

ePACT data is also used to monitor practice and PCT performance against national and local prescribing indicators/targets.
Graphs are produced by the medicines management team to compare practices with other practices within their clusters and local PCT area.

Practice data is not anonymised for this purpose.

Specific information in respect of individual practice performance may be requested from the medicines management team but electronic Prescribing & Financial Information for Practices (ePFIP) data can also be accessed by the practice – go to:

http://www.nhsbsa.nhs.uk/PrescriptionServices/815.aspx

ePFIP is available under “Systems” and details of how to register are available on the website.

17 British National Formulary - availability

The British National Formulary (BNF) is published every six months (in March and September). The Department of Health arranges for distribution to NHS doctors, pharmacists and non-medical prescribers in England.

The BNF for Children (BNFC) is published annually in July and is distributed largely on the same basis as the adult BNF.

Both the BNF and BNFC are available on-line through the National electronic Library for Medicines, National Library for Health or via the internet at www.BNF.org . Electronic access will be more convenient than the traditional book for some users and can help reduce the costs for purchase of the hard copy version.

Information on how individuals/organisations able to receive centrally purchased copies of the BNF/BNFC can obtain extra copies, or update distribution details for future editions, is in the table below:

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7 DH; Guidance for NHS organisations ordering supplies of the British National Formularies; Dec 2007
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