<table>
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<tr>
<th>AUTHOR:</th>
<th>Medicines Management Team</th>
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MEDICINES MANAGEMENT GUIDE TO PRESCRIBING

Foreword
This document aims to support the delivery of consistent prescribing advice to practitioners prescribing on behalf of the CCG 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 Clinical Executive, November 2013

The intention is that the document is updated when required to provide up-to-date information on changes to advice or legislation.

Implementation and Monitoring
The information in this guide is advisory in nature and should be regarded as good practice. Prescribing in the CCG is monitored routinely through analysis of ePACT.net data (which is used to formulate the practice Eclipse reports) and clinical audits. All GP practices in the CCG have allocated pharmacy support on a regular basis.

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.

Linda Honey
Head of Medicines Management
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1. SCOPE
This guidance is offered to all practitioners working for or on behalf of North West Surrey CCG

2. DOCUMENT PURPOSE
This document aims to support the delivery of consistent prescribing advice to practitioners prescribing on behalf of the CCG 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 North West Surrey CCG.

The Medicines Management Team is made up of a number of pharmacists and pharmacy technicians:

Linda Honey Head of Medicines Management 07803 124289
Sophie Bhandary Practice Support Pharmacist
Emma Cade Practice Support Pharmacist
Nipa Patel Practice Support Pharmacist
Sanjeev Sudera Practice Support Pharmacist
Perminder Oberai Practice Support Pharmacist
Lis Stanford Practice Support Pharmacist
Mandep Allingham Practice Support Pharmacist
Manjit Atwal Practice Support Pharmacist
Gemma Draper Practice Support Pharmacy Technician
Lorraine Kelly Practice Support Pharmacy Technician
Adeola Adisa Practice Support Pharmacy Technician

GUIDANCE

3. PRESCRIBING RESPONSIBILITIES: PRIMARY/SECONDARY CARE INTERFACE

North West Surrey CCG interfaces with a wide range of providers, the main Acute Trust being Ashford & St Peters NHS Foundation Trust.

The Medicines Management team interface with these Trusts on a regular basis and formally at the following forums:

- The Prescribing Clinical Network (PCN)
- Ashford & St Peters - Drugs & Therapeutics Committee (D&TC)
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 CCG and local Acute Trusts have developed drug formularies and a traffic light system that provides a framework for defining where clinical and, therefore, prescribing responsibility should lie through the 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).

Click icon to enter the PAD:

The system is only advisory but is intended to clarify expectations of prescribing responsibility. See section 9.1 for further details

<table>
<thead>
<tr>
<th>RED DRUGS / HOSPITAL ONLY DRUGS</th>
<th>For specialist use in secondary/tertiary care on the grounds of one or more of the following:</th>
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<tr>
<td></td>
<td>1. Only available in hospital</td>
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<td></td>
<td>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</td>
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<td>3. Clinical trial drugs that are being used in the hospital</td>
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<td>4. Complex monitoring requirements and specialist drugs</td>
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<td></td>
<td>7. Drugs that are funded by NHS England</td>
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Medicines that require preparation by the hospital pharmacy: unless an acceptable procedure for supply through a community pharmacy can be arranged.

<table>
<thead>
<tr>
<th>AMBER DRUGS</th>
<th>Prescribing initiated in secondary care with the potential to transfer to primary care when:</th>
</tr>
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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

Where a shared-care protocol has been developed and agreed it will be made available on the Prescribing Advisory Database (PAD) See section 9.1 for more details.

<table>
<thead>
<tr>
<th>AMBER* DRUGS</th>
<th>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</th>
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<tr>
<td></td>
<td>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</td>
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<th>GREEN DRUGS</th>
<th>Can be initiated and continued in primary, secondary or tertiary care</th>
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<tr>
<td></td>
<td>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 CCG Medicines Management team for clarification.</td>
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### 3.3 Requests for GPs to prescribe Red/ hospital only drugs

GPs should not be asked to accept prescribing responsibility for Red or Black drugs from our local Acute Trusts. If this occurs, the GP should contact the CCG using the Talk to Us clinical alert system or alternatively the Head of Medicines Management Linda Honey – linda.honey@nwsurreyccg.nhs.uk 07803 124289.

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 CCG Medicines Management team for further advice if necessary – drugs funded by NHS England that are for specialised services should not be prescribed by GPs.
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 CCG 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. [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214902/PbR-Guidance-2013-14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214902/PbR-Guidance-2013-14.pdf). Some of the PbR excluded drugs are funded by NHS England for specialised services and some are funded by the CCG.

North West Surrey CCG has agreed specific commissioning arrangements for PbR excluded drugs (which fall under the remit of CCGs) with the providers from which it commissions services. The commissioning intentions document details North West Surrey CCG’s criteria and specific funding arrangements for each of the PbR excluded drugs; it cannot be assumed that North West Surrey CCG will automatically fund these drugs.

A series of standard forms have been developed (‘tick box’ or individual funding request form) in line with CCG PbR excluded drug commissioning intentions. Acute trusts must use these forms for either prior approval or notification as applicable. Forms must be submitted electronically via the web-based database [https://www-blueteq-secure.co.uk/trust](https://www-blueteq-secure.co.uk/trust). The patient must meet ALL pre-determined criteria for funding to be approved.

An individual funding request (IFR) should be submitted where a request for a PbRe drug is made for use outside of the commissioning intentions or when the commissioning intentions specify that an IFR must be submitted for that particular drug and indication. If the IFR clinical triage panel agrees that the case is eligible for consideration as an IFR, it will be discussed at the next available IFR panel. IFR panels are held on the 4th Wednesday of each calendar month.

Although the majority of the PbR excluded drugs are Red drugs on the 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 the Prescribing Advisory Database (section 9.1)

NB: Where a Red drug is prescribed by a practice the financial impact should be considered. An adjustment to the practice prescribing allocation is unlikely to be made 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 CCG 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.

**Adverse Drug Reactions (ADR) – Yellow Card Scheme**

An adverse drug reaction (ADR) can be reported online using the Yellow Card Scheme at [http://yellowcard.mhra.gov.uk/](http://yellowcard.mhra.gov.uk/)

Additional information about the Yellow Card Scheme and the reporting of ADRs can be found at [http://www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/Reportingsuspectedadversedrugreactions/index.htm](http://www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/Reportingsuspectedadversedrugreactions/index.htm)

Before prescribing any new innovative treatments, it is suggested that the GPs discuss this with a member of the CCG 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 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).
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 CCG Medicines Management team, the PCN / Medicines Commissioning Group
- 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 CCG Medicines Management 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 products 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.

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 CCG Medicines Management team and their medical defence organisation (on each occasion), as appropriate.

For further information see:
“North West Surrey CCG Recommendations to prescribers on the use of unlicensed medicines and licensed medicines for unlicensed indications”
This is accessible on the Prescribing Advisory Database.
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://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096576.pdf

- Policies for Cancer “top-ups” should be available from local acute trust organisations.

- 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”
This is accessible on the Prescribing Advisory Database

6.2 Infertility Treatment

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.

North West Surrey CCG 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 CCG.

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.

For further information see:

North West Surrey CCG’s Assisted Conception Commissioning Policy, Criteria for Access to Treatment and the NICE Pathway for Fertility Treatment:

Further information can be found on the NICE website:

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 1 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.nathnc.org and the TRAVAX website www.travax.nhs.uk

Other useful advice can be found by clicking the link to the Health Protection Agency website below.

http://www.hpa.org.uk/publications/PublicationDisplay.asp?PublicationID=87
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

## 6.6 Clinical Trials / research

All trials of medicines within North West Surrey CCG 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 North West Surrey CCG is managed by Sussex Research Consortium contact details are below:

**Helen Evans**
Research Governance Manager
Sussex NHS Research Consortium

Research & Innovation Department
Western Sussex Hospitals NHS Trust
Worthing Hospital
Lyndhurst Road
Worthing, West Sussex, BN11 2DH

Internal extension: 5224/4195
Direct line: 01903 285224
Fax: 01903 209884
Email: helen.evans@wsht.nhs.uk
www.sxrc.nhs.uk

## 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](http://www.travax.nhs.uk) or NaTHNaC website [www.nathnac.org](http://www.nathnac.org)
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.

It is down to individual practices whether they wish to register with TRAVAX or use NaTHNaC which is a freely available website.

7.1 Global sum vaccinations

A number of vaccinations are available on the NHS for specific indications/circumstances – see Appendix 1

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.

The following services are managed by NHS England (Public Health team). Some are subject to additional payments that can be claimed through an Enhanced Service:

- Influenza & Pneumococcal programme over 65 years and at risk patients = £7.64 per vaccines
- Influenza – Children 2 & 3 year olds only - £7.64 per completed course
- Influenza Housebound – recently launched a programme to monitor and vaccinate those housebound patients for flu. Payment will be split into 2 payments 1 when signing up to the scheme and the other when activity is returned at the end of the year showing outcomes and patients vaccinated. This payment is based on practice list size.
- Childhood Immunisation programme – payment via vaccinations and immunisations as part of the core contract. However a payment will be made if practices reach a certain target of patients vaccinated. (price depends on the level reached and is calculated by the PCSS.)
- Men C has been added to the childhood immunisation programme this year.
- Shingles patients aged 70 years and a catch up programme for patients aged 79 years. Payment per vaccine of £7.64
- Rotavirus vaccines provided when patients are 2 & 3 month olds £7.64 per completed course.
- MMR
  - Part 1 - Identifying patients and offering a written call and recall programme - £1.50 per qualifying child
  - Part 2 – Provide one or two doses as required to the patient aged 16 or over - £7.64 per dose.
  - Patients under 16 years would be included in the vaccinations & immunisations payment within the core contract.
- HPV – Most of the HPV vaccines are administered by the school nursing programme but GPs pick up those patients who fall through. £7.64 per vaccine administered.
- Hep B Babies – Patients deemed at risk where a hospital has initiated the treatment. Continued vaccination programme - £7.64 per vaccine.
HPV and mainly vaccines for children cannot be claimed on FP34D as they are supplied free of charge to practices. 

8 PRESCRIBING ISSUES

8.1.1 Quantities – 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 Quantities - 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.

North West Surrey CCG 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. 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.

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.
Pre-payment certificates

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 NHSBSA website for details http://www.nhsbsa.nhs.uk/1127.aspx

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

- Over the telephone on 0300 330 1341
- Send an application form (Available from GP surgeries and community pharmacies (form FP95) by post to:

NHS Help with Health Costs
PPC Issue Office
152 Pilgrim Street
Newcastle Upon Tyne
NE1 6SN

8.1.3 Reviewing prescribing

You must make sure that suitable arrangements are in place for regular monitoring, follow-up and review, taking account of the patients’ needs and any risks arising from their medicines. When you review a patient’s medicines, you should re-assess the patient’s need for unlicensed medicines for example antipsychotics used for the treatment of behavioural and psychological symptoms in dementia.

