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North of England Commissioning Support

Medicines Optimisation

Useful Prescribing Information
A Guide for Prescribers

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1. Introduction

1.1. Background

This purpose of this document is to provide guidance on a range of dilemmas prescribers may come across in practice and answers to frequently asked questions surrounding prescribing and medicines management for health professionals.

The information included in this document includes links to other guidance documents and information sources which should be read in conjunction with this document.

2. Clinical Responsibility

Legal responsibility for prescribing lies with the practitioner who signs the prescription[1]. It is important that, as the prescriber, you understand the patient's condition as well as the treatment prescribed and can recognise any adverse effects of the medicine should they occur[2].

Independent prescribers may prescribe any licensed or unlicensed medicine ("licensed" meaning any product with UK marketing authorisation) for any medical condition within their therapeutic area of competence.

Prescribing responsibility will be based on clinical responsibility, where it is good medical practice and in the best interests of the patient[3]. Systems should be in place to ensure such responsibility can be accepted.

3. Private Referral

A large number of patients opt to have some or all of their investigations and 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

[1] NHS Management Executive Letter EL (91) 127. Responsibility for prescribing between hospitals and GPs. Nov 1991.
[2] General Medical Council. Good practice in prescribing medicines, 2013: http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp
[3] A report for the Secretary of State for health by Prof. Mike Richards. Improving access to medicines for NHS patients. Nov 2008. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_089927

the NHS or privately. There has been a blurring of the boundaries between NHS and private treatment, with patients switching freely between the two sectors.

Whilst administratively convenient, but not always practical, treatment is defined by '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

Such patients are expected to pay the full cost of any treatment they receive in relation to the care provided privately: consultation fees, drugs prescribed or treatment provided by a clinician in the course of a private consultation should be at the patient's expense[4]. Patients should be informed of this expectation prior to referral.

3.2. Top-up payments

There is no legal barrier to top-up payments for medicines prescribed outside general practice and not routinely funded for use in England. These measures were set out by the health secretary in November 2008 following a report produced by Prof. Mike Richards[5]. The principles of the report recommend that patients opting for top-up treatment should not lose their entitlement to NHS treatment. This means that NHS patients who choose to pay for private treatment alongside their NHS treatment can do so, provided the extra treatment is carried out in a private facility and is not subsidised by the NHS. Any extra costs associated with the private treatment, such as tests and time spent by NHS staff, will also need to be paid for by the patient.

4. Private prescriptions

4.1. Following a private consultation

A consultant may see a patient privately in order to give an opinion to an NHS practitioner 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, and a practitioner may refuse to prescribe on the NHS in such a situation as they do not have the clinical responsibility for managing that particular condition. The practitioner must, however, continue to provide

[4] NHS electronic drug tariff. Part XVIIIA: drugs, medicines and other substances not to be ordered under a GMS contract. http://www.nhsbsa.nhs.uk/PrescriptionServices/4940.aspx

[5] A report for the Secretary of State for Health by Prof. Mike Richards. Improving access to medicines for NHS patients. Nov 2008. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_089927

NHS treatment and prescriptions for other conditions for which they retain clinical responsibility[6].

Exceptions to this would be where the medication is specialised in nature and is not something the practitioner would generally prescribe (for example anti-TNF, interferon or fertility treatment), where the medication recommended is not clinically necessary, or where the medication is generally not provided within the NHS (e.g. a drug listed under part XVIIIA of the NHS drug tariff[7]).

For a specific condition, where a private consultant recommends medication that is more expensive, without good evidence that they are more effective than that recommended by the NHS, then locally approved prescribing advice should be considered by the NHS practitioner. This advice should be explained to the patient, who will retain the option of purchasing the more expensive drug via the private consultant.

4.2. For NHS patients

A practitioner may issue a private prescription for any item that is not available on the NHS and for drugs to treat indications not covered by the 'SLS' conditions[8]. Examples of such circumstances are:

1. The product is blacklisted and not available for prescribing on an FP10, or it is outside of specific listed conditions. Such products may be found in the most recent Drug Tariff
2. some vaccines required for travel e.g. Tuberculosis, Rabies, Yellow fever, Japanese encephalitis and Tick-borne encephalitis (see also section 6 and Appendix 1)
3. a drug which is prescribed solely in anticipation of the onset of an ailment whilst outside the UK and for which, the patient does not require treatment when the medicine is prescribed (see also section 6 and Appendix 2)
4. drugs for malaria prophylaxis

4.3. Mixing NHS and private care

Even though an individual opts for private treatment or assessment they are still entitled to NHS services.

If the patient's GP considers the medication to be clinically necessary, the terms of service would require the GP to prescribe that medication on the NHS, even if the assessment from which that need was identified was undertaken in the private sector[9].

[6] General Medical Council. Good practice in prescribing medicines, 2013. http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

[7] NHS electronic drug tariff. Part XVIIIA: drugs, medicines and other substances not to be ordered under a GMS contract: http://www.nhsbsa.nhs.uk/PrescriptionServices/4940.aspx

[8] NHS electronic drug tariff. Part XVIIIB: drugs, medicines and other substances that may be ordered only in certain circumstances. http://www.nhsbsa.nhs.uk/PrescriptionServices/4940.aspx

4.4. For a branded product

GPs cannot issue private prescriptions alongside NHS prescription forms (FP10s), including in the context of locally commissioned services outside the core GMS/PMS contract, as this would be a breach of the GMS Contract Regulations. This is in line with current advice from the British Medical Association (BMA).

Whilst issuing an NHS prescription for patients who request a branded equivalent is not prohibited, practitioners should be aware that this could be considered an example of inappropriate or excessive prescribing as stated in the GMS contract[10] in cases where no clinical justification exists.

5. Controlled Stationery and Prescriber Codes

NHS England Contractor Services should be contacted for the following situations:

- Ordering FP10 prescription pads
- Ordering controlled drug requisition forms
- Obtaining controlled drug prescriber codes
- Amendments to practice based non-medical prescribers
- When a prescriber leaves a practice – for further information please see Prescriber Leaving Practice (http://medicines.necsu.nhs.uk/download/what-to-do-when-prescribers-join-or-leave-a-gp-practice-briefing-document/) .

Forms are available on the NHS Business Services Agency (NHSBA) website:
http://www.nhsbsa.nhs.uk/PrescriptionServices/3972.aspx

Please refer to appendix 2 for a list of contractor services contacts.

6. Prescribing of Medicines for an Unlicensed Use

Prescribing of medicines that are licensed but are being used outside of their licensed indication is generally not recommended. However, it is recognised that some circumstances may necessitate a prescription.

Points for consideration:

- prescribers should be satisfied that an alternative, licensed medicine would not meet the patient's needs

[9] BMA. The interface between NHS and private treatment: a practical guide for doctors in England, Wales and Northern Ireland, 2009.
http://bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Ethics/interfaceguidanceethicsmay2009.pdf
[10] BMA. Focus on excessive prescribing. March 2013 http://www.bma.org.uk/support-at-work/gp-practices/service-provision/prescribing/focus-on-excessive-prescribing

- 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
- The responsibility for prescribing falls to the practitioner who signs the prescription. It is therefore important that the prescriber understands the patient's condition as well as the treatment prescribed, can recognise adverse effects and is able to monitor the prescribed drug completely (or can be satisfied that adequate monitoring is taking place)[11]
- in situations following a recommendation by a consultant, the prescriber is unlikely to be found negligent if they can convincingly demonstrate that they acted in accordance with a responsible body of relevant professional opinion
- when unlicensed use of a medicine is prescribed, the prescriber is professionