Guidance on Prescribing in Primary Care

Produced by Derbyshire Medicines Management on behalf of NHS Derby & Derbyshire

Approved by: Guideline Group

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Document control	Date

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1 INTRODUCTION

1.1 Aside from consultations, the most common intervention of the National Health Service is the issuing of a prescription.

2 PURPOSE

2.1 The purpose of this guidance is to outline expectations for NHS prescribing, detailing standards that all prescribers are expected to aspire to. It also seeks to provide clarification for prescribing situations not covered by the NHS or where NHS responsibility for prescribing is not clear. This guidance is intended to provide information on current best practice to ensure a consistent approach by primary care prescribers.

3 SCOPE OF THE GUIDANCE

3.1 This guidance is appropriate for all prescribers; General Practitioners, secondary care prescribers, locum and junior doctors, trainees and community practitioners, supplementary and independent non-medical prescribers within Derbyshire. In addition, this guidance is appropriate for all dispensers of medicines and appliances including community pharmacies and appliance contractors.

3.2 Prescribers should also refer to other relevant documents relating to prescribing in their respective organisations.

4 DEFINITIONS

4.1 ACBS: In certain conditions some foods (and preparations) have characteristics of drugs and the Advisory Committee on Borderline Substances advises as to the circumstances in which such substances may be regarded as drugs.

4.2 SLS: Certain drugs may only be prescribed on the NHS to specified patient groups for a specified condition. When such conditions are met the prescriber must endorse the prescription SLS (Selective List Scheme).

4.3 JAPC: Joint Area Prescribing Committee. The Joint Area Prescribing Committee is a group with NHS representation from primary and secondary care across the Derbyshire Health Community. It provides recommendations on drugs and medicines management issues.

4.4 Formulary: A list of medicines. The term is often used to describe a limited list of medicines that have been approved for use in a locality.

4.5 Guideline: An official recommendation indicating how something should be done or what sort of action should be taken in a particular circumstance.

4.6 Policy: A policy is a plan of action which is then applied as concrete programmes and actions. Policy documents will be prescriptive by nature and will detail expectations for the actions of individuals in a particular subject area, setting the parameters within which individuals will operate.

5 PRESCRIBING AGAINST NATIONAL AND LOCAL GUIDANCE

5.1 The expectation is that prescribing should be in line with guidance issued by the Derbyshire Joint Area Prescribing Committee (JAPC), national guidelines and policies. Any departure from this requires sound clinical reasons or to accommodate the nine protected characteristics defined by the Equalities Act (age, disability, gender re-assignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation).

N.B. Veganism or vegetarianism is not a protected characteristic according to the 2010 Equality Act. The Vegan Society website acknowledges that it isn't always possible to make a choice that avoids the use of animals, and sometimes there may not be an alternative to taking a prescribed medication containing animal derived ingredients. Excipients are used in the manufacture of medicines for various purposes and may be derived from animals and it may not be obvious from the SPC or PIL which excipients are animal derived. Patients may contact the manufacturer for information regarding the suitability of the product for vegans, although they may not be able to guarantee or differentiate the specific sources of animal derived ingredients. The Vegan Society does not recommend that people avoid taking medicines prescribed by their doctor but encourage discussion about possible alternatives to medicines containing animal-derived ingredients with healthcare professionals. Any adjustment to prescribing should remain consistent with guidance issued by the Derbyshire Joint Area Prescribing Committee (JAPC), national guidelines and policies.

5.2 Legal responsibility for prescribing lies with the prescriber who signs the prescription. They should understand the patient's condition, the treatment prescribed and be able to recognise any adverse effects of the medicine should they occur. Prescribing responsibility will be based on clinical responsibility with JAPC ensuring that local arrangements are in place to ensure such responsibility can be accepted where appropriate.

5.3 National and local guidance will often clarify what GPs should prescribe for identified individuals e.g., who should receive an influenza vaccination. Whilst issuing an FP10 outside these recommendations is not prohibited, practices should be aware that this could be considered an example of inappropriate or excessive prescribing as stated in the GMS, PMS or APMS contract.

5.4 Where there is a choice of drugs within a therapeutic class, the one with the lowest NHS reimbursement cost should generally be used first line. First and second line choices of many commonly prescribed medicines are included in the JAPC primary care formulary. If a non-formulary medication is required, the reason for prescribing out-side the formulary should be documented.

5.5 Prescriptions should be written generically unless there is a cost or clinical reason not to do so. Prescribers may be asked to justify any departure from this. An information leaflet for patients is available in Appendix 1 and a list of drugs recommended to be prescribed by brand (Appendix 2).

5.6 Hospital clinicians should not ask GPs to prescribe medication that is not listed on their trust's formulary or has not been approved by JAPC. Prescribing outside of local formulary, national or local guidance may be considered an example of inappropriate prescribing that would be challenged through provider contracts. Primary care prescribers should feedback such instances to the ICB using the inappropiate request facility on the Derbyshire medicines management website (www.derbyshiremedicinesmanagement.nhs.uk)

5.7 NHS England has provided specific information to general practitioners on their responsibilities in prescribing and monitoring hormone therapy for transgender and non-binary adults (updated April 2016). This is available on the Derbyshire medicines management website along with advice from the GMC and BMA. General Practitioners should co-operate with the specialist NHS Gender Identity Clinics and prescribe hormone therapy (feminising or virilising endocrine therapy) recommended for their patients by the NHS Gender Identity Clinic as well as undertaking associated monitoring. Although most products recommended do not have an approved indication for the treatment of gender dysphoria, there is extensive clinical experience of the use of these products in the treatment of gender dysphoria. Guidance published by the General Medical Council in March 2016 advises General Practitioners that they may prescribe 'unlicensed medicines' where this is necessary to meet the specific needs of the patient and where there is no suitably licensed medicine that will meet the patient's need. Requests to prescribe from private clinics should be considered by the practice team on a case by case basis, in line with the Private Prescribing in Primary Care guideline which can be found here

6 ADDITION TO APPROVED MEDICINES STATUS

6.1 JAPC must approve all new drug entities for use within primary care in Derbyshire prior to use. This allows the entry of new medicines to the local health economy within an equitable and managed process within the available budget. Primary care prescribers should not continue or initiate prescribing unless funding for use in primary care has been agreed.

6.2 JAPC will classify drugs according to the Derbyshire traffic light classification, in order to clarify prescribing responsibility:

RED: Prescribing responsibility lies with a hospital consultant or specialist. Prescribers should follow the best practice guidance on recording medicines on GP clinical systems that are prescribed and issued by other healthcare providers

AMBER: Initiated within a hospital/specialist setting but suitable for shared care with a GP under a shared care agreement

GREEN: Suitable for primary care prescribing

GREY: Not recommended for use, except in exceptional circumstances, due to lack of data on safety, effectiveness and/or cost effectiveness

Do Not Prescribe (DNP): Not recommended or commissioned. Clinicians should submit an individual funding request, and await a positive outcome, before initiation of treatment for a DNP medicine/treatment/medical device for NHS prescribing. See the Do Not Prescribe (DNP) Drug Policy.

Details of approved drugs and current traffic light list can be found at Traffic Light Classification.

Approval routes are as follows:

6.2.1 **For products initiated within an acute trust, mental health trust or community hospital and intended to be continued in primary care**. An application should be made by the relevant clinicians to their Trust's Drug and Therapeutic Committee (DTC) with a further application to JAPC with an estimate of anticipated costs in primary care and shared care arrangements where appropriate. As a default the JAPC application form for new drugs should be used. This is available from the JAPC secretary along with shared care templates.

6.2.2 **For products used predominantly in primary care**. The ICB Prescribing groups will discuss with the medicine management team and an application will be submitted directly to JAPC. Input to this process from all prescribers within primary care is welcomed (via ICB locality prescribing leads or the Medicines Management Team). The application form used for JAPC submissions should be used and is available from the secretary.

6.2.3 In exceptional clinical circumstances, prescribing of a medicine that has not been approved for funding may be considered for individual patients. In these circumstances the prescriber wishing to initiate treatment should make an application to the ICB for funding according to the Individual funding request (IFR) policy. Details are available from Individual Funding policy.

7 PRESCRIBING UNDER SHARED CARE GUIDELINES

7.1 Treatments which are suitable for shared care between primary care physicians and specialists are designated shared care status. Prescribers are advised to ensure there is a written agreement from the requesting specialist confirming how and by whom the patient will be monitored both for evaluating effectiveness of treatment, side effects and routine tests required.

7.2 Shared care guidelines are normally specific to a drug and an indication. In some cases the guidelines are also specific to the form of the drug.

7.3 Shared care will only be requested by specialists where the drug has been approved through their clinical governance process (normally via the Trust's DTC) and is included in their formulary as approved for shared care. Normally a JAPC approved shared care guideline will be available, although in exceptional circumstances, for rarely used medication, a primary care prescriber may accept on-going prescribing for a particular patient under an individual patient specific agreement.

7.4 All communication to the GP and patient will refer to the drug by the generic name unless prescribing by brand name due to bioavailability or other issues has been approved by the acute trust's DTC and JAPC.

7.5 It is the responsibility of the specialist to initiate the production of shared care guidelines where they feel they are appropriate or where JAPC indicates they are necessary.

7.6 Details of agreed Derbyshire shared care documents can be found at Shared Care guidelines

7.7 Primary care physicians should be consulted on the content of shared care guidelines and final approval for their use rests with JAPC.

7.8 A copy of the shared care guideline (where available) or an electronic link to the document should be included in the letter requesting shared care sent to the GP.

7.9 GPs should not refuse to prescribe under shared care for financial reasons alone. GPs may refuse to prescribe where they feel they have insufficient expertise to manage the drug; where they feel the patient's condition warrants specialist management and/or they feel the request falls outside the scope of the approved shared care agreement. Prescribing in this case should remain with the specialist.

7.10 Where prescribing continues to take place in secondary care arrangements should be in place to allow patients convenient access to their medicines.

7.11 Practices should ensure they have robust systems in place to ensure that medicines supplied by prescribers outside the GP practice are appropriately recorded on the GP clinical system to allow warnings and other alerts to be flagged up. Guidance on recording medication prescribed by other healthcare providers is available on the medicines management website.

7.12 A patient information leaflet on prescribing following an NHS referral is available in Appendix 3.

8 RECOMMENDED PRESCRIBING INTERVALS

8.1 The ICB does not enforce a primary care policy for repeat medication supply lengths, although 28-day prescription lengths are seen as being a best practice option for many patients, balancing convenience for patients with minimising waste. However, the ultimate decision on appropriate prescription length rests with the prescriber when a shorter or longer length may be considered appropriate in some circumstances.

8.2 There should be careful consideration where patients request longer prescription quantities, particularly for those that pay prescription charges. The decision to provide a longer quantity has to be balanced against patient need (including financial considerations), safety and the potential for waste. Pre-payment certificates may help some patients financially and repeat dispensing may offer convenience for patients on regular, stable medication (see section 8.8).

8.3 There are also situations when a shorter prescription quantity is appropriate for example for patients who are at risk of overdosing, medication needs are changing rapidly or there are issues with medication stability. **Weekly prescriptions should only be used exceptionally if there is a clinical or pharmaceutical need.**

8.4 The Department of Health strongly recommends that prescriptions for controlled drugs (schedule 2, 3, and 4) should be limited to a supply of up to 30 days treatment; in exceptional situations, to cover a justifiable clinical need and after consideration of any risk, a prescription can legally be issued for a longer period, but the reason for the decision should be recorded in the patient's notes. Prescription quantity of controlled drugs is monitored by the ICB through electronic prescribing data (ePACT).

8.5 Regardless of the prescription supply length that is deemed suitable for an individual patient, prescribers should consider the following practical issues:

- Ensure prescription supply lengths are the same for an individual patient (usually 7, 28 or 56 days). This will help minimise inadvertent over-ordering of items. In particular avoid mixing 28 and 56 day prescription lengths.
- Items required only occasionally should not generally be placed on repeat prescription unless there is an ongoing need in which case the quantity prescribed should be sufficient to cover the prescription supply length but should not be excessive.
- Ensure the issue duration is entered correctly on the repeat template and is in line with the quantity to be issued. This will ensure systems to alert to over and under ordering will work properly on the clinical system.

8.6 It is recommended that GP practices have robust repeat prescribing standard operating procedures (SOPs) in place in order to support the continued safe, effective and efficient use of medicines. Circumstances will vary from practice to practice and individual patients but SOPs should include consideration of ordering, record keeping, repeat prescription intervals, recall, reauthorisation of prescriptions, medication review, referral and triage.

8.7 GP practices have a contractual obligation to have safe prescribing systems in place and not prescribe excessively. Prescriptions which cover long periods of time without adequate review may contribute to medicines waste and may be considered excessive.

8.8 Prepayment certificates (PPC) are the most economical way of paying for prescriptions where more than one regular prescription item is required each month. Patients can purchase a prepayment certificate online from the NHS Business Services Authority (www.nhsbsa.nhs.uk), over the phone by calling the PPC order line on 0300 330 1341 or direct from a pharmacy registered to sell PPCs. These can be purchased to cover a 3 month or a 12 month period.

8.9 Repeat dispensing allows a predetermined number of batch prescriptions to be dispensed where the patient's condition, medication and dosage are stable. Medication can be collected from the pharmacy without the need for a further repeat prescriptions being ordered from the surgery. This provides convenience for the patients and to enable the workload to be managed for practices and pharmacies. Care should be taken to ensure patients are selected appropriately for repeat dispensing and patients and practice staff understand the repeat dispensing process and actions to be taken if medication changes during a repeat dispensing cycle.

8.10 When dispensing batch prescriptions, it is the responsibility of the dispensing pharmacist to check 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.

9 ISSUING OF PRESCRIPTIONS

9.1 Practices must develop and implement Standing Operating Procedures for the handling and issuing of prescriptions.

9.2 Medicines reconciliation following hospital admission or specialist appointment requires clinical judgement and should only be undertaken by competent health care staff. The level of therapeutic knowledge required would normally be achieved by prescribers, pharmacists or suitably experienced pharmacy technicians or nurses. Good practice guidance is available on the medicines management website.

9.3 Non-clinical staff should only undertake administrative aspects of reconciliation and good checking processes by those with clinical knowledge should always be in place.

9.4 Non-clinical staff should not generate acute or new repeat prescriptions and only assist in genuine repeat prescriptions.

9.5 Before signing a repeat prescription, prescribers should be satisfied that systems are in place to ensure that

- The patient is issued with the correct prescription.
- Each prescription is regularly reviewed so that it is not issued for a medicine that is no longer required.

- The correct dose is prescribed for medicines where the dose varies during the course of the treatment.
- The patient's condition is monitored appropriately, and prescriptions are not issued for patients who require further examination or assessment. This is particularly important in the case of medicines with potentially serious side-effects.

10 MANAGED REPEAT PRESCRIPTION SYSTEMS BY PHARMACIES AND OTHER SUPPLIERS OF MEDICINES

N.B. These services are distinct from "repeat dispensing" which is the process by which patients can obtain supplies of their repeat medicines over a defined period of time (usually 6 months or one year), without the need to contact their GP practice for a new prescription each time a further supply is required.

Repeat dispensing is an Essential Service under the pharmacy contract and all pharmacies must be able to offer this service with appropriate standard operating procedures in place.

Where a patient (or their personal representative) is capable of ordering their own repeat medication they should do so. If a patient struggles to order their own repeat medication then electronic repeat prescription dispensing (eRD) should be considered where appropriate. Only where a patient is not capable of ordering their own repeat medication and is not suitable for electronic repeat dispensing should the pharmacy invite the patient to make use of a managed repeat prescription service.

10.1 Community pharmacies and other companies requesting prescriptions on behalf of patients should have discussed the need for further repeat items with the patient or carer not earlier than 5 working days prior to submitting the repeat request.

10.2 Requests for repeats must be triggered by the patient and decisions to reorder are not taken by pharmacy or other staff without input from the patient.

10.3 The Derbyshire Repeat Prescription Management Code of Practice provides a framework for best practice for managed repeat prescription systems. Where pharmacies have either not signed up to or are not adhering to the code, practices are not obliged to accept managed repeats from that pharmacy (although steps should be taken to ensure vulnerable patients can still obtain supplies of their medicines).

10.4 Patients should be free to choose from which pharmacy they wish to have their prescribed medicines dispensed.

11 RETROSPECTIVE PRESCRIPTIONS

11.1 No products should be supplied to a patient without a signed prescription. Retrospective prescriptions will not be issued by the prescriber except in an emergency situation at the request of the patient/patient's carer or clinical specialist. Dispensing appliance or pharmacy contractors must not request retrospective prescriptions for items already supplied. There is no obligation for prescribers to provide a retrospective prescription and therefore prescribers should strongly consider refusing requests for retrospective prescriptions unless as a result of an emergency situation (see NHS (GMS) regulations 2004, Schedule 5, para 39 (6) and corresponding PMS regulations).

12 PRESCRIPTIONS FOR MULTI-COMPARTMENT COMPLIANCE AIDS (MCAs)

Royal Pharmaceutical Society recommendations:

1. The use of original packs of medicines with appropriate support is the preferred option of supplying medicines to patients in the absence of a specific need requiring an MCA as an adherence intervention

2. In support of independence and re-ablement, patients who can safely self-administer their medicines should be encouraged to do so and where they are unable to do so, there must be appropriate training for carers so that they are able to administer medicines from original packaging

3. Every patient identified as having medicines adherence issues should have a robust individual assessment to identify the best intervention based on their needs and the evidence currently available. This assessment should incorporate a clinical medication review, any reasons for nonadherence, medicines suitability, a consideration of all possible options to support the patient and follow up.

4. Where a patient assessment indicates an MCA is the intervention of choice, it is important that this is supported with the provision of information, appropriate counselling and follow up for the patient and that the health or social care professional is aware of the legal, professional and practice considerations.

   The decision to supply MCAs should only be made after taking all factors into consideration.

12.1 The provision of 7 day prescriptions remains at the discretion of the prescriber. This should be used to facilitate the most appropriate care for a patient e.g., where there is a clinical or pharmaceutical need for medicines to be supplied every 7 days and not as a method of funding MCAs.

12.2 If a patient is assessed by the community pharmacist as needing MCAs under the Equality Act with no other clinical or pharmaceutical issues, MCAs should be provided by the pharmacist (free of charge to the patient) usually via 28 day scripts. Four weeks supply of MCAs should be dispensed at each interval. This applies to patients living in the community, those receiving social care support, and self-medicating patients living in residential homes.

12.3 Under the terms of the Equality Act where a person has a physical or mental impairment which has a substantial long term adverse effect on his ability to carry out normal day-to-day activities then it may be decided that medicines be provided in a dosing system, to help the patient to overcome the aspect of their disability that prevents them using their dispensed medicines. Having a disability does not equate with an entitlement to dosing systems – the nature of the disability must be such as to prevent the patient from being able to use their medicines, if not supplied in a dosing system. It should be noted that other interventions e.g. changes to labels and packaging may be as beneficial in some situations.

12.4 Provision of MCAs under the Equality Act falls within the Pharmacy contract and no further reimbursement is allowed. Prescriptions should usually be provided for 28 days.

12.5 Community Pharmacists who decide not to provide MCAs, as they either feel the patient does not meet the Equality Act criteria or that provision of an MCA is not a reasonable adjustment, should keep records clearly showing the rationale for the decision.

12.6 If a patient is assessed by the community pharmacist as needing MCAs under the Equality Act, but there is a clinical or pharmaceutical issue involved requiring weekly dispensing (e.g., the medicines are only suitable for weekly dispensing; the patient is at risk of overdose or medicines regime changing frequently), MCAs should be provided by the pharmacist (free of charge to the patient) via 7 day scripts. One week of MCA will be dispensed at each interval. This applies to patients living in the community, those receiving social care support, and self-medicating patients living in residential homes. N.B Repeat dispensing may be considered appropriate in these circumstances.

12.7 If a GP believes that a patient would benefit from an MCA but on assessment by the community pharmacist the patient does not meet the Equality Act requirements, then the GP can choose to provide 7 days scripts with the pharmacist dispensing the MCA on a weekly basis, so long as the pharmacist is happy to provide the service in this manner. Alternatively, arrangements could be made for the patient to pay the pharmacist for providing an MCA service, or other local arrangements made.

12.8 If Care Homes want patients' medicines to be supplied in MCAs as part of their internal policies, then this will be outside the scope of the NHS and will be negotiated between the nursing home and the community pharmacist.

12.9 Derbyshire County Council providers and Derby City Council providers will provide medication assistance to patients already receiving home care support as a last resort. The health sector has an obligation to try all possible avenues of supporting patients to self-medicate first, which may include the supply of MCAs if appropriate.

Therefore, there may be instances where patients with social care support are also receiving MCAs, as this enables the patient to safely self-medicate without social care needing to provide this additional support.

12.10 GPs and other healthcare professionals are reminded that they too have a duty to make reasonable adjustments to the management of patients' medicines under the Equality Act; in the first instance this should include rationalisation of the medication and administration times, but this may include the prescribing of weekly prescriptions if there are clinical or pharmaceutical reasons why a longer length of supply would be problematic. Where weekly prescriptions are issued, the pharmacist is expected to supply one week's supply of medicines at weekly intervals. If a pharmacist identifies clinical or pharmaceutical reasons why weekly prescriptions might be required, this can be facilitated using the Request form for Weekly Prescriptions and the pharmacist should send this completed form to the GP detailing the reasons why weekly prescriptions have been requested.

12.11 The GP can only make a reasonable adjustment as a GP. They cannot make an adjustment to a Pharmacist's Equality Act assessment.

12.12 If a patient or their carer (including provider carers) need or want an MCA but the patient does not meet the Equality Act requirements, then this will be outside the scope of the NHS and will be negotiated between the patient, their GP and the community pharmacist.

12.13 Supplying 7 day prescriptions where there is not a clinical or pharmaceutical need is not appropriate.

13 PRESCRIBING OF TREATMENTS INITIATED AS PART OF A CLINICAL TRIAL AFTER THE TRIAL HAS FINISHED

13.1 NHS Derby & Derbyshire will not normally agree to pick up the ongoing funding of treatments for patients who have completed clinical trials unless either:

13.1.1 The ICB has agreed through normal commissioning processes prior to the trial commencing that the ICB will provide funding for the trial participants' ongoing treatment once they have left the trial. This agreement will be documented through normal commissioning processes and according to the Trust's governance procedures. In that event, the NHS organisation hosting the clinical trial is required to document the agreed exit strategy in the trial protocol and state the ICB will provide funding for the trial participants' ongoing treatment once they have left the trial and provide detail as is appropriate to each individual study; or

13.1.2 The ICB has agreed to fund the treatment as a service development for all patients in the clinical category of those patients leaving the clinical trial; or

13.1.3 The ICB's IFR Panel has considered and approved a request to provide individual funding for a patient. However, if such a request is made the fact that the patient has been involved in a clinical trial shall not amount to an exceptional clinical circumstance or be used by the IFR Panel to justify a finding of exceptionality. It is the consenting clinician's responsibility to ensure that patients are fully informed of and agree to their management plan at the end of the trial. This includes making patients aware of this commissioning policy and, where relevant, any successful or unsuccessful request for post-trial funding. Their consent should be documented.

14 PATIENTS TRAVELLING ABROAD

14.1 **Travel vaccinations**

14.1.1 Guidance for prescribers on risk assessment for travellers and appropriate advice can be found at the National Travel Health Network and Centre website (NaTHNaC) at www.nathnac.net

14.1.2 Travel vaccines that were previously set out in the 'Red Book' are included in the global sum and may be provided on the NHS free of charge to patients who require them under some circumstances. These are tetanus, polio, hepatitis A & typhoid.

14.1.3 Travel vaccinations available under the NHS should be obtained in one of two ways:

- purchased by the practice and personally administered. Payment claimed through FP34PD or FP34D (for typhoid and hepatitis A) or by issuing an FP10 and claiming via the NHS Business Services Authority (NHSBSA).
- obtained by the patient on FP10 prescription. A prescription charge is payable to the pharmacy unless the patient is exempt. In this situation no claim for a personal administration fee should be made.

14.1.4 Centrally supplied vaccines should not be used for travel purposes. Note: different batch numbers are used to identify use between those vaccines for use in the childhood programme and those used for travel purposes - Immform stock should not be used for travel vaccinations.

14.1.5 Hepatitis A&B combination vaccine - NHS patients cannot be charged for Hepatitis A where indicated for travel and therefore cannot be charged for combination Hepatitis A & B where indicated for travel.

14.1.6 Travel vaccines that are not available on the NHS can be offered to patients as a separate private service (see below). A private script can be issued for the patient to take to a pharmacy and practices may charge at their discretion. Alternatively, practices may keep a stock and may invoice the patient. It is advised that practices develop a practice protocol outlining the charges for private travel services which is available to patients. The DH recommends that vaccines against diseases that are not likely to be transmitted to others on return should be paid for by the patient.

- For destinations where a vaccination available under the NHS is not specifically recommended but the patient requests vaccination, this should be paid for by the patient.
- The following vaccines are not available on the NHS: Meningitis, Tick Borne Encephalitis, Hepatitis B, Japanese Encephalitis, Rabies, Yellow Fever Vaccine.

14.1.7 General practices are entitled to charge NHS registered patients a private fee for vaccinations supplied as noted in section 15.

14.1.8 Reimbursement for vaccines provided privately cannot be claimed on the FP34PD form

14.1.9 No charge should be made to any NHS patient of the practice for providing travel advice. This represents appropriate health promotion for patients wishing to travel abroad and is therefore classed as an essential service within the GMS contract. It is also unacceptable for GP practices to charge a fee for the administration of NHS travel vaccinations.

14.2 Travel medication

14.2.1 Malarial prophylaxis: The Department of Health has issued guidance (FHSL(95)7) that medication for malaria prophylaxis may not be reimbursed under the NHS.

14.2.2 Some medicines for malaria prevention are available to purchase “over the counter” at community pharmacies and patients should be advised to purchase where possible. Community pharmacists have access to up to date advice about appropriate prophylactic regimes and can advise travellers accordingly.

14.2.3 Prescription Only Medicines for malaria prophylaxis should be prescribed on private prescription. When issuing a private prescription or if they provide the medication, practices can charge a fee for one but not both (i.e. prescription or supply).

14.2.4 Patients should be advised to purchase sufficient prophylactic medicines to cover the period of their travel, commencing one week (two and a half weeks for mefloquine) before departure so that if adverse events occur there will be time to switch to an alternative and continuing for at least four weeks on return. Malarone is an exception being started 1-2 days before travel and stopped one week after leaving. The importance of mosquito nets, suitable clothing and insect repellents to protect against being bitten should be stressed.

14.2.5 Drugs prescribed in anticipation of illness whilst abroad: patients may be offered and charged for a private prescription for prescription only medicines e.g., ciprofloxacin for traveller’s diarrhoea. See section 15.

14.3 Supply of regular medication

14.3.1 Under NHS legislation, the NHS ceases to have responsibility for medical care of patients when they leave the UK. People travelling within an EU country or Switzerland are advised to carry a European Health Insurance Card (EHIC) or a UK Global Health Insurance card (UK GHIC) at all times, this gives entitlement to local health care arrangements. More information can be found here. People should be advised to consider

travel insurance that comes with healthcare cover and check specific entitlements prior to travel. The following guidance is provided to ensure good patient care:

14.3.2 Medication required for a pre-existing condition should be provided in sufficient quantity to cover the journey and to allow the patient to obtain medical attention abroad. For patients who will be out of the country for less than 3 months, it is reasonable to provide sufficient medicines for an existing condition if clinically appropriate.

14.3.3 Patients leaving the UK for more than 3 months should be advised to register with a local health care provider for their continuing medical needs. This may need to be paid for by the patient. It is reasonable for GPs to provide sufficient medication to give the patient time to do this. Patients may be advised that medicines can be purchased without a prescription from pharmacies in some countries. NB: It is wise for patients to check with the manufacturer that the medicines required are available in the country being visited.

14.3.4 Any patient absent (or intending to be absent) from the country for more than three months should be removed from the practice list [Clause 216 of the Standard Medical Services Contract].

14.3.5 General practitioners are not responsible for NHS prescriptions for items required for conditions which may arise while travelling e.g., travel sickness or diarrhoea. Patients should be advised to purchase these items from community pharmacies prior to travel, or to obtain a private prescription for POMs if appropriate. For conditions unresponsive to self-medication, the patient should normally seek medical attention abroad.

14.3.6 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. The kits or a list of suppliers are available through travel clinics or community pharmacies. Neither kit is available under the NHS.

14.3.7 Patients leaving the UK with medicine that contains a controlled drug should be able to prove it's theirs with either a prescription or letter from their clinician. Other countries have their own import laws for prescription medicine and controlled drugs and patients should check with the embassy of the country they're going to before travelling to check the medicine is legal in that country. If necessary, patients can email dflu.ie@homeoffice.gov.uk for more advice on leaving the UK with controlled drugs. More information can be found here.

15 PRESCRIBING FOR MINOR AILMENTS

15.1 The General Medical Council (GMC) advise that prescribers should only prescribe drugs to meet the identified needs of patients and not for their own convenience or simply on patient demand. Declining patient requests from the outset (e.g. requests for simple analgesia or for antibiotics for viral infections) may deter patients from making similar future demands.

15.2 The Derbyshire Self-Care Policy provides information to promote the concept of patient self-care with the aim of reducing prescribing of medicines which are available to purchase "over the counter" when appropriate.

16 PRESCRIBING OF LICENSED MEDICINES WITH LIMITED THERAPEUTIC VALUE OR EVIDENCE BASE

16.1 Prescribing of products considered by both the British National Joint Formulary Committee and the Derbyshire Joint Area Prescribing Committee to be of limited therapeutic value and/or where there is no recognised evidence base is not supported. Such products are included in the Derbyshire JAPC DNP List.

16.2 An information leaflet is available in Appendix 4

17 PRESCRIBING LICENSED MEDICINES FOR AN UNLICENSED USE (OFF LABEL)

17.1 Prescribing of medicines that are licensed but are being used outside of their product license is not generally recommended. However, it is recognised that some circumstances may necessitate prescribing “off-label”.

Points for consideration:

17.1.1 Prescribers have a duty in common law to take reasonable care and to act in a way consistent with the practice of a responsible body of peers of similar professional standing.

17.1.2 Prescribers should be satisfied that an alternative, licensed medicine would not meet the patient’s needs.

17.1.3 Legal responsibility for prescribing falls to the practitioner who signs the prescription.

17.1.4 In situations following a recommendation by a specialist, the prescriber is unlikely to be found negligent if they have taken steps to become familiar with the drug; are able to monitor the drug completely; and have access to effective specialist support.

17.1.5 When an unlicensed use of a medicine is prescribed, the prescriber is professionally accountable for his judgement in doing so and may be called upon to justify his actions. It is recommended that the decision is discussed with the patient and documented in the patient record.

18 PRESCRIBING UNLICENSED MEDICINES and SUBSTANCES NOT IN THE ADVISORY COMMITTEE ON BORDERLINE SUBSTANCES (ACBS) LIST

18.1 NHS Derby & Derbyshire advises against prescribing at NHS expense, products that do not have a UK Product License unless they are included in specific guidance that has been approved by JAPC or the MHRA or DHSC. This includes:

18.1.1 Medicines licensed outside of the UK and imported into the UK, products being used outside of UK licensed indications (see above)

18.1.2 Other preparations such as health supplements e.g.:

Antioxidants for Age-related Macular Degeneration (e.g., ICAPS®, Ocuvite® etc),
Gamolenic acid
Cod liver oil
Co-enzyme Q10®
Elena®’s skin product
Progest Cream®

18.1.3 Herbal medicines e.g., Ginkgo Biloba, St John's Wort.

18.1.4 Other unlicensed products (any preparations not listed in the BNF) such as specials (see below). Please note this list is not exhaustive.

18.1.5 Prescribing of borderline foods and dietary products should comply with the recommendations of the Advisory Committee of Borderline Substances (ACBS) who recommend products on the basis that they may be regarded as drugs for the treatment of specified conditions. Doctors should satisfy themselves that the products can be safely prescribed, that patients are adequately monitored and that where necessary, expert hospital supervision is available.

18.1.6 A complete list of conditions can be found in the BNF or Drug Tariff Part XV. Prescriptions should be endorsed "ACBS".

18.1.7 There are several areas where prescriptions for dietary products do not comply with the ACBS recommendations and responsibility lies with the individual GP who may use their judgement to make exceptions. This may occur following recommendations from a dietician or for a medical condition requiring nutritional support for a defined period of time.eg following maxillo-facial surgery.

18.1.8 JAPC will strongly support any doctor who declines prescribing dietary products for patients (or nursing or residential homes) outside the ACBS criteria or using them as an alternative to liquidising/purchasing appropriate food.

19 PRESCRIBING OF UNLICENSED SPECIALS

Commercial companies may manufacture individual products known as 'specials' where there is no commercially available, licensed, preparation to meet a patient's clinical needs. These products do not have a license. Before prescribing a special, consideration should be given to alternative licensed preparations available (first choice option), or whether a licensed preparation can be given in an unlicensed way e.g. crushing tablets, opening capsules (second choice option). The Medicines Management Team can provide advice on specific products.

19.1 Liquid specials generally tend to have shorter shelf lives, can be difficult for patients to obtain, and are usually much more expensive than the capsule or tablet version of the same drug, although it is acknowledged that these products may be unavoidable for a small number of patients.

19.2 Prior to considering prescribing an unlicensed special the treatment should be reviewed and if still necessary, alternatives should be considered.

19.3 Unlicensed drugs are not covered by the Medicines Act, so there is no approved summary of product characteristics (SPC) for prescribers to consult. (N.B. prescribers are only indemnified by a drug company if there is an SPC and if the drug is used within licensed indications)

19.4 Practices are advised to review patients receiving prescriptions for these items and consider an alternative licensed preparation if appropriate. Initiation for new patients is not recommended unless there is no alternative. See further specials guidance

20 *PERSONALLY ADMINISTERED ITEMS*

20.1 Items that can be claimed as personally administered include

- Vaccines, anaesthetics and injections.
- Intrauterine contraceptive devices (including drug releasing IUCDs, contraceptive caps and diaphragms).
- Pessaries which are appliances
- Sutures (including skin closure strips) – for emergency wounds etc.

N.B Implanon/Nexplanon cannot be claimed as a personally administered item (since an implant, rather than injection). An FP10 prescription should be provided. A prescription charge is not payable since a contraceptive. Goserelin (even though an implant) can be claimed as personally administered item, as can leuprorelin and triptorelin.

High volume vaccines (e.g., influenza, typhoid, hepatitis A, hepatitis B, pneumococcal, meningococcal) can be claimed for on the form FP34PD. For other items an FP10 prescription needs to be submitted.

Items that cannot be claimed as personally administered include dressings used in minor surgery, hormonal implants, nebules, catheters, clinical reagents etc.

Items that are personally administered do not attract a prescription charge. If a prescription is provided, a prescription charge would be payable (unless patient is exempt).

21 DOCTORS PRESCRIBING FOR THEMSELVES OR THEIR FAMILIES

21.1 It is considered poor practice for doctors and their families to be registered at the doctor's own practice. Unless there are exceptional circumstances, doctors and their families should register with a GP outside the family. Doctors who believe they and/or their family cannot avoid being registered at their own practice should contact their Responsible Officer.

