Prescribing Recommendations May 2017

The purpose of these recommendations is to outline expectations for NHS prescribing, detailing standards that all prescribers are expected to adhere to.

It also seeks to provide clarification for prescribing situations where NHS responsibility for prescribing is not clear.

This document provides information across a number of areas and will be regularly updated. The current version is that held on the CCGs intranet, available by clicking here.

Document Control

Version No.	Date	Author	Status	Comments
2.00	September 2016	Sheila Brown	DRAFT	Multiple revisions from the original
2.1	October 2016	Sheila Brown	DRAFT	Revisions to following sections following EKPG • Section 8 Amounts for providers to supply -to align with commissioning intentions and cover telephone consultations • Section 12- ordering repeat items • Section 16 PRESCRIBING FOLLOWING TREATMENT ABROAD AND OUTSIDE NHS SERVICES • Section 21 off licensed use
2.2	January 2017	Sheila Brown	DRAFT	Further amended to cover telephone consultations and for circulation to other key providers in local health economy, KCHFT, KMPT, OOH, Hospice, Private providers
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Contents

1. INTRODUCTION

1.1 Aside from consultations, the most common intervention of the National Health Service is the issuing of a prescription.
The recommendations cover the following organisations in East Kent who will be referred to in the document as 'the CCGs'

- NHS Ashford CCG,
- NHS Canterbury and Coastal CCG
- NHS South Kent Coastal CCG
- NHS Thanet CCG

2. PURPOSE

2.1 The purpose of this recommendation is to outline expectations for NHS prescribing, detailing standards that all prescribers are expected to adhere to. It also seeks to provide clarification for prescribing situations where NHS responsibility for prescribing is not clear.

3. SCOPE OF THE GUIDANCE

3.1 This policy is appropriate for all prescribers; General Practitioners, Hospital consultants, Locum and Junior doctors, trainees and Community Practitioner, Supplementary and Independent non-medical prescribers within the CCGs and members of staff who request items to be prescribed by others on an NHS prescription.

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

4. DEFINITIONS

4.1 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. The East Kent formulary can be found on the CCG public website by clicking here.

4.2 Recommendation: A suggestion or proposal as to the best course of action, especially one put forward by an authoritative body

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

4.4 Policy: A policy is a plan of action which is then applied as a concrete program 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 RECOMMENDATIONS AND GUIDANCE

5.1 Expectation is that prescribing should be in line with the following and any departure from this requires sound clinical reasons:

- Recommendations issued by the East Kent Prescribing Group (EKPG) which reviews

submissions for use of prescribed items in primary care on behalf of the CCGs
- National guidelines and policies

5.2 Where there is a choice of approved drugs within a therapeutic class or appliances with similar characteristics, the one with the lowest NHS acquisition cost should be used first line. Any departure from this requires documented and endorsed clinical reasons.

5.3 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.

5.4 Clinicians from other providers such as acute or community trusts should not ask GPs to continue prescribing of medication that is not listed in their trust's formulary. Prescribing outside of local formulary, national or local guidance may be considered an example of inappropriate prescribing that would be challenged through Provider contracts. It is up to the prescribing clinician to make themselves aware of the availability of a drug before offering it as a treatment option

6. ADDITION TO APPROVED MEDICINES STATUS

6.1. Approval for all new prescribed items for use within the CCGs is required by the EKPG 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 on formulary

6.2. Approval routes currently are as follows, however please note that a joint primary care/secondary care formulary process is under development in East Kent. Details will be available on the intranet :

6.2.1 **For products initiated within an acute trust and intended to be continued in primary care.** An application should be made by the relevant clinicians to the acute trust's Drug and Therapeutic Committee (DTC) with a further application to the EKPG with estimate of anticipated costs in primary care and shared care/transfer of care arrangements where appropriate. Applications can be made to the EKPG using the relevant acute trust's standard form.

6.2.2 **For products used almost exclusively in primary care**. The CCGs commissioning team will discuss with the medicine management team and an application will be submitted directly to the EKPG. Input to this process from all prescribers within primary care is welcome and requests for application forms should be sent to the East Kent generic email address accg.eastkentprescribing@nhs.net.

6.2.3 **Individual funding requests (IFRs)** should be used where funding has not been agreed through the above routes. Contact details are available on each CCGs website. Click here for a link to the Canterbury & Coastal example.

7. PRESCRIBING UNDER SHARED CARE and TRANSFER OF CARE GUIDELINES

7.1 Treatments which are suitable for shared care between primary care physicians and specialists are designated shared care status. In addition some medication may be designated as suitable for 'Transfer of care' where close collaboration between primary and secondary care is required in the event of concerns about the patient but care can be delivered in primary care. Prescribers are advised to ensure there is a written agreement from the requesting consultant 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/transfer of care plans are approved through the EKPG and also include an assessment of the impact of workload moving between providers

7.3 Shared care/transfer of care plans are specific to a drug and an indication e.g. a guideline developed for azathioprine for suppression of transplant rejection is not suitable for where azathioprine is being used in autoimmune conditions. In some cases the

Shared care/transfer of care documents are also specific to the form of drug e.g. methotrexate tablets but not injections.

