Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

Prescribing Dilemmas

A Guide for Prescribers

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1.0 INTRODUCTION

This document provides guidance for health professionals regarding prescribing situations not covered by the NHS, including private care and private prescriptions, unlicensed medicines, prescribing outside national guidance, prescribing duration, foodstuffs, complementary medicines and alternative therapies, common ailments, fertility treatment, erectile dysfunction, prescribing for self and family, visitors from overseas, travel and occupational health vaccines.

The information has been collated from various resources including those produced by the General Medical Council (GMC), NHS England, the Department of Health, British Medical Association (BMA), Royal College of General Practitioners (RCGP) etc.

2.0 CLINICAL RESPONSIBILITY

Legal responsibility for prescribing lies with the prescriber who signs the prescription[1]. It is important that prescribers prescribe drugs or treatment, including repeat prescriptions, only when they have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs[2].

Please note that throughout this document reference has been made to primary care prescribers – a term which applies to General Practitioners (GP's) and independent Non-Medical Prescribers (NMPs) who have responsibility for prescribing in the relevant areas. Independent Non-Medical Prescribers include Nurse, Pharmacist, Optometrist, Physiotherapist & Chiropodist/Podiatrist Independent Prescribers[3,4]:

All prescribers are encouraged to report suspected adverse drug reactions using the Yellow Card reporting scheme[5].

At the interface between hospitals and GPs, 'prescribing responsibility will continue to be based on clinical responsibility'. This is good medical practice and is in the best interests of the patient[1].

BHR CCGs have an Interface Prescribing Policy with Barking Havering and Redbridge University Trust (BHRuT) and Barts Health which clarifies responsibility for prescribing. These policies have been approved by the BHR CCG Area Prescribing sub-Committees which has representation from the Trusts, the CCG's, the Local Medical Committees (LMC), Local Pharmaceutical Committee (LPC) etc. Please click on this link to access the policy.

3.0 PRIVATE REFERRAL

A number of patients opt to have some or all of their investigations and/or treatment privately. Some use private health insurance, whilst others are willing to pay to be seen more quickly, or for the added convenience or comfort of receiving their care in private facilities.

In addition to the increasing emphasis on patient choice within the NHS, it is also recognised that patients are entitled to choose whether they receive their treatment within the NHS or privately. Treatment can be considered in terms of ‘episodes of care’, which may be either continuous or consist of a series of treatment and care episodes, some of which may be funded by the patient and some by the NHS.

3.1 Patients who request to be referred privately

Patients who request a private referral are expected to pay the full cost of any treatment they receive in relation to the care provided privately. **This includes associated consultation fees, diagnostic tests, drugs prescribed or treatment provided by a clinician in the course of a private consultation.** Patients should be informed of this expectation prior to referral.

Prescribers may wish to make use of the “BHR CCG patient information letter for private referrals” as available in Appendix 1 of this document.

3.2 Patients who are referred to private care as part of an NHS episode of care

Where a GP refers a patient who is entitled to NHS care to a private establishment as part of an NHS episode of care, the patient will be entitled to receive all elements of that care in the same way as if they were referred to an NHS Trust. This means there will be no charge for any associated consultation, diagnostic tests or treatment. Patients who are required to pay for their prescriptions will be expected to pay the NHS prescription fee that applies as per usual practice.

4.0 PRIVATE PRESCRIPTIONS

4.1 Following a private consultation

A private consultant (i.e. the person providing the private opinion, which may be a physician, dentist or other healthcare consultant) may see a patient privately in order to give an opinion to a primary care prescriber regarding diagnosis or further management. Alternatively, the consultant may treat a private patient for whom they will continue to have clinical responsibility and will personally determine the ongoing treatment for that particular condition.

Until the consultant discharges the patient, this remains an episode of care. In this case, the consultant should prescribe privately for their private patient. A primary care prescriber may refuse to transfer such a prescription to an NHS script, if they

consider they do not have sufficient expertise or the necessary information to share clinical responsibility for managing that particular condition/episode of care.

In the case where the patient is recommended treatment by the private consultant which the primary care prescriber considers would not be of overall benefit to the patient, or where the medication is generally not provided within the NHS (e.g. a drug that is contrary to locally agreed guidance and pathways or on the Drug Tariff Black List), the prescriber must explain this to the patient and include the option to seek a second opinion from a local NHS commissioned service/specialist.

The primary care prescriber will however, continue to provide NHS treatment and prescriptions for other conditions for which they retain clinical responsibility[1, 2].

The GMC advises that it is good medical practice to "contribute to the safe transfer of patients between healthcare providers", "share all relevant information with colleagues involved in your patient's care" and "when you do not provide your patients' care yourself… be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient"[1]. Patients should be informed that unless it is an emergency, prescription requests would be subject to the usual delay for routine prescription requests as specified by the practice.

For a specific condition, where a private consultant recommends a medication that is more expensive without good evidence that it is more effective than that recommended in the local health economy, local prescribing advice and pathways should be followed by the primary care prescriber. This advice should be explained to the patient, who will retain the option of purchasing the more expensive medicine via a private prescription from the consultant.

4.2 For NHS patients

A GP may issue a private prescription for any item in circumstances where the medicine is not available on the NHS. These circumstances are where:

• The item is listed in Schedule 1 of the National Health Service (General Medical Services Contracts) (Prescription of Drugs Etc.) Regulations 2004 as amended (the so called "blacklist"). This list of products may also be found in part XVIIIA of the NHS Drug Tariff [6,7].

• The item is listed in Schedule 2 of the National Health Service (General Medical Services Contracts) (Prescription of Drugs Etc.) (England) Regulations 2004 as amended (the so called "SLS list") and where its use is for persons or purposes other than those specified in the Schedule[8].

• The product is a travel vaccine, e.g. Japanese encephalitis vaccine, yellow fever vaccine (if at a yellow fever vaccination centre) (see section 15.1).

• The product is being prescribed in connection with travel and is for an anticipated condition (e.g. antibiotics for travellers' diarrhoea, acetazolamide, or the oral cholera vaccine Dukoral®).

4.3 For a branded product

Where NHS policy recommends that a generic medicine is used and a patient requests the branded equivalent, a private prescription cannot be issued if the patient is being treated within the NHS, unless the product cannot be prescribed on the NHS as specified above in "the blacklist". Whilst issuing an NHS prescription for patients who request a branded equivalent is not prohibited, practices should be aware that this could be considered an example of inappropriate or excessive prescribing as stated in the GMS contract.

5.0 PRESCRIBING OF MEDICINES FOR AN UNLICENSED USE

The GMC defines 'unlicensed medicines' as medicines used outside the terms of their UK licence (sometimes referred to as 'Off Label' use) or which have no licence for use in the UK[9].

Points for consideration: (see GMC guidelines for full version[9])

Prescribing unlicensed medicines may be necessary where:

a. There is no suitably licensed medicine that will meet the patients need
b. A suitably licensed medicine is not available
c. The prescribing forms part of a properly approved research project

Prescribers are reminded that:

i.) If you intend to prescribe unlicensed medicines where that is not routine or if there are suitably licensed alternatives available, you should explain this to the patient, and your reasons for doing so.

ii.) Exercise caution when considering using medical devices for purposes for which they were not intended[10].

BHR CCG's have developed a Specials Information Pack[11] which contains detailed guidance on identifying when a product might be an unlicensed special, the risk hierarchy for specials, appropriate management for patients with swallowing difficulties etc. The pack lists potential cost effective alternative products for liquid preparations, dermatology products, ophthamology products etc. It also contains a Patient Information Leaflet (PIL) which along with suitable counselling can be used to ensure the patient is appropriately informed in order to be adequately involved in the decision making process about their care. Where there is an established body of evidence to support off label prescribing then you can do so.

Leaflet for unlicensed use of medications in children:

www.medicinesforchildren.org.uk/search-for-a-leaflet/unlicensed-medicines/

Leaflet of use of unlicensed medication for pain:

www.britishpainsociety.org/static/uploads/resources/files/useofmeds_professional_final.pdf

6.0 PRESCRIBING OUTSIDE NATIONAL GUIDANCE

Whilst issuing an FP10 in circumstances which fall outside of the national/local 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 contract[7].

National and local guidance will often clarify what prescribers should do for identified individuals, e.g. who to immunise against influenza. Prescribers may make a decision, on a case-by-case basis, to prescribe outside any national guidance or programme if there is a compelling clinical reason to do so. Appropriate records should be made in the patient's notes in such circumstances.

7.0 PRESCRIBING DURATION

A 28-day repeat prescribing interval is broadly recommended across many Clinical Commissioning Groups in the NHS as a way of reducing medicines waste.

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.

BHR CCGs 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).

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

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

Clinical judgement and discretion should be used to determine appropriate prescribing intervals for individual patients or medicines. This should be coupled with a rigorous and effective medication review process.

People that are stabilised on their medicines and are suitable for longer prescribing intervals can be considered for a 56 day repeat prescribing interval or repeat dispensing (e.g. 28/56 day prescriptions for 6–12 months).

The NHS does not support routine prescription durations of 84 days or more.

8.0 PRESCRIBING OF BORDERLINE FOODS AND DIETARY PRODUCTS

In certain conditions some foods (and toilet preparations) have characteristics of drugs and the Advisory Committee on Borderline Substances (ACBS) advises as to the circumstances in which such substances may be regarded as drugs [9].

Prescribing of borderline foods and dietary products should comply with the recommendations of the ACBS: ACBS recommends products on the basis that they may be regarded as drugs for the treatment of specified conditions. Prescribers should satisfy themselves that the products can be safely prescribed, that patients are adequately monitored and that, where necessary, expert hospital supervision is available.

A complete list of products can be found in the British National Formulary (BNF)[12] or Part XV of the NHS Drug Tariff . Most of the conditions for which they can be prescribed fall into the following categories:

• dysphagia

• gastrectomy

• inflammatory bowel disease

• liver disease

• malabsorption states

• malnutrition (disease-related)

• metabolic disorders

• renal failure

• specific skin disorders

There are several areas where prescriptions for dietary products do not comply with the above recommendations, and the responsibility lies with individual GPs who may use their judgement to make exceptions to the above recommendations. This may occur following recommendations from a dietician, or for a medical condition requiring nutritional support for a defined period of time. An example of the latter would be a patient having had maxillofacial surgery, being discharged from hospital with a wired jaw and requiring nutritional support for six to eight weeks post-

operation. Such a patient would be unlikely to receive adequate nutrition from a manageable volume of liquidised foodstuffs.

GPs are strongly advised against prescribing dietary products for patients (including in nursing or residential homes) outside the uses listed in this section, and using them as an alternative to liquidising/purchasing appropriate food.

BHR CCG's in conjunction with the North East London Foundation Trust (NELFT) Dietetic services have produced resources to support the Prescribing and Supply of Oral Nutritional Supplements (including the full guide, a quick reference guide and a patient support leaflet). Please click this link to go to the relevant MM webpage.

There is also guidance on the Identification and Management of Malnutrition in Care Homes (available at this link) as well as a Guideline on prescribing infant formula for infants with Cows' Milk Protein Allergy (CMPA) (available at this link).

9.0 COMPLEMENTARY MEDICINE AND ALTERNATIVE THERAPIES

NHS Choices defines Complementary Medicine as treatments that fall outside of mainstream healthcare[13]. These medicines and treatments range from acupuncture and homeopathy to aromatherapy. Complementary and Alternative Medicines (CAMs) include, but are not limited to:

- acupuncture
- Alexander technique
- aromatherapy
- herbal medicine
- hypnosis
- massage
- nutritional therapy
- reflexology

The availability of CAMs on the NHS is limited, and in most cases the NHS will not recommend or offer such treatments" [13].

The National Institute for Health and Care Excellence (NICE) provides guidance to the NHS on effective treatments that are value for money. NICE has recommended the use of CAMs in a limited number of circumstances.

For example:

- ✓ the Alexander technique for Parkinson's disease
- ✓ ginger and acupressure for reducing morning sickness
- ✓ acupuncture and manual therapy for lower back pain

Use of complementary therapies will not be supported in BHR CCGs outside of NICE recommendations.

In addition, BHR CCGs have a position statement which clarifies that homeopathic preparation will not be prescribed on the NHS due to lack of clinical effectiveness evidence. Please click on this link for the BHR CCG position statement.

10.0 COMMON AILMENTS

The GMC advises that prescribers "should prescribe medicines only if you have adequate knowledge of the patient's health and you are satisfied that they serve the patient's needs"[16]. Declining inappropriate patient requests and signposting to relevant alternatives (e.g. self-care, community pharmacies) from the outset may deter patients from making similar future demands (e.g. requests for simple analgesia or for antibiotics for viral infections).

NHS England commissions community pharmacies to provide a minor ailments service where a local need is identified. Minor ailments are 'common or self-limiting or uncomplicated conditions which can be diagnosed and managed without medical intervention17; many of these ailments, such as coughs, colds, sore throats and earache frequently occur during the winter months.

Practices are encouraged to contact the NHSE Local Area Team or local community pharmacist to identify pharmacies that provide this service.

11. FERTILITY TREATMENT

BHR CCG's maintain a fertility policy which is regularly updated and accessible on the CCG intranet webpages via the search button.

Prescribers are encouraged to consult the most up to date document on the intranet in order to ensure any recommendations made to patients are in line with the latest local policy.

Prescribers are to note that prescribing of fertility treatments in BHR CCG's remains Hospital Only and should not occur in primary care.

12.0 MEDICINES FOR THE TREATMENT OF ERECTILE DYSFUNCTION

12.1 Treatment of erectile dysfunction

BHR CCGs preferred choice of phosphodiesterase-5 (PDE5) inhibitor is generic Sildenafil. Please see this link for the BHR CCG Erectile Dysfunction prescribing guidelines.

There are no longer any restrictions on the quantity or criteria for prescribing generic Sildenafil [14].

Other medicines for the treatment of erectile dysfunction can be prescribed in line with the Department of Health guidance (as detailed in the Drug Tariff, November 2017 part XVIIIB)[8] and must be endorsed SLS (Selected List Scheme) on the prescription. One treatment per week would be appropriate for most patients unless different recommendations are provided by the local NHS specialists.

12.2 Private Prescriptions

For those NHS patients (excluding those prescribed generic sildenafil) not meeting the NHS criteria, a private prescription can be provided. These should be provided free of a prescription writing charge[2]. Repeats can be provided on private prescriptions. When a private prescription is written the cost of the medication will be determined by the dispensing pharmacy and the patient should be made aware of this.

13.0 PRESCRIBING FOR ONESELF OR FAMILY

The GMC states that 'wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship'[16]. Ideally, doctors, family and staff from a practice should be registered with, and treated by, another practice. This gives the doctor and their family members access to objective advice and avoids the conflicts of interest that can arise when doctors treat themselves or those close to them.

The following guidance applies to all prescribers, not just GPs.

The GMC states:

• 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:

a. save a life
b. avoid serious deterioration in health, or
c. 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.

14.0 VISITORS FROM OVERSEAS

A patient does not need to be “ordinarily resident” in the England to be eligible for NHS primary medical care –this only applies to secondary (hospital) care. In effect, therefore, anybody in England may register and consult with a GP without charge[17].

Where a GP refers a patient for secondary services (hospital or other community services) they should do so on clinical grounds alone; eligibility for free care will be assessed by the receiving organisation.

The length of time that a patient is intending to reside in an area dictates whether a patient is registered as a temporary or permanent patient. Patients should be offered the option of registering as a temporary resident if they are resident in the practice area for more than 24 hours but less than 3 months.

General Practices are also under a duty to provide emergency or immediately necessary treatment, where clinically necessary, irrespective of nationality or immigration status. This will include all necessary medications as would be normally applicable within the NHS.

The practice is required to provide 14 days of further cover following provision of immediate and necessary treatment.

15.0 TRAVEL ABROAD

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

People travelling within Europe should be advised to carry the European Health Insurance Card (EHIC) at all times; this gives entitlement to local healthcare arrangements. Patients are advised to check specific entitlements and appropriate health advice prior to travel and obtain adequate travel insurance cover.

Guidance for GPs on risk assessment for travellers and appropriate advice is available from the National Travel Health and Network Centre (NaTHNaC - https://travelhealthpro.org.uk) and TRAVAX (http://www.travax.nhs.uk) websites.

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. If the patient is returning within the timescale of a normal prescription (usually one and no more than three months as a maximum) then this should be issued, providing it is clinically appropriate.

Patients carrying certain prescribed medication for their own personal use may require a doctor's letter or a personal licence. This will depend on the duration of travel, the type of medicine (e.g. codeine, Sativex®) and the country of travel. More information on the carrying of prescribed controlled drugs abroad for personal use is covered in section 15.3. Patients who require over-the-counter (OTC) medicines should check that the medicine is available OTC in the country of destination.

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

GPs are not required to provide prescriptions for medication that is requested solely in anticipation of the onset of an ailment whilst outside the UK, but for which treatment is not required at the time of prescribing (e.g. travel sickness, diarrhoea). Patients should be advised to purchase these items in the UK prior to travel; advice is available from community pharmacists if required. A private prescription may be provided for any prescription-only medicines if deemed appropriate and necessary, such as ciprofloxacin for traveller's diarrhoea. Patients should be advised about the appropriate use of self-medication and when they would need to seek medical attention abroad.

Travellers should consider carrying a personal emergency medical travel kit tailored to their needs and their travel destination (advice on what to include is available from the NaTHNaC and TRAVAX websites). There are occasions where the traveller may wish to include prescription-only medicine (POM) items and/or plasma substitutes in their personal emergency medical travel kit. A private prescription is required for the former.

15.1 Immunisation for travel abroad

The Immunisation against infectious disease document (also known as "The Green Book" – see link to website) gives clinical recommendations for the use of vaccines, but does not identify those that are recommended to be NHS funded.

Immunisations that are available for reimbursement under the new GMS contract must be provided **free of charge** to patients who require them. Under GMS and the Statement of Financial Entitlements (SFE), practices that do Additional Services – Vaccinations & Immunisations, must offer and provide the travel vaccines that are listed in the SFE, Annex B, Chapter 3. All APMS and PMS practices are signed up to provide all additional services. APMS contract – Schedule 2, Part 2, Section 7. Practices are advised to check the latest GMS documents to remain up to date with this requirement.

The vaccines that are available for travel via the NHS for which reimbursement is received include:

a. Cholera
b. Polio and tetanus booster
c. Hepatitis A
d. Typhoid

BHR CCG's are no longer funding the provision of the following travel related vaccines on the NHS [18]:

i. Hepatitis A and B combined
ii. Hepatitis B
iii. Meningococcal meningitis
iv. Japanese encephalitis
v. Rabies
vi. Tick-borne encephalitis
vii. Tuberculosis (TB)
viii. Yellow fever

Practices may charge for both the prescription and the administration of these vaccines at their discretion. No charge should be made to any NHS patient of the practice for providing advice.

Prescribers may find it useful to consult the BMA "Focus on Travel Immunisations" webpages for further advice and case studies. Please click this link to access.

15.2 Malaria chemoprophylaxis

Malaria chemoprophylaxis should not be provided on the NHS in line with current GMS guidance. A GP may provide medicines for malaria chemoprophylaxis via a private service and charge the patient for prescription and/or the supply of medication (pharmacy ['P'] medicines and POMs).

Patients can purchase some 'P' medicines for malaria chemoprophylaxis directly from the community pharmacy. Local community pharmacists also have access to up-to-date advice regarding appropriate prophylactic regimes and can advise travellers accordingly.

Patients should be advised to purchase sufficient prophylactic medicines to cover the period of their travel within an endemic area. 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.

15.3 Controlled drugs: implications for patients

Department of Health guidance recommends that, in general, prescriptions for controlled drugs in Schedules 2, 3 and 4 should be limited to a supply of up to 30

days treatment. Exceptionally (to cover a justifiable clinical need and after consideration of any risk) a prescription can be issued for a longer period, but the reasons for the decision should be recorded in the patient's notes.

Patients who are travelling for less than 3 months and carrying less than 3 months' supply of prescribed controlled drugs listed under Schedules 2, 3, 4 Part I and 4 Part II to The Misuse of Drugs Regulations 2001, will not need a personal import or export licence to enter or leave the United Kingdom. They should carry a letter from the prescribing doctor with the carrier's name, travel itinerary, names of prescribed controlled drugs, dosages and total amounts of each to be carried.

Additionally, it is always advisable to contact the Embassy, Consulate or High Commission of the country to be visited regarding their policy on the import of controlled drugs, as the legal status of controlled drugs varies between countries.

Controlled drugs should be:

• carried in original packaging;

• carried in hand luggage (airline regulations permitting);

• carried with a valid personal import/export licence (if necessary; see below).

Persons travelling abroad (or visitors travelling to the UK) in excess of three months and carrying controlled drugs, or carrying more than three months' supply of controlled drugs, will require a personal export or import licence[19]. A personal licence has no legal standing outside the UK and is intended to assist travellers passing through UK customs controls with their prescribed controlled drugs. Travellers are advised to contact the Embassy, Consulate or High Commission of the country of destination (or any country through which they may be travelling) regarding the legal status and local policy on the importation of controlled drugs.

16.0 VACCINES FOR OCCUPATIONAL HEALTH PURPOSES

The provision of vaccines for occupational health reasons is the responsibility of the employer and not the patient's GP (unless private contractual arrangements have been made between the practice and the employer). The employer (not the patient) will have to make private arrangements for administration of the vaccine(s). This may be with a GP practice or an occupational health provider.

Occupation – Hepatitis B vaccinations for occupations as listed in the Green Book and the British National Formulary (BNF) should normally be provided by the employer via their own occupational health provider or via private agreement with a practice. Categories are:

• NHS General Dental Practice employees

• Primary care employees

• Other occupational groups considered at risk. These include:

− NHS Trust, private and charity health workers,

− nursing home and old peoples' home staff

− prison staff, police, ambulance officers, morticians and embalmers.

Special consideration may need to be given to a patient who is at risk where the employer refuses to provide the intervention, or no occupational health service is available.

There are occasions where the vaccine is for occupational health reasons and the patient is from a group of patients identified as 'at risk'. It is then the responsibility of the GP to provide the vaccine if necessary and appropriate. See 'At risk' patients below.

Students – Prospective and current students of healthcare (e.g. medical, nursing, dental students) should be vaccinated by their educational organisation and not in general practice, as, practically, the provision of vaccination might include prior blood screening to assess immunity status, and guidance from an appropriate specialist on whether vaccination is necessary. Students will also receive specific advice on how to avoid blood-borne infections, needle-stick injuries etc. If hepatitis B vaccination is given in general practice, it could deprive the students of the necessary and important occupational health induction they will get at their educational organisation prior to their hepatitis B immunisation. This will also include advice on hepatitis C, HIV etc.

'At risk' patients – Where the patient is identified as being 'at risk', it is the responsibility of the GP to provide the vaccine if necessary and appropriate. The GP should use either an FP10 for supply through community pharmacy or personally administered item (FP34) to reclaim vaccine cost. There is no item of service fee. Examples of patients 'at risk' are provided in the BNF and Green Book and include:

• parenteral drug users,

• patients with multiple sexual partners,

• close family contact of a case or carrier especially infants,

• people with learning disabilities living in residential care,

• patients and carers of patients receiving frequent blood transfusions,

• foster carers of children at increased risk.

17.0 MANAGING PATIENTS WHO DO NOT ATTEND ROUTINE REVIEWS

Patients who are receiving regular medication are expected to be invited for medicines reviews by the practice on a regular basis.

Some patients are poor compliers with this practice and will on occasion refuse to present at the practice for a review or attend necessary blood tests.