21.2 Doctors (or any other prescribers) should not prescribe for themselves or their family. Prescribers must not treat themselves or family members other than in an emergency, or other exceptional circumstances (which should be discussed with the prescriber's Responsible Officer).

22 PRESCRIBING FOR VISITORS FROM OVERSEAS

Anyone, regardless of their country of residence, is entitled to receive NHS primary medical services at a GP practice. This means tourists, or those from abroad visiting friends or family in England, should be treated in the same way as a UK resident. It also means GP practices cannot charge for this.

NHS England has further advice on how to register with a doctor.

Patients should be registered as temporary if they intend to reside in the practice area for more than one day but less than three months.

22.1 If they intend to stay for longer than 3 months, see the BMA full guidance on registering overseas visitors for more detail.

23 DISPOSAL OF UNWANTED MEDICINES

23.1 All pharmacies are obliged to accept unwanted medicines from patients, including dressings and medicines considered as hazardous (e.g. hormonal preparations, oral cytotoxic medicines etc.) as an essential service under the national Pharmacy Contract. Patients presenting at a GP practice with such items should be asked to return them to their local pharmacy for disposal. This also applies to patients who are resident in a residential home, however nursing homes providing nursing care to patients are required to make their own waste disposal arrangements.

23.2 Pharmacies are not able to accept sharps waste from patients e.g., insulin needles or medicines contained in pre-filled syringes etc. Patients who are prescribed such items should also be provided with a sharps bin and be instructed in how to use it safely and where to return it when full. Patients prescribed insulin needles and other items requiring disposal in a sharps bin in primary care should be prescribed an appropriate sharps bin on prescription and be advised to return to their GP practice when full.

A Derby City and Derbyshire County council sharps collection service for housebound patients is available. See link below or contact the relevant Borough Council:
Clinical waste - Derby City Council

24 MEDICINES DONATIONS OVERSEAS

24.1 The Environment Agency support the views of the Royal Pharmaceutical Society of Great Britain, the World Health Organisation and Department of Health that patient returned waste medicines should not be exported for re-use overseas as the recycling of such medicines is regarded as unsafe due to concerns over the quality of the returned medicine and the difficulties in managing these medicines at the receiving end.

APPENDIX 1: GENERIC MEDICINES

Generic medicines contain the same active ingredient as a branded medicine, for example Nurofen is the branded name for the medicine ibuprofen (the generic name). Generic medicines are made to the same standard as branded medicines so they are as safe and effective and of the same high quality as the branded medicines. Generic medicines contain the same ingredients and are identical in strength to the branded medicine, so they treat conditions in just the same way as a branded medicine.

There may be some difference in colour, shape or size which does not affect the medicine or the way it works.

Using generic medicines usually saves the NHS money which is used in other ways to benefit you, your family and other patients. The advice from the Department of Health is to use generic medicines where they are available and appropriate.

For these reasons, your repeat prescription will change and you will now be prescribed generic medicines.

Remember, generic medicines:

- Have the same active ingredients as branded medicines
- Meet the same quality standards as branded medicines
- Are as safe and effective as branded medicines.

APPENDIX 2: ITEMS THAT SHOULD BE PRESCRIBED BY BRAND NAME FOR PATIENT SAFETY REASONS

The Specialist Pharmacy Service provides information on example medicines to prescribe by brand name for patient safety reasons here.

APPENDIX 3: INFORMATION FOR PATIENTS FOLLOWING AN NHS REFERRAL

When you are referred by your GP to an NHS specialist your medication may change.

Your specialist may give you a one-off prescription as part of your treatment and if appropriate may ask you to go to your GP so that you can get the medicines as part of your long-term care. If the GP does not feel able to accept clinical responsibility for prescribing the medication, the specialist will remain responsible for further prescriptions.

Your GP must have a full clinical report from the specialist before providing further treatment so you may not be able to get another prescription right away. The specialist should give you enough medicines until your GP has received the report but please speak to your practice if you are concerned that you will not have enough.

Local GPs have agreed to prescribe in line with local policies. If the recommendation from your consultant is for medicines that are not in line with local policies, then your GP may change the medication to be in line with the medicines used for NHS patients.

APPENDIX 4 - UNLICENSED MEDICINES AND MEDICINES WITH LIMITED THERAPEUTIC VALUE

Medicines are provided with a license by the manufacturers to ensure they are safe. NHS Derby & Derbyshire advises GPs not to prescribe products that do not have a UK medicine product license.

Examples of items where there is no product license are:

Health supplements e.g., Antioxidants for Age-related Macular Degeneration (Ocuvit®, ICAPS®),
Gamolenic Acid,
Cod Liver Oil,
Q10,
Elena®,
Progest Cream®,
Herbal medicines e.g., Ginkgo Biloba, St John's Wort

Other unlicensed products not listed in official information sources such as the British National Formulary.e.g., co-proxamol

Please note this list is not exhaustive.

Your GP is reviewing prescriptions where unlicensed medicines have been provided. You may be recommended an alternative or you may be able to buy the product yourself.