Reviewing medicines will be particularly important where:
- patients may be at risk, for example, patients who are frail or have multiple illnesses
- medicines have potentially serious or common side effects
- the patient is prescribed a controlled drug or other medicines that are commonly abused or misused
- the BNF or other authoritative clinical guidance recommends blood tests or other monitoring at regular intervals
- continued usage may not be necessary or appropriate

Pharmacists can help improve safety, efficacy and adherence in medicines use, for example by advising patients about their medicines and carrying out medicines reviews. This does not relieve you of your clinical responsibility and duty to ensure that your prescribing and medicines management is appropriate. You should consider and take appropriate action on information and advice from pharmacists and other healthcare professionals who have reviewed patients’ use of medicines, especially following changes to their medicines or if they report problems with tolerance, side effects or with taking medicines as directed.

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.

1 GMC Good Practice in Prescribing and Managing Medicines and Devices; February 2013
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.

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 Contracts Team at their local NHS England Area Team 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 Contracts Team at their local NHS England Area Team 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 3.2 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) enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient’s choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.

EPS will bring gains in both efficiency and safety for both patients and health professionals. Once fully operational, EPS will:

- Improve patient safety by reducing the likelihood of dispensing errors due to unclear or illegible prescriptions
- Allow the instant cancellation of prescriptions thought no longer clinically appropriate

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2 The National Health Service (General Medical Services Contracts) Regulations 2004
3 Service Specification ES2 (version 1 10-10-04)
- Prevent the loss of prescription forms
- Reduce the number of fraudulent prescriptions
- Allow preparation of prescriptions in advance of collection, saving patient time at the dispensary, and making workflow and stock control easier for pharmacists to manage
- Relieve patients 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
- Allow faster and more accurate processing of prescriptions by the BSA (Business Services Authority)

For further information visit:

http://systems.hscic.gov.uk/eps/gppractice

Or visit http://systems.hscic.gov.uk/eps/contacts to request information / raise queries with the information centre

Your local contact is the EPS project sponsor at the Area Team:
Mike Hedley m.hedley@nhs.net

8.4 Patients travelling or moving abroad - access to NHS care

NHS funding and healthcare abroad, in other European countries, including emergency care, is now the responsibility of NHS England. For further information contact Mike.lander@nhs.net from the Surrey & Sussex Area Team.

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 NHS Business Services Authority (NHSBSA) 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.
- By phone on 0300 3301350. The card will be delivered within 10 days.
- By post - pick up a form from the Post Office. The card will be delivered within 21 days.
Beware! Unofficial websites offering EHIC’s

An internet search will produce a number of unofficial sites offering to process your EHIC application or a fast-track service. These sites often ask for a processing or service charge.

ALWAYS use the official site www.ehic.org.uk to get your free EHIC

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.

8.5 Temporary Residents / 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 NHS Choices website

http://www.nhs.uk/nhsengland/aboutnhsservices/uk-visitors/Pages/accessing-nhs-services.aspx

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 from NHS England can be found on the NHS Choices website.
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 Prescribing for yourself or those close to you

Wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship.

Controlled medicines present particular dangers, occasionally associated with drug misuse, addiction and misconduct. You must not prescribe a controlled medicine for yourself or someone close to you unless:

- no other person with the legal right to prescribe is available to assess and prescribe without a delay which would put your, or the patient’s, life or health at risk or cause unacceptable pain or distress, and
- the treatment is immediately necessary to:
  - save a life
  - avoid serious deterioration in health, or
  - alleviate otherwise uncontrollable pain or distress.

If you prescribe for yourself or someone close to you, you must:

- make a clear record at the same time or as soon as possible afterwards. The record should include your relationship to the patient (where relevant) and the reason it was necessary for you to prescribe
- tell your own or the patient’s general practitioner (and others treating you or the patient, where relevant) what medicines you have prescribed and any other information necessary for continuing care, unless (in the case of prescribing for somebody close to you) they object

8.7 Private scripts for NHS patients

A private prescription may be issued under a number of circumstances, for example where an item is not available on the NHS (drugs and preparations listed in Part XVIIA of the Tariff), for drugs to treat indications not covered by the ‘SLS’ conditions,
vaccinations/antimalarials for travellers or drugs prescribed in anticipation of an ailment for patients travelling abroad (i.e. there is no clinical need at the point of prescribing). Under these circumstances a charge could be levied for the issue of a private prescription.

**8.7.1 Private scripts for a branded product**

The GP NHS terms of service require that a patient receives an NHS prescription where a treatment is clinically necessary. If a patient requests a particular branded product, despite local NHS policy to prescribe generically, the GP may issue a private prescription but must note the following:

- An NHS prescription must be offered. The view of the MCG is that the NHS prescription should be generically prescribed.
- The patient can choose whether to accept the NHS or private prescription. If the private prescription is chosen then this should be clearly documented in the patients notes.
- The private prescription can be written generically and the patient should be informed to request the branded equivalent at the point of dispensing. This negates the need to enter the branded drug onto the patients clinical notes and thus avoid the risk of the branded product accidentally appearing on subsequent NHS prescriptions.
- The patient should be informed that the pharmacist will charge them accordingly.
- The prescriber must NOT levy a charge for the issue of a private prescription under these circumstances.

**8.7.2 Private scripts to avoid NHS prescription charges**

There are circumstances where the NHS prescription charge is greater than the cost of a private prescription (including dispensing on-costs applied by the pharmacy). Therefore, where a patient pays for their NHS prescriptions, it is possible that the patient may request a private prescription.

Although this practice does not contravene any regulations, the implications and limited significant benefits render this inadvisable as a matter of routine. The view of the Local Medical Committee (LMC) is as follows:

- The patient must also be offered an NHS prescription and choose which one to accept. There is a view that the patient should not be given both prescriptions as both may be obtained. However, this might cause difficulties at the point of dispensing if costs have changed and the private prescription is going to cost the patient more than the NHS prescription charge.
- Although this may be an attractive option, the practicalities and potential hazards make this difficult to work and therefore inadvisable.
- In circumstances where the purchase price of the drug is less than the NHS prescription charge, any significant cost benefit is often negated by the addition of the pharmacist’s dispensing fee.
- It is thought that there are only a limited number of patients prescriptions for whom there would be a tangible benefit, and the time spent explaining the process may also make it an unrealistic option for most consultations.
- If this process were to be used for a number of circumstances, it would be advisable for all of the GPs within the practice to adopt a consistent approach and a patient explanatory letter developed.
8.8 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 charts
- 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, because 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.

8.9 Prescribing for Nursing & Residential Homes – 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
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 written:
- 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.

8.10 Remote prescribing

The GMC Guide to Prescribing states that “before you prescribe in the absence of the patient (via telephone, video-link, online) you must be satisfied that you have adequate knowledge of the patient’s health, can make an assessment of their needs and establish the appropriate patient consent.” This is particularly relevant when prescribing for children of for drugs that may be subject to abuse for example, strong analgesia or controlled drugs.

The GMC continue to state that “you must consider the limitations through which you are communicating with the patient for example, the need for a physical examination of the patient and access to the patient’s medical records.

Note: Products such as Botox, Dysport or Vistabel must only be prescribed after physical examination of the patient and cannot be prescribed remotely

If prescribing for a patient in a care home, nursing home or hospice, you should communicate with the patient (or carer) to make your assessment and provide the necessary information and advice. Instructions for administration or monitoring must be clearly understood by the recipient and written confirmation should be sent as soon as possible.”

9 Prescribing decision aids, tools and information

9.1 Prescribing Advisory Database (PAD)

The Surrey Prescribing Advisory Database (‘PAD’) is an innovative, web-based resource which can be accessed by healthcare professionals in primary and secondary care and by patients. The PAD provides guidance and key information on medicines use within Surrey. Information available on the PAD includes:

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4 Drug Tariff March 2008; Part VIII paragraph 9
• Recommendations, policy statements and submission papers from our Prescribing Clinical Network (PCN) and Medicines Commissioning Group (MCG)
• Links to associated NICE Technology Appraisals
• Relevant drug / safety alerts issued by the NPSA, EMEA and the MHRA
• Local policies, procedures, protocols and guidelines relating to the use of medicines
• Materials used in the course of optimising medicines use e.g. audit tools, letter templates

Each drug entry on the PAD has been assigned a Traffic Light Status which is a locally agreed colour-coded guidance system 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. The system is only advisory but is intended to clarify expectations of prescribing responsibility.

The PAD is maintained by members of the Medicines Management Teams who provide services to the local Clinical Commissioning Groups.

For comments or suggestions regarding the PAD please email thePAD@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 North West Surrey CCG and Surrey and Borders Partnership NHS Trust. It has been designed to help with diagnosis of depression and anxiety, management and treatment choices, the management of lack of efficacy and / or tolerability issues and appropriateness of referrals to secondary care.

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

9.3 Software Solutions for GP clinical Systems in relation to Medicines Management

North West Surrey CCG is currently piloting a system with DXS for Vision practices (currently unable to interact with EMIS). This is a 6 month pilot which:

- Enables information from the Prescribing Advisory Database to be linked to the clinical system at point of prescribing
- Allows interactive switch recommendations to appear at point of prescribing

This will be evaluated in Q4 of 13/14 and a decision made about how best to move forward will be made at this point.

Further work is being undertaken with EMIS in building a NW Surrey CCG formulary.

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”.

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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 CCG will support any doctor wishing to refuse prescriptions of dietary products for patients (or nursing / residential homes) not complying with the above uses and using them as a convenience rather than liquidising/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 Medicines Management team for further advice when necessary.

9.4.1 Drugs requiring Selected List Scheme “SLS” endorsement

The following drugs are only prescribable on the NHS for specific groups of patients with specific conditions - see Part XVIIIIB 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 (Levitra)

*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 bread or flour per patient, per month.

Since March 2011 North West Surrey CCG has 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.

The list of bread, flour and bread mix agreed for funding by North West Surrey CCG is available on the Prescribing Advisory Database.

10 Home Oxygen

The New Home Oxygen contract started on 26th March 2012 and the supplier for North West Surrey CCG 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.improvement.nhs.uk/lung/GoodPracticeGuides/Homeoxygen/service/tabid/193/Default.aspx) 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-cic.org.uk/article/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-cic.org.uk/article/home-oxygen-order-form
Training on how to complete the HOOF Part A is available on the Dolby Vivisol website here: http://www.dolbyvivisol.com/england/our-services/oxygen-therapy/health-care-professionals.aspx

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
- 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 CCG 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 CCG must be notified, so their Oxygen account can be closed, otherwise North West Surrey CCG may continue to be billed until notification.**

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 to 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 North West Surrey CCG 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 CCG was charged a daily tariff for oxygen regardless of actual use, the CCG is now charged per delivery and per refill, and for equipment rental, 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.

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

<table>
<thead>
<tr>
<th>Registered nurses (first level)</th>
<th>Registered specialist Community Public Health Nurses</th>
<th>Registered pharmacists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered midwives</td>
<td>Registered optometrists</td>
<td></td>
</tr>
</tbody>
</table>

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/ and 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

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:

<table>
<thead>
<tr>
<th>nurses</th>
<th>optometrists</th>
<th>chiropodists/podiatrists</th>
</tr>
</thead>
<tbody>
<tr>
<td>midwives</td>
<td>radiographers</td>
<td>pharmacists</td>
</tr>
<tr>
<td>health visitors</td>
<td>orthoptists</td>
<td>dieticians</td>
</tr>
<tr>
<td>paramedics</td>
<td>physiotherapists</td>
<td>occupational therapists</td>
</tr>
<tr>
<td>prosthetists</td>
<td>orthotists</td>
<td>speech and language therapists</td>
</tr>
</tbody>
</table>
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 CCG.
- 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. North West Surry CCG
- 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 North West Surry Medicines Management Committees

13.1 Medicines Commissioning Group (MCG)

The Surrey CCGs collaborate as a commissioning group to promote a consistent approach to medicines management across Surrey. The group provides oversight, governance and assurance to CCG Governing Bodies on the safe, effective and affordable use of medicines.

13.2 Prescribing Clinical Network (PCN)

The PCN uses a collaborative approach with its constituent CCG and Acute Trust representatives to promote equity and provide rational, safe and transparent recommendations on the use of medicines across the local health economy. Recommendations from the PCN are considered at the Clinical Executive prior to acceptance and implementation within the CCG.

13.3 Medicines Optimisation Group (MOG)

The NW Surrey CCG Medicines Optimisation Group is a subcommittee of the Clinical Executive Committee and has responsibility for advising on medicines optimisation and management of the prescribing budget for the CCG.

14 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.

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 guidance.  

14.1 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 role lies with the Area Team. Enquiries relating to Controlled Drugs should be directed to cboarer@nhs.net

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.


14.2 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. Contacts for Sharps waste collection by local Borough Councils

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.

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*5 Pharmaceutical Services Negotiating Committee (PSNC); FAQs*
### 14.3 Drug donations to other countries

The World Health Organisation revised their Guidelines for Medicine Donations in 2010. One of their core principals is that “There should be no double standard in quality. If the quality of an item is unacceptable in the donor country, it is also unacceptable as a donation.”

They go on to explain that “Donating returned medicines (unused medicines returned to a pharmacy for safe disposal, or free samples given to health professionals) is an example of a double standard because in most countries their use would not be permitted owing to regulations on quality control. Such donations also frustrate management efforts to administer medicine stocks in a rational way. Prescribers are confronted with many different medicines and brands in ever changing dosages, while patients on long-term treatment suffer because the same medicine may not be available in future. For these reasons this type of donation is forbidden in an increasing number of countries and is discouraged elsewhere.”

### 15 British National Formulary - availability

The British National Formulary (BNF) is published every six months (in March and September). The BNF for Children (BNFC) is published annually in July.

Access online at [www.BNF.org](http://www.BNF.org)

Download the free app for users of [Android](http://Android) and [iPhone](http://iPhone) (Users will need to use their NHS Athens password. Technical support, email: contact@evidence.nhs.uk)

In **England**, free copies of the BNFs are mailed individually to the following healthcare professionals:(see table below for order/registration contact details):

- NHS doctors
- Dentists
- Pharmacists
- non-medical prescribers
- community pharmacies
User/organisation | How to obtain copies
---|---
Members of the public and healthcare organisations that are not part of the NHS | Paper copies may be obtained through any bookseller or direct from: Pharmaceutical Press [www.pharmpress.com](http://www.pharmpress.com) c/o Macmillan Distribution (MDL) Brunel Rd Houndmills Basingstoke RG21 6XS UK
- Tel: +44 (0) 1256 302 699
- Fax: +44 (0) 1256 812 521
- Email: direct@macmillan.co.uk

GPs in GP practices
Including Partners, salaried GPs and locums | Direct distribution
Please contact the DH Publications Order line: 0300 123 1002 to obtain a registration form.

Community Pharmacies
To obtain a copy for a new pharmacy, or an extra copy for a large pharmacy. | Direct distribution
Please contact BNF@binleys.com

Public Health/Pharmaceutical or Medical Advisors in organisations | Central distribution to organisation
Please contact BNF@binleys.com

Non-medical prescribers | Direct distribution
Please contact BNF@binleys.com

16 **Diabetes and the DVLA**

Under certain circumstances it is necessary for patients with diabetes to inform The Driver and Vehicle Licensing Authority (DVLA).

There are two groups of licence holders and the medical standards differ according to each group:

- Group 1 includes motorcars and motorcycles.
- Group 2 includes large lorries (category C) and buses (category D).

The medical standards for Group 2 are much higher than those for Group 1 because of the size and weight of the vehicle.

**Driving large goods vehicles (LGVs) and passenger carrying vehicles (PCVs) – Group 2 licence**

People whose diabetes are treated by diet alone or by tablets are normally allowed to hold Group 2 licenses, which includes LGVs and PCVs, provided they are otherwise in good health and have passed the relevant driving test. (Until 1991 these were known as heavy goods vehicles [HGV] and public service vehicles [PSV].)

**Patients treated with medication that may cause hypoglycaemia:**

If a patient with diabetes holds a Group 2 licence and are treated with a sulphonylurea or prandial glucose regulator they must notify the DVLA as these increase the risk of hypoglycaemia.

If patients are on any other diabetes treatment, including non-insulin injections, it may not cause hypoglycaemia when taken on its own. But when used in combination with any of the tablets listed below, then the risk of hypoglycaemia is increased and so the DVLA must be informed:
<table>
<thead>
<tr>
<th>Medicine Group</th>
<th>Generic (proper) name</th>
<th>Brand (trade) name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sulphonylurea</td>
<td>Glibenclamide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gliclazide</td>
<td>Diamicron/ Diamicron MR</td>
</tr>
<tr>
<td></td>
<td>Glimepiride</td>
<td>Amaryl</td>
</tr>
<tr>
<td></td>
<td>Glipizide</td>
<td>Glibenese/Minodiab</td>
</tr>
<tr>
<td></td>
<td>Tolbutamide</td>
<td></td>
</tr>
<tr>
<td>Prandial glucose regulator</td>
<td>Nateglinide</td>
<td>Starlix</td>
</tr>
<tr>
<td></td>
<td>Repaglinide</td>
<td>Prandin</td>
</tr>
</tbody>
</table>

After being notified the DVLA would, with the patient’s consent, seek further information from the patient’s healthcare team. Therefore, each case will be considered individually.

Note: the use of exenatide or gliptins on their own currently carries no specific driving restrictions for Group 1 (car or motorcycle) licences.

**Patients treated with insulin**

From 15 November 2011, the DVLA have removed the ban for people on insulin driving Group 2 vehicles (larger vehicles, and some passenger-carrying vehicles). People with diabetes treated with insulin can now undergo individual independent medical assessment annually to assess their fitness to drive these vehicles.

To apply for a licence for these larger vehicles the following criteria will need to be met:

- No episode of hypoglycaemia requiring the assistance of another person has occurred in the preceding 12 months
- Has full awareness of hypoglycaemia
- Regularly monitors blood glucose at least twice daily and at times relevant to driving
- Must demonstrate an understanding of the risks of hypoglycaemia
- There are no other debarring complications of diabetes such as a visual field defect

The Diabetes UK website provides some useful information for patients around DVLA requirements:
Appendix 1

GUIDANCE ON PAYMENTS FOR VACCINES

The Green Book 'Immunisation against infectious diseases' gives Department of Health advice on the circumstances when patients should be offered vaccination. This does not necessarily mean the vaccines should be offered under the NHS. The purpose of this document is to clarify situations where vaccines may be given free of charge under the NHS (paid for under the global sum) and where patients should be charged (as a private service).

<table>
<thead>
<tr>
<th>Vaccine name</th>
<th>Global sum</th>
<th>Method for claiming payment under global sum</th>
<th>Private service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthrax</td>
<td>Persons at an identifiable risk, mainly those who come into contact with imported / infected animal products – see Green Book</td>
<td>FP10</td>
<td>Only the cost of the vaccine can be claimed from the global sum. The cost of providing an occupational service is not covered. Practices should seek appropriate remuneration for providing such a service.</td>
</tr>
<tr>
<td>Cholera</td>
<td>Aid workers assisting in disaster relief or refugee camps</td>
<td>FP10</td>
<td>Travellers seeking vaccination that do not qualify for vaccination under the NHS. If charge is levied to patient, vaccine must not be claimed on FP10.</td>
</tr>
<tr>
<td>Diphtheria</td>
<td><strong>Usually part of childhood immunisation for under 6 years</strong></td>
<td>FP10 if not part of childhood immunisation schedule</td>
<td>Only the cost of the vaccine can be claimed from the global sum. The cost of providing an occupational service is not covered. Practices should seek appropriate remuneration for providing such a service.</td>
</tr>
<tr>
<td></td>
<td>• Children aged 10 and over who have not had the basic course of immunisation</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Hospital staff considered at risk of infection – see Chapter 12 of Green Book</td>
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</tr>
<tr>
<td></td>
<td>• Children aged 6 and over that have had basic course but require a reinforcing dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>For travellers visiting epidemic or endemic areas</strong> where diphtheria protection is required and the last dose was given more than 10 years ago (see Green Book and latest advice from CMO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Adults and children over 10 years requiring either a primary course or a booster should be given the low-dose vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Previously immunised travellers requiring a booster if they are to live or work with local residents and their primary immunisation was more than 10 years ago</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccine name</td>
<td>Global sum scenarios</td>
<td>Method for claiming payment under global sum</td>
<td>Private service?</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| **Haemophilus Influenza type b (Hib)** | ▪ **Usually part of childhood immunisation.** Haemophilus influenza type b (Hib) vaccine is given as part of the combined 5 disease vaccine. For childhood vaccination schedule see Green Book and latest advice from CMO.  
▪ **Asplenic children and adults.** Children and adults who have been fully immunised with Hib as part of the routine programme who then develop splenic dysfunction should be offered an additional dose of Hib (usually as combined Hib/Men C vaccine). | FP10 if **not** part of childhood immunisation schedule (vaccines are supplied free to the NHS for childhood immunisation) | (Issue a private prescription or supply vaccine from stock and charge patient) |
| **Hepatitis A**      | ▪ Patients with chronic liver disease  
▪ Haemophiliacs  
▪ Homosexuals  
▪ Persons in institutions who are exposed to a high risk of infection and for whom vaccination is recommended by the Medical Officer of Environmental Health  
▪ Parenteral drug users. Hepatitis A is recommended for injecting drug users and can be given at the same time as Hepatitis B as separate/combined vaccines.  
▪ Recommended for travellers to areas of poor sanitation and where the degree of exposure to infections is likely to be high. See Green Book and latest advice from CMO.  
▪ Persons (particularly those going to reside for 3 months or more and if infected might be less resistant due to pre-existing disease) travelling outside of Northern Europe, Australia or New Zealand to areas of poor sanitation, where degree of exposure is likely to be high | FP34D | (Issue a private prescription or supply vaccine from stock and charge patient) |

* Occupational exposure (refer to employer to undertake or refer to another practice)*  
* Travellers seeking vaccination that do not qualify for vaccination under the NHS. If charge is levied to patient, vaccine must not be claimed on FP34D.  

*FP10 if not part of childhood immunisation schedule (vaccines are supplied free to the NHS for childhood immunisation)*  
*FP34D*
<table>
<thead>
<tr>
<th>Vaccine name</th>
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| Hepatitis B | Babies born to mothers who are chronic carriers of hepatitis B virus or to mothers who have had acute hepatitis B during pregnancy  

- Parenteral drug users  

- Individuals who change sexual partners frequently  

- Close family contacts of a case or carrier  

- Families adopting children from countries with a high prevalence of hepatitis B  

- All short term foster carers and their families who receive emergency placements and those accepting high risk foster children.  