In this case, practices are advised to consider a number of strategies to encourage the patient to attend a review including:

1. Sending out follow up letters to the patient highlighting the possible risks that may be associated with non-attendance
2. Calling patients to identify any stumbling blocks and discussing how these can be overcome
3. Reducing the duration of repeat prescribing to a 28 day cycle (if this was not already applicable) in order to allow a speedy intervention where needed

17.1 Patients on medicines with a narrow therapeutic window

Patients who are on medicines with a narrow therapeutic window should be particularly targeted and consideration given to stopping therapy if there is a risk that the patient is more likely to come to harm without appropriate review. Where applicable, the patient's specialist can be consulted in order to come to a consensus. Any decisions made should be communicated to the patient and community pharmacist.

17.2 Patients on polypharmacy, frail or otherwise at high risk of an adverse event

Patients who are on polypharmacy i.e. use of more than one medicine as defined in NICE guidance Medicines Optimisation – safe and effective use of medicines, NICE guidance - NG 5, those who are frail or at high risk of an adverse event for any reason (e.g. recent discharge from hospital) should be proactively followed up for a clinical review.

In cases where there might be significant concern and where the measures suggested above have been unfruitful, other local healthcare professionals can be enlisted to support e.g. the patients community pharmacy, the local community matron etc.

17.3 Patients who are not attending as they are out of the country

Where it is determined that the patient is not attending the practice due to the fact that they are not in the country, the practice may ascertain if the patient will be out of the country for longer than 3 months (see section 15).

If so, in line with BMA guidance, the practice may consider removing the patient from the practice register and sending a letter communicating this decision to the last known address. The patient will be at liberty to re-register with the practice on their return to the country if appropriate.

18.0 DEALING WITH REQUESTS FOR ITEMS LISTED ON THE DRUG TARIFF BUT NOT ON FORMULARY

BHR CCG's are signed up to the Barking Havering and Redbridge University Trust (BHRUT) and Bart's Health Trust Formularies as applicable to primary care.

From time to time, prescribers in primary care may receive requests for items which are prescribable on the Drug Tariff but for which there is no specific local guidance. Examples include garments in eczema, vaginal lubrication, silicone keloid creams etc.

Prescribers are advised that any item that is not listed on the local formularies is not for prescribing locally.

Patients should be referred back to the source of the request with this information. Specialists are able to request the addition of relevant items to the formulary with the provision of adequate evidence and assessment by the relevant Prescribing Committees.

APPENDIX 1 - Prescribing on the NHS following a private consultation – CCG position statement

5th floor, Becketts House

2-14 Ilford Hill, Ilford

Essex

IG1 2QX

Tel: 020 3182 3133

Reference: ?/?/?/?

Dear Patient,

Prescribing on the NHS following a private consultation

In line with supporting patient choice within the NHS, it is recognised that patients are entitled to choose whether they receive their treatment within the NHS or privately.

Patients who request a private referral should note that they will be expected to pay the full cost of any treatment they receive in relation to the care provided privately. This includes associated consultation fees, diagnostic tests, drugs prescribed or treatment provided by a clinician in the course of a private consultation. Until the consultant discharges you, this remains an episode of care.

Your GP will however continue to provide NHS treatment and prescriptions for other conditions for which they retain clinical responsibility. Patients who receive prescriptions after being seen privately should be aware that a private prescription cannot routinely be transferred to an NHS prescription. If the consultant writes to the GP informing him that the patient will be on long term medication, it will be the GP's decision whether or not to take clinical responsibility and provide a prescription on the NHS.

If the medication is specialist, not listed on the local formulary or not available for prescribing by a GP (e.g. blacklisted drugs), then the GP will not be able to prescribe this on the NHS. You will need to obtain private prescriptions from the specialist for the duration of the course of treatment. You retain the right to be referred within the NHS for any appropriate care that your GP recommends.

Your GP will continue to ensure that your care is not compromised.

Yours faithfully,

Dr G S Kalkat, Chair, BHR CCG Area Prescribing sub-Committee

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