7.4 Shared care/transfer of 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/transfer of care. Shared care/transfer of care plans produced by the acute trust in East Kent also need to be approved through the EKPG and CCGs.

7.5 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 EKPG.

7.6 It is the responsibility of the specialist to initiate the production of Shared care/transfer of care guidelines where he/she feels they are appropriate or where the EKPG indicates they are necessary.

7.7 Shared care/transfer of care templates are available here. An assessment of the impact on the health economy must also be provided as part of the application.

7.8 A copy of the proposed Shared care/transfer of care plan completed with the relevant patient details must be included in any correspondence to the patients GP requesting shared care/transfer of care. It is not sufficient to provide a link to a website or send a generic copy.

7.9 GPs should not refuse to prescribe under Shared care/transfer of care for financial reasons alone.
GPs may refuse to prescribe where that feel they have insufficient expertise to manage the drug and/or condition or the patient is outside of agreed criteria. The GP should notify the consultant promptly with their decision and if the GP is unable to accept ongoing prescribing this should remain with the specialist.

8. PRESCRIBING FOLLOWING AN NHS APPOINTMENT OR EPISODE OF CARE AT A PROVIDER OUTSIDE GP SERVICES e.g ACUTE TRUST, PARTNERSHIP TRUST, COMMUNITY SERVICE, PRIVATE PROVIDERS, OUT OF HOURS , MINOR INJURIES, SPECIALIST SERVICES etc

8.1 Prescriptions or a supply of medication or prescribed items such as dressings and appliances which have been initiated or changed by a specialist service must be provided to the patient by the specialist service.

8.2 Patients must NOT be requested to obtain this initial supply of medication or prescribed item from their GP

8.3 If on-going prescribing is required a supply must be provided by the specialist to enable sufficient time for information to be sent to the GP to consider on-going prescribing (unless a shorter duration of treatment is clinically indicated)

8.4 Information on changes to prescribing must be communicated to primary care in a timely manner IN WRITING before on-going prescription can be considered

8.5 Information on expected duration of supply of medicines and prescribed items to be supplied in East Kent is details in Appendix 2

8.6 Any tests required due to initiation or change of medication must be ordered and arranged by the specialist

8.7 The specialist is responsible for reviewing results, taking required actions and notifying the patient and the GP.

8.8 If medication can only be collected from the hospital pharmacy the specialist must inform the patient to avoid any delay in supply

8.9 A patient information leaflet on prescribing following an NHS referral to an acute trust or specialist service is available in Appendix 3

9 PROMOTING SELF CARE

9.1 Prescribing items for self-limiting conditions which are available over the counter at relatively low cost is poor use of NHS resources both in terms of the cost of the prescribed items and the organisational cost. Healthcare professionals should promote self-care wherever possible. Patients should not be advised to obtain such items from their GP by other Healthcare Professionals.

9.2 However, please note, patients in care homes **will** usually require a supply as staff are unable to administer medication in most instances unless prescribed especially long term.

10 REQUESTS FOR BRANDED PREPERATIONS

10.1 If a prescription has been provide to a Community Pharmacy for a generic product but the pharmacy can only obtain the branded version, the pharmacy must supply the branded version against the prescription for the generic item. The terms of service

require pharmacies to dispense drugs with "reasonable promptness" (see Terms of Service paragraph 5), therefore supply cannot be withheld on cost grounds.

10.2 The pharmacy should not request the prescriber to supply a prescription for a branded product

10.3 The pharmacy should report the incident to the Pharmaceutical Services Negotiating Committee (PSNC) who liaise with the Department of Health regarding supply chain issues and can apply an adjustment to secure fair reimbursement. Click here for details.

11 PRESCRIBING INTERVALS

11.1 Medication **should be supplied for a maximum of 28 days** for :

- all acute prescriptions
- initial prescriptions for those items intended to be repeated

11.2 Repeat prescriptions should be for a maximum 28 days to avoid waste. A maximum supply of 56 days may be considered if clinically appropriate with the exception of oral contraceptives where a supply up to 6 months may be made . The only exception would be for patients requiring up to a three month supply for travel abroad and this should be an exceptional circumstance.

11.3 Items placed on repeat basis but only prescribed on a 'when required' basis may be ordered by patients inadvertently and so should only be placed on repeat status where there is an ongoing need. Items required only occasionally should not be placed on repeat status.

11.4 Prepayment certificates are the most economical way of paying for prescriptions where more than one regular prescription item is required each month. Information on prepayment certificates is available here. A 12 month prepayment certificate can be purchased by Direct Debit, which spreads the cost over 10 monthly instalments.

11.5 The Electronic Prescription Service (EPS) repeat dispensing process allows repeat prescriptions to be produced electronically for medication where patient's condition, medication and dosage are stable, for the convenience of patients and to enable workload to be managed for practices and pharmacies. Details for prescribers are available here.

11.6 When dispensing repeat prescriptions through the EPS process, there are national standards for the pharmacist to comply with to 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.

12 ORDERING REPEAT PRESCRIPTION ITEMS by Community Pharmacies (CP) and Dispensing Appliance Contractors (DAC)

12.1 Some Community Pharmacies (CP) and Dispensing Appliance Contractors (DAC) offer a service to submit a request for repeat items which the patient has pre-authorised. Patient's medication may change at short notice (i.e. due to an unplanned admission). To ensure requests are only made for current medication, the CCG's preferred process is that patients or their carers are contacted to confirm which repeat items are required no earlier than 5 working days prior to submitting the repeat request.

12.2 If a prescriber has concerns that repeat items are being requested inappropriately by a CP or DAC, the CCG may request NHS England to ask assurance on the providers process for this activity. The information should provide evidence of how the pharmacy or company's risk management program addresses the issue of ensuring items are still required when there is a gap of more than 5 working days between the request being made by the patient and submitted to the prescriber.

12.3 Care home providers should retain responsibility for ordering medicines from the GP practice and should not delegate this to the supplying pharmacy in Line with NICE Social care guideline (SC1)on Managing medicines in care homes.

13 RETROSPECTIVE PRESCRIPTIONS

13.1 Supply of medicines or appliances by pharmacies or companies in advance of a prescription is at the pharmacies or companies financial risk.

13.2 There is no obligation for prescribers to provide a retrospective prescription. Prescribers should therefore refuse requests for retrospective prescriptions issued without prior discussion and approval from the prescriber.

14 7 DAY PRESCRIPTIONS

14.1 Supplying 7 day prescriptions purely to finance the provision of a monitored dose system (MDS) for a patient is not correct and may be viewed as fraudulent use of NHS funds.

14.2 Under the terms of the Disability, Discrimination Acts (DDA) 2005, 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.

14.3 Provision of MDS under DDA falls within the Pharmacy contract and no further reimbursement is allowed under the essential dispensing contract although CCGs may have local contracts for a commissioned service . Prescriptions should be provided for 28 days.

15 PRESCRIBING FOLLOWING A PRIVATE CONSULTATION

15.1 Patient referred to a private consultation by the patient's GP

15.1.1 Any prescription provided as part of the initial consultation is part of the 'private' episode of care. Private care and NHS care must be kept separate and the cost of this prescription is the responsibility of the patient. Private health insurance rarely covers the cost of medication.

15.1.2 Following a private consultation, there is no obligation for the GP to continue to prescribe the recommended treatment if it is contrary to his/her normal clinical practice.

15.1.3 A consultant who, following a private consultation, has recommended on-going treatment for the patient's clinical circumstances should continue to prescribe until the GP has agreed to prescribe treatment.

15.1.4 The patient's GP may consider prescribing on-going treatment at the request of the consultant following a private consultation, as long as it is for a medication normally available on the NHS, the GP considers it to be medically appropriate, in line with local recommendations and the GP is willing to accept clinical responsibility for prescribing the item.

15.1.5 If the usual process for prescribing the medication is to 'share care' with a specialist, the GP needs to consider carefully how this will be provided following a private consultation, to ensure the expected level of specialist input remains available.

15.1.6 If the GP does not feel able to accept clinical responsibility for the medication, responsibility for prescribing remains with the private consultant. The GP may consider whether to refer to an NHS consultant who can consider whether to prescribe the treatment as part of NHS funded treatment but only if this is in line with normal referral protocols for the NHS

15.1.7 Medication recommended by private consultants may be more expensive than those prescribed for the same clinical situation as part of NHS treatment. In such circumstances, local prescribing recommendations should be followed by the NHS GP.

15.1.8 When a private referral is made, patients may be given the leaflet shown in Appendix 4, explaining the situation regarding NHS prescriptions following private consultations. Enclosing a copy with any referral letter may also be useful.

15.2 When self-referred

15.2.1 People who refer themselves independently of the GP (i.e. outside of the NHS) whether in the UK or abroad are expected to pay the full cost of any treatment they receive in relation to the care provided privately. The leaflet shown in Appendix 4 may be useful to explain this to patients.

16 PRESCRIBING FOLLOWING TREATMENT ABROAD AND OUTSIDE NHS SERVICES

16.1 People who arrange for treatment to be undertaken abroad outside the NHS are expected to pay the full cost of any treatment they receive in relation to the care provided privately. There is no obligation for the GP to continue to prescribe the recommended treatment if it is contrary to his/her normal clinical practice.

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

All clinical trials must go through the Provider's Research Governance process and be subject to Research Ethics Committee approval. This should address whether the trial is in line with the strategic objectives of the organisation (for research and clinical care) and how medicines will be supplied at the end of the trial if a continued supply is needed. In order to respond appropriately to any suspected adverse events that occur outside the Provider, the GP should be adequately informed if a patient is participating in a clinical trial.

Prescribing and supply of clinical trial medicine is the responsibility of the Provider. Standard out-patient or in-patient treatment costs will be met for patients on a trial as required by DH guidelines; this will not include the cost of the trial medicines either during or after the trial, except where explicit agreement for re-charging has been agreed by the CCG.

Patients participating in a clinical trial must be made aware that there is no guarantee that the medicine will be continued at the end of the trial, irrespective of the results. Where trial results indicate that treatment should continue, post-trial costs will only be considered for funding by CCGs if agreed before the trial commences.

18 PRIVATE PRESCRIPTIONS

18.1 Under a GPs Terms of service a GP is not allowed to issue a private prescription for a patient on their NHS list except in the for the issue of the following prescriptions:

- malaria prophylaxis
- travel related prescriptions not provided under the NHS. See section 19 for details of vaccines available under the NHS.

18.2 Other than the situations listed above, GPs may only provide private prescriptions as part of private care provided to patients not on the practice list for NHS care e.g. private GP appointments or an occupational health service; issuing an NHS prescription in these cases would constitute a breach of the GMS contractual regulations.

18.3 Note re: Occupational Health vaccinations - The 'Immunisation against infectious disease' (2006) gives clinical recommendations for the use of vaccines, however it does not identify those which are recommended to be NHS funded. Where no remuneration is available from the CCGs for individual vaccines, NHS prescribing is strongly discouraged. A patient sent by an employer to request occupational health immunisations should be advised that this is not the responsibility of the practice. The

employer (not the patient) will have to make private arrangements with a practice, or occupational health provider to administer the vaccine(s). Hepatitis B vaccinations for occupations as listed in the BNF should normally be provided by the employer via their own occupational health provider or private agreement with a local practice. This includes healthcare students where Hepatitis B vaccination should be provided by the educational establishment. Further information on supply of Hepatitis B vaccine is provided on the CCGs intranet, available here.

19 PATIENTS TRAVELLING ABROAD

19.1 Travel vaccinations

19.1.1 Travel vaccines available through the NHS, for which practices receive reimbursement where the vaccine is indicated for travel include the following (but only where there is a need for supply - click here to see Green Book for further information).

- Tetanus
- Polio
- Hepatitis A
- Typhoid

19.1.2 Travel vaccinations available under the NHS should be obtained via an account with the manufacturers/suppliers directly and bought in by practices.

19.1.3 Note: different batch numbers are used to identify use those vaccines for use in the childhood program and those used for travel purposes - ImmForm/Movianto stock should not be used for travel vaccinations

19.1.4 Newer (and more expensive) vaccines should normally only be provided at NHS expense if they are demonstrated to be of improved efficacy or when there are other compelling clinical advantages

19.1.5 Combined hepatitis A and B vaccination. This should not be prescribed on the NHS for travel purposes (NB hepatitis A on its own and in combination with typhoid may be supplied under the NHS if the vaccination schedules align). Further information on travel vaccines is provided on the CCG's intranet here.

19.1.6 The following are not available on the NHS for travel purposes and must therefore be offered to patients as a private service:

- Meningitis ACWY
- Tick Borne Encephalitis
- Hepatitis B
- Japanese Encephalitis
- Rabies*
- Yellow Fever Vaccine

19.1.7 * If rabies vaccine is required for occupational purposes (bat handlers) or post exposure contact, Public Health provides vaccines at no cost to primary

care. Contact details are available on the following link. This vaccine should NOT be provided on FP10. However please note information about Occupational Health services in section 18 of this document. Rabies vaccination guidance is available here.

19.1.8 General practices are entitled to charge NHS registered patients a fee privately for vaccinations supplied as noted in section 18. Private prescriptions and reimbursement cannot be claimed on the FP34PD form.

19.2 Travel medication

19.2.1 Malarial prophylaxis: Patients should be advised to purchase where possible over the counter.

19.2.2 For prescription only medicines: GPs may charge for and issue a private prescription.

19.2.3 Drugs prescribed in anticipation of illness whilst abroad: For Prescription Only Medicines (POM), patients may be offered and charged for a private prescription e.g. Ciprofloxacin for traveller's diarrhoea.

19.2.4 Drugs prescribed to alter menstrual cycle whilst abroad: patients may be offered and charged for a private prescription e.g. norethisterone.

19.2.5 Low molecular weight heparin (LMWH) For people assessed as having a relatively high risk of developing travel-related deep vein thrombosis (DVT), Clinical Knowledge Summaries (CKS) advises as follows, if traveling is unavoidable seek specialist advice from a haematologist regarding whether the use of LMWH is required http://cks.nice.org.uk/dvt-prevention-for-travellers#!scenario If required, LMWH can be provided on the NHS.