- Haemophiliacs and their carers  

- Patients with chronic renal failure  

- Patients with chronic liver disease  

- Persons in institutions who are exposed to a high risk of infection and for whom vaccination is recommended by the Consultant in Communicable Disease Control (Health Protection Agency).  

- Children born outside the UK and who have received a primary dose in their country of origin and who are now domiciled in the UK should have their course of the vaccine completed under GMS | Occupational exposure where worker is involved in invasive procedures or caring for drug misusers or patients with severe learning difficulties - (refer to employer to undertake or refer to another practice)*  

Note: The risk for workers NOT involved in invasive procedures is no greater than the population as a whole and for whose welfare they are responsible e.g. prison, police, ambulance officers, morticians and embalmers |
| Hepatitis A and B combined | In the few limited cases where hepatitis A & B is required the combined vaccine may be used.  

- Children under 16. Where combined Hepatitis A and B are indicated this may be given in the paediatric two dose combined vaccine (Ambirix) which reduces the number of injections still further from 5 to just two. These are given 6 months apart and so this is unsuitable for rapid immunisation. | Travellers seeking vaccination that do not qualify for vaccination under the NHS. If charge is levied to patient, vaccine must not be claimed on FP34D. |
| Hepatitis A and Typhoid Combined | Advised where sanitation is primitive and where the degree of exposure to infection is likely to be high. See Green Book and latest advice from CMO.  

- Persons (particularly those going to reside for 3 months or more and if infected might be less resistant due to pre-existing disease) travelling outside of Northern Europe, Australia or New Zealand to areas of poor sanitation, where degree of exposure is likely to be high | Travellers seeking vaccination that do not qualify for vaccination under the NHS. If charge is levied to patient, vaccine must not be claimed on FP34D. |
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<tr>
<td><strong>Human Papillomavirus (HPV)</strong></td>
<td>▪ Gardasil™ vaccination is available to Year 8 girls (aged 12-13 years) as part of</td>
<td>Vaccine supplied free to NHS for eligible patients. Use FP10 for those outside of the national programme</td>
<td>Patients who fall outside the NHS programme and request the vaccination should be referred to another practice since GP practices may not provide a private service for HPV vaccination and charge patients on their NHS list.</td>
</tr>
<tr>
<td></td>
<td>❍ the NHS vaccination programme (delivered via a school based programme).</td>
<td></td>
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<tr>
<td></td>
<td>▪ Catch-up vaccination may be offered to girls aged 13-18 (i.e. have completed year 9 at school)</td>
<td></td>
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<tr>
<td></td>
<td>▪ It is reasonable to complete the vaccination schedule if a female over 18 has started the schedule</td>
<td></td>
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<tr>
<td><strong>Influenza</strong></td>
<td>▪ Immunisation offered under the NHS on an annual basis for those aged 65 years and over or those aged under 65 years in a risk category</td>
<td>FP34D and Item of Service Payment</td>
<td>Patients who fall outside an at risk category and request the vaccination as a private service may be directed to a facility offering that service e.g. private clinic, community pharmacy or another practice. GP practices may not provide a private service for influenza vaccination to patients on their NHS list. Practices may offer a private service to patients who are not registered with the practice. If charge is levied to patient, vaccine must not be claimed on FP34D.</td>
</tr>
<tr>
<td><strong>Japanese B encephalitis</strong></td>
<td></td>
<td></td>
<td>In connection with travel abroad. Vaccine not licensed in UK - available only on named patient basis.</td>
</tr>
<tr>
<td><strong>Measles, Mumps and Rubella (MMR)</strong></td>
<td>▪ Usually part of childhood immunisation / catch-up campaign. For childhood vaccination schedule see Green Book and latest advice from CMO. May be recommended by the Consultant in Communicable Disease Control (Health Protection Agency) for contacts of a case of measles.</td>
<td>Vaccine supplied free to NHS for childhood immunisation</td>
<td>It is recommended that all NHS staff born after 1970 having regular contact with patients should be immunised with MMR. This is an occupational health issue and should be provided by the employing NHS organisation.</td>
</tr>
<tr>
<td><strong>Meningococcal A,C, W135 &amp; Y</strong></td>
<td>▪ Not usually available under NHS for travel</td>
<td>FP34D or Vaccine supplied free to NHS for childhood immunisation</td>
<td>Travel vaccination. Those requiring immunisation for travel as suggested in the Green Book may be charged privately. If charge is levied to patient, vaccine must not be claimed on FP34D.</td>
</tr>
<tr>
<td></td>
<td>▪ Asplenic children and adults, if travelling to a country where there is increased risk of serogroup A, W135 or Y disease, should be given the vaccine under the NHS</td>
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| Meningococcal C  | - Usually part of childhood immunisation or catch-up campaign (Hib/Men C). For childhood vaccination schedule see Green Book and latest advice from CMO.  
- A catch-up booster of Men C is to be offered to children of 12 and 13 years  
- Adults (under 25 years) entering university for the first time after August 2014 and who did not receive the Meningococcal C vaccine at 13 – 15 years of age  
- Asplenic patients (use Hib/Men C). Children and adults who have been fully immunised with Men C as part of the routine programme who then develop splenic dysfunction should be offered an additional dose of Men C (usually as combined Hib/Men C vaccine).  
- May be recommended by the Consultant in Communicable Disease Control (Health Protection Agency) for contacts of a case of meningococcal disease | FP34D if not part of childhood immunisation schedule (vaccines are supplied free to the NHS for childhood immunisation) | - Travel vaccination. Those requiring immunisation for travel as suggested in the Green Book may be charged privately. If charge is levied to patient, vaccine must not be claimed on FP34D |
| Pneumococcal (PCV) | - Part of the routine childhood vaccination schedule. See Green Book and latest advice from CMO. | Vaccine supplied free to NHS for childhood immunisation | |
| Pneumococcal (PPV) | - Offered under the NHS for those aged 65 years and over or those aged under 65 years in a clinical risk category outlined in latest advice from CMO. | FP34D | |
| Inactivated Poliomyelitis (only available as combined vaccines) | - Offered to children under 10 as part of the national Childhood Immunisation programme.  
- **For travellers visiting epidemic or endemic areas** it is recommended that the combined D/T/P-IPV is given where a booster of any element is required.  
- Previously immunised but without receiving a reinforcing dose, it is recommended that the D/T/P-IPV is given where a booster of any element is required. Where immunisation history is incomplete or unknown as many doses as required to complete a 5 dose schedule should be offered.  
- Single dose vaccine is available where clinically appropriate | FP10 if **not** part of childhood immunisation schedule (vaccines are supplied free to the NHS for childhood immunisation) | Occupational exposure (refer to employer to undertake or refer to another practice)* |
| Rabies            |                                                                                       |                                                                                                              | **- Travellers seeking vaccination**  
**- Occupational exposure (refer to employer to undertake or refer to another practice)*** |
<p>| Rota Virus        | - Part of the childhood immunisation programme                                          | Item of service payment                                                                                     |</p>
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| **Shingles** | ▪ Introduced on 1st September 2013 for patients aged 70  
▪ Catch-up campaign for those aged 79  
▪ Patients not included in the target groups may be vaccinated at the practice discretion when all eligible patients have been vaccinated and if stocks permit | Item of service payment |  |
| **Tetanus (only available as combined vaccines (DTP))** | ▪ **Usually part of childhood immunisation.** Tetanus vaccine is given in combination with diphtheria, pertussis, poliomyelitis and haemophilus influenza type b as a component of the primary course of childhood immunisation. For childhood vaccination schedule see Green Book and latest advice from CMO  
▪ Children aged 15-19 who were not previously immunised  
▪ Individuals aged 10 years or over who have only had 3 doses of a tetanus containing vaccine, with the last dose at least 5 years ago, should receive the first tetanus booster combined with diphtheria and polio vaccines (Td/IPV)  
▪ As a second reinforcing/final school booster dose ideally given 10 years after the first reinforcing dose (or at least 5 years after the first reinforcing dose if previous doses have been delayed).  
▪ Travellers requiring vaccination or booster. Additional doses may be required according to the destination and nature of travel (see DOH Yellow Book 2010 for further information). For travellers to areas where medical attention may not be accessible and where dose of tetanus containing vaccine was more than 10 years previously, a booster dose should be given prior to travelling. This is a precautionary measure in case immunoglobulin is not available to the individual should a tetanus prone injury occur (see Green Book and latest advice from CMO).  
▪ **Reinforcing dose following a tetanus prone wound.** Extra cover should not be necessary if the patient is up to date with normal vaccination schedule. See Green book for detailed information. | FP10 |  |
| **Tick-borne encephalitis** |  |  |  |
| **Typhoid polysaccharide** | ▪ Travellers to countries where typhoid is endemic (e.g. South Asia, parts of South-East Asia, the Middle East, Central and South America, and Africa), especially if staying with or visiting the local population  
▪ travellers to endemic areas (see above) with frequent and/or prolonged exposure to conditions where sanitation and food hygiene are likely to be poor  
▪ Travel to countries where it is a condition of entry that visitors should have been immunised | FP34D | Travellers seeking vaccination that do not qualify for vaccination under the NHS. If charge is levied to patient, vaccine must not be claimed on FP34D. |
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| Varicella (Chickenpox)| ▪ Healthy susceptible close household contacts of immunocompromised patients (e.g., siblings of a leukaemic child, or a child who is undergoing chemotherapy).  
▪ Management of at-risk individuals following significant exposure to chickenpox or varicella zoster (See Green Book for detailed information).  
▪ Frontline healthcare workers (through their occupational health departments)                                                                 | FP10                                          | Occupational exposure for private organisations (refer to employer to undertake or refer to another practice)* |
| Yellow fever          |                                                                                                                                                                                                                      |                                               | Travellers seeking vaccination may only be offered as a private service via designated Yellow Fever Vaccination Centres. |

*Occupational Health Services:
GPs cannot provide occupational health services to their own registered patients and charge the patient. The patient should be advised that it is not the responsibility of the practice to provide this under the NHS. This includes the provision of Hep A or B vaccination for occupational purposes for medical or nursing students. The immunisation should ideally be given under the employer’s or university’s private occupational health scheme. However, the employer may negotiate a private contract with a private clinic or GP practice to undertake an occupational health programme, but the employer must be charged directly for this service and not the patient. In the absence of such a scheme, the patient should be referred to another practice for a private service (practices may charge patients for occupational health services as long as they are not registered at that practice).

Patient Group Directions (PGDs):
GP practices with an NHS contract may use PGDs developed and approved by their CCG for vaccinations provided under the NHS. CCG PGDs may not be used for vaccinations given privately. Practices may not use their own PGDs for these purposes. This means that for private vaccinations, Patient Specific Directions must be used.

Post-exposure immunisation:
Certain vaccinations may be recommended by the local Health Protection Unit for possible contacts of vaccine-preventable infectious diseases, and these should be offered free of charge under the NHS.

Acknowledgements
Kent Local Medical Committee

GPC Focus on Vaccines & Immunisations – Guidance for GPs – November 2013