19.3 Supply of regular medication

19.3.1 The NHS ceases to have responsibility for medical care of patients when they leave the UK. People travelling within Europe are advised to carry a European Health Insurance Card (EHIC) at all times, this gives entitlement to local health care arrangements. Patients should be advised to check specific entitlements prior to travel. 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. For patients leaving the UK for more than 3 months, they should be advised to register with a local doctor for their continuing medical needs. It is reasonable for GP's to provide sufficient medication to give patients time to do this. It may be worth mentioning to patients that medicines can be purchased without a prescription from pharmacies in some countries. NB: It is wise to check with the manufacturer that the medicines required are available in the country being visited. 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]. General practitioners are not responsible for prescription of 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. Further information can be obtained from

the following link.

20 VISITORS FROM OVERSEAS

Information is provided on the NHS Choices website for:

- Visitors from the European Economic Area EEA or Switzerland
- Visitors from outside the EEA
- Categories of exemption
- Visitors' FAQ
- Moving to England from the EEA or Switzerland
- Moving to England from outside the EEA

21 PRESCRIBING OF LICENSED MEDICINES FOR OFF LICENSED USE (OFF LABEL)

21.1 Prescribing of medicines that are licensed, but are being used outside of their product license is not generally recommended. However, it is recognised that it is acceptable in some circumstances.

21.2 Points for consideration:

21.2.1 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.

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

21.2.1 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. A suggested proforma is provided in Appendix 5.

Where there is a substantial body of evidence to support the use of a licensed medicine outside of its license (e.g. in paediatrics), a consultant may ask the GP to consider to prescribe if on-going prescriptions are required. However the GP must be fully informed and made aware of the licensing status. The full agreement of the GP concerned must be obtained before prescribing is transferred along with the source of evidence.

22 PRESCRIBING UNLICENSED MEDICINES

22.1 The CCGs advises against the prescribing, at National Health Service expense, all products that do not have a UK Product License.

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).

Prescribing of unlicensed medicines should usually remain the responsibility of the clinician initiating treatment. The Provider will accept full responsibility for the continued sourcing, quality and supply, which should be under the control of the Provider Pharmacy Department.

22.2 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.

23 PRESCRIBING 'SPECIALS'

23.1 Specials-Commercial companies may manufacture products known as 'Specials' where there is no commercially available, licensed, preparation. However there may be alternative licensed preparations available.

23.2 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.

23.3 List prices of 'Specials should be viewed with caution as substantial administration and wholesaler charges can be applied.

23.4 Thousands of pounds are spent each month across the CCG on the most commonly prescribed Specials. Much of this expense can be avoided although it is acknowledged that these products may be unavoidable for a small number of patients.

23.5 Prior to considering prescribing an unlicensed Special the treatment should be reviewed and if still necessary, alternatives should be considered. The CCG subscribes to specialist information source known as NEWT to evaluate options - please contact your Medicine Management team for further details.

23.6 There are no controls to the costs of Special formulations ('Specials') and given the above it is always advisable to prescribe a licensed product wherever possible

24 PRESCRIBING Appliances and Dressings

24.1 Only products listed in the Drug tariff can be supplied on FP10.

24.2 The same principles of safe and cost effective prescribing used to evaluate formulary status for medicines, also apply to Appliances and dressings. They are only seen suitable for prescribing in the local health economy once they have been through the formulary approval process as described in section 6 and information will be provided on the CCGs intranet and/or ScriptSwitch.

25 THE ADVISORY COMMITTEE ON BORDERLINE SUBSTANCES (ACBS) LIST

The Advisory Committee on Borderline Substances (ACBS) is responsible for advising on the prescribing of foodstuffs and toiletries. The preparations reviewed are mainly

foodstuffs, such as enteral feeds and foods that are specially formulated for people with medical conditions, but also include some toiletries, such as sun blocks for use by people with conditions such as photodermatosis. They are listed in the Drug tariff and the British National Formulary.

The same principles of safe and cost effective prescribing used to evaluate formulary status for medicines, also apply to ACBS preparations. They are only seen suitable for prescribing in the local health economy once they have been through the formulary approval process as described in section 6 and information will be provided on the CCGs intranet and/or ScriptSwitch.

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

26.1 Prescribing of products considered to be of limited therapeutic value and/or where there is no recognised evidence base is not supported. Products are annotated in the British National Formulary by the symbol - , and noted on ScriptSwitch.

26.2 An information leaflet is available in Appendix 6.

27 DISSEMINATION

27.1 The dissemination of this policy will be via the internet on the following site.

http://www.canterburycoastalccg.nhs.uk/about-us/prescribing-advice/?categoryesctl9740418=9846&categoryesctl10344807=13849

Important Note: When printed this version may not be the latest. **Always** refer to the document on the CCG website.

27.2 The internet version of the document is the definitive version.

28 LINKS TO STANDARDS/PERFORMANCE INDICATORS

28.1 This policy document links to the regulatory and statutory requirements for medicines, for example medicines licensing laws and documents issued by the National Institute for Health and Clinical Excellence (NICE).

28.2 The requirements of the NHS Commissioning Board Special Health Authority on Patient Safety will be reflected in the decisions taken by the health economy decision making groups.

28.3 National Performance indicators, including Better Care, Better Value, will be reflected in the local measures.

29 MONITORING

29.1 Performance measures will be introduced to monitor prescribing across all sectors within the Health Economy.

29.2 Medicines Management Teams will use data to monitor FP10 supply from the NHS Prescription Services (previously known as the Prescription Pricing Division (PPD) of

the NHS Business Services Authority).

29.3 All practitioners will be asked to identify any activity that fails to comply with this policy and bring it to the attention of the Head of Medicines Management for the CCG for investigation.

29.4 Any prescribing which is not in line with this policy will be investigated and where appropriate challenged through Provider contracts.

30 REFERENCES

30.1 Dept. Health Terms of service of Pharmacists Schedule 1 http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf

30.2 Good practice in prescribing and managing medicines and devices (2013)http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

30.2 NICE-Managing medicines in care homes Social care guideline [SC1] Published date: March 2014

GLOSSARY OF TERMS

Item	Glossary Definition
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.
BNF	British National Formulary
CCG	Clinical Commissioning Group There are 4 in East Kent: Ashford, Canterbury, South Kent Coast & Thanet.
CKS	Clinical Knowledge Summaries
DDA	Disability, Discrimination Acts (2005)
DTC	Drug and Therapeutic Committee
DVT	Deep Vein Thrombosis
EEA	European Economic Area
EHIC	European Health Insurance Card
EPS	Electronic Prescription Service
EKPG	East Kent Prescribing Group
FAQ	Frequently Asked Questions
FP10	The term FP10 is used to cover all types of prescriptions written by prescribers in the NHS and given to patients, which can be dispensed as part of NHS care
IFR	Individual Funding Request
LMWH	Low Molecular Weight Heparin
NEWT	The NEWT Guidelines aims to provide prescribers and other healthcare professionals with a single point of reference which draws together the available information relating to medicines management in patients with enteral feeding tubes or swallowing difficulties.
MDS	Monitored Dose System
NICE	National Institute for Clinical Excellence
POM	Prescription Only Medicine

PSNC	Pharmaceutical Services negotiating Committee
SPC	Summary of Product Characteristics

APPENDIX 1 - GENERIC MEDICINES

Generic medicines are the same 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 saves 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.

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 – EXPECTED DURATION OF SUPPLY

Quality of medication and prescribed items to be supplied in East Kent following an NHS appointment

If quantity supplied is less than noted below AND there is no clinical reason to justify this providers should notify their CCG as below

CCG	Reporting by GP	Reporting by other providers
Ashford	The Service Provider Contract Queries & Issues section in the ' Referral support tool	accg.eastkentprescribing@nhs.net
Canterbury and Coastal		
South Kent Coast	heatherlucas@nhs.net	
Thanet	tccg.mmt@nhs.net	

Please note – quantity may be varied in some circumstances e.g. supply of antibiotic in liquid form only has limited stability so less than full course may be supplied from OOH and patient directed to GP. Wherever possible providers are asked to supply full course or 28 days but this is not possible in all cases. Discussion is in hand with Kent and Medway Partnership Trust (KMPT) on quantity and this document will be updated in the event of change.

Methods of supply are under review and the on-line version of this document is the current version, which is available by clicking here.

National standards do differ (quantities are lower) from those in Kent , for further information please see notes at the end of this appendix.

Antibiotics- Full courses of antibiotics should be provided in all scenarios unless treatment is in excess of 28 day period. This may be shorter or longer than the agreed duration stated in the sections above

A shorter duration of supply may be provided where clinically indicated e.g. analgesic for an acute indication or to reduce risk of self-harm or abuse

Scenario	Quality to be supplied	Comment
Admission arrangements- Planned care Prescribing and request for teats such as MRSA which is related to a procedure/planned admission should rest with the individual/team planning the procedure/admission	Any medicines required prior to the procedure e.g. MRSA decolonisation therapy, bowel cleansing, Low molecular weight heparin (LMWH) where bridging from warfarin is required	The only exception is for Highly specialised products such as specialised feeds and appliances which may require a 2-5 day lead time to order and patients may be asked to bring supplies to ensure continuity of supply Warfarin- written communication on any changes in anticoag treatment should be sent both to (1) patients GP AND (2) patients anticoag provider to ensure continuity
In patient discharge-[Acute trusts within Kent- see below for KMPT]	14 days	
In patient discharge-[Kent and Medway Partnership Trust (KMPT)]	7 days	Under discussion to increase to 14 days. This document will be re-issued in the event of change
In patient discharge [for organisations other than above]	7 days	
Day case supply to take away (TTA)	7 day*	
Day case supply to take away (TTA) **Eye drops for management of post op symptoms e.g. post cataract**		The Provider must ensure sufficient drops are provided for the treatment period, the patient is aware of how to correctly administer eye drops and that the patient should contact the clinic if a further supply is required
Out-patient discharge [Providers within Kent although	28 Days	Provision of prescribed items required due to receipt of test results following the appointment is within the episode of care

Scenario	Quality to be supplied	Comment
see below for KMPT] Medicines either newly initiated or a change in dose		are the responsibility of clinician requesting the test.
Out-patient discharge [Kent and Medway Partnership Trust (KMPT)] Medicines either newly initiated or a change in dose	14 Days	Under discussion to increase to 28 days. This document will be re-issued inj the event of change
Out-patient discharge [for organisations other than above] Medicines either newly initiated or a change in dose)	14 days	
Attendance at Accident and Emergency	7 days	
Walk in Centres, Urgent Care Centres,	As required by service provision	Supply is usually a one- off supply
Contraceptive and Sexual Health clinics (CASH)	As required by service provision	
Items seen as self-care items	Nil- apart from patients in care homes	Patients should be directed to purchase items which are available as over the counter items. Patient should **not** be directed to obtain from their GP. However, please note, patients in care homes **will** require a supply as staff are unable to administer medication in most instances unless prescribed.

Scenario	Quality to be supplied	Comment
Dressings	Minimum of 5 working days. A smaller quantity can be provided if sufficient until next clinic appointment	The Provider should only request GPs to continue prescribe dressings or appliances included on the CCG's formulary or through the 'First Choice' process. These are not normal stock items and may not be immediately available in primary care.
Topical negative pressure therapy (TNPT)	Sufficient dressings to provide cover until review at 2 weeks	Budget for TNPT in East Kent is held by KCHFT
Continence appliances- Intermittent Self Catheterisation-	7 days	DN teams t be mu notified of all new catheterisations pre discharge
Continence appliances- leg bags	Home-pack containing sufficient for one week	If '*Trial without Catheter*' (TWOC) or clinic appointment is planned , sufficient stock is supplied until next appointment (max 4 weeks)
Stoma appliances- new stoma	One month's supply of products at the point of discharge	There can be a number of changes in the first few weeks of a stoma and the stoma team will use in-house stock to help find the best and most appropriate appliances *before* requesting supplies and prescriptions from each practice. The stoma pathway must be followed
Stoma appliances- existing	No supply	Patients will have a supply at home and a further supply is not usually made.
Home Enteral Nutrition- post in-patient for patients newly initiated on HEN	7 days' supply of feed and associated plastics	Patients already on HEN will have a supply at home and a further supply is not usually made. Acute dietitians will be aware of delivery date and supply as required to

Scenario	Quality to be supplied	Comment
		ensure continuation of supply
Oral Nutritional supplements post in-patient stay	7 days' supply	Post discharge- supply in primary care should **only** be continued on a specific recommendation from a dietitian
Oral Nutritional supplements for Head and neck oncology (outpatients)	24x200ml to identify acceptable products if not already prescribed in primary carte	Patients are usually already being prescribed ONS in primary care. Oncology dietitians use a flexible approach to ensure sufficient supply is provided to cover holiday periods balanced with avoiding waste.
Specialised formula	7 days' supply	
Appliances (other than listed above		The Provider should only request GPs to continue to prescribe dressings or appliances included on the CCG's formulary or through the 'First Choice' process. Only items listed in the Drug Tariff are available through the FP10 route. On-going supply of items which are not on the Drug Tariff will remain the responsibility of the Provider unless specifically agreed with commissioners

APPENDIX 2 – Notes: National standards

Medication on discharge and following clinic attendance
39.27 We included new provisions relating to provision of medication on discharge from inpatient or daycase care in the 2016/17 Contract, and we have expanded these for 2017-19 to cover prescribing by hospitals following outpatient clinic attendances.

39.28 We are aware that there is different practice around the country in respect of both issues. To be clear, the purpose of the measures in the Contract is, in summary, to set minimum requirements which all providers must meet. These are

 for discharge from inpatient or daycase care, a minimum of 7 days' supply; and

 following clinic attendance, sufficient supply for a patient's immediate needs, at least up to the point where the clinic letter has reached the GP and the GP can then prescribe on an ongoing basis.

In each case, the Contract wording deliberately sets these as minimum requirements; if local practice and protocols require supply for a longer period, this must be honoured unless alternative local arrangements are agreed.
39.29 These national-mandated requirements only cover medication. Clearly, hospitals may also supply dressings or appliances, and requirements in relation to these may be specified locally within Schedule 2J (Transfer of and Discharge from Care Protocols).

NHS Standard Contracts 2017/18-2018/19: https://www.england.nhs.uk/nhs-standard-contract/17-18/

APPENDIX 3 - INFORMATION ABOUT YOUR MEDICINES FOR PATIENTS GOING TO A HOSPITAL OR SPECIALIST APPOINTMENT 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 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.

Obtaining your first supply
Please check carefully before you leave the hospital in case you can only collect your medicines from the hospital pharmacy.

Your local pharmacy will NOT be able to supply some types of hospital forms as an NHS prescription And you will need to contact the original hospital to see how you can obtain your medicine. You may need to return to the hospital to collect or it may be possible to post it to you. Please **do not** ask your GP for a prescription.

It can take some time for the information about your appointment to be sent to your GP. Your GP will be unable to provide a prescription until they have this information
To avoid delay check before you leave the hospital

This applies to all hospital appointments under the NHS. It is particularly important if your appointment is an NHS appointment held at a private hospital as they often use prescription forms which can only be supplied at their hospital pharmacy

Test and appointment required
Your specialist is responsible for organising any tests or appointments required due to the initial supply.

Further prescriptions
If your 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.

You may not need to make an appointment with your GP to obtain a further supply. Your specialist should send all the required information and this will be added to your record. If you want to check to see if a supply has been added to your record **please contact your practice first to avoid you making an unnecessary appointment**

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

In summary your specialist is responsible for

- Providing prescriptions when a new medicine has been started or changed

- Looking after all your tests relating to any new or changed medication
- Providing you with a follow up appointment if necessary.

Information produced with thanks to the Local Medical Committee.

APPENDIX 4 - INFORMATION FOR PATIENTS CONSIDERING PRIVATE MEDICAL CONSULTATIONS

When you are see a private specialist you should be aware what may happen about medication you may need after the consultation.

NOTE: Private health insurance rarely covers the cost of medication

1 Independent Private referral

People who refer themselves to a consultant independently of the GP (i.e. outside the NHS), whether in the UK or abroad, are expected to pay the full cost of any treatment they receive in relation to the care provided privately.

2 Private referral through your GP

After a private referral made by your GP, your private specialist may give you a prescription.

Any prescription provided as part of a private consultation is part of the 'private' episode of care.

Private care and NHS care must be kept separate and the cost of this prescription is the responsibility of the patient.

Private health insurance rarely covers the cost of medication

Sometimes you may only need one prescription.

If you need continued treatment you may be given one private prescription (which you will need to pay for) and advised to return to your GP to see if further NHS prescriptions can be provided.

A NHS prescription to continue your treatment will only be provided if your GP considers there is a clinical need and that an NHS patient would be treated in the same way; there is no obligation for the GP to prescribe the treatment recommended by a private specialist**.** In order to judge your clinical need your GP must have received a full clinical report from the private specialist and therefore you may not be able to have a prescription immediately.

GPs have agreed to prescribe in line with local recommendations. If the request from your private specialist is for treatment that is not in line with local policies, then your GP may change the medication in line with the drugs used for NHS patients.

If the GP feels the treatment is for a specialist area the GP can ask the specialist to remain responsible for the treatment and to provide further prescriptions which the patient will need to pay for.

APPENDIX 5 - SUGGESTED PROFORMA FOR CONSENT FOR Off-LICENSED TREATMENT

Practice Logo

Off LICENSED PRODUCT PATIENT CONSENT FORM

Patient Name: ……..

Patient DOB: ……..

Patient Identifier ……..

I understand that the medication …….

Prescribed by ……

Is an licensed product being used for an unlicensed indication and the implications of this have been explained to me.

Signed: ……..

Name (please print) …….

Date: ……..

APPENDIX 6 - REQUESTS FOR UNLICESNED PREPARATIONS – INFORMATION FOR HEALTHCARE PROFESSIONALS

Patients often present at their GP practice requesting unlicensed products such as fish oils, glucosamine and other vitamins and health supplements on prescription. On some occasions this can be following the advice of other healthcare professionals.

Medicines which are provided on prescription by the NHS are expected to have gone through a number of steps to provide assurance on safety and cost effectiveness, be included within GP clinical systems (so interactions can be identified) and be available through a recognised supply chain. Further information on this process is provided below:

The CCGs would therefore request that patients are not directed to GP practices to ask for unlicensed preparations on an FP10 to ensure patients are provided with consistent advice from all Healthcare Professionals.

The following are specifically not recommended as they have not been through any of the steps above (but this list is not exhaustive)

- Glucosamine
- Chondroitin
- Fish Oil
- iCAPs and similar products
- Over the Counter (OTC) multivitamins and mineral preparations
- Green lipped mussel extracts

Self-care is promoted by the NHS as it is often quicker to obtain supplies and these items are usually available at relatively low cost.
Please note, costs for medicines which are unlicensed or not approved by the Advisory Council on Borderline Substances (ACBS) process may be uncontrolled. Prescriptions in excess of £1000 for a month's supply of an unlicensed preparation are seen at regular intervals. All NHS staff have a duty to ensure best use of NHS resources.

Steps required to provide assurance on safety and cost effectiveness

1. Medicines are licensed through the MHRA process and their details are available on the Medcines.org web site http://www.medicines.org.uk/emc/glossary?view=130

2. A number of alternative products are reviewed though the Advisory Council on Borderline Substances (ACBS) process and listed in the BNF https://www.medicinescomplete.com/mc/bnf/current/

3. Costs for the majority of the above products are set out in the NHS Drug tariff http://www.ppa.org.uk/ppa/edt_intro.htm

4. Once items have been through this route, they are considered by the local prescribing groups and committees and a decision made whether these should be recommended for use locally with or without any restriction. Information on prescribing in East Kent is available on the following web site http://www.canterburycoastalccg.nhs.uk/about-us/prescribing-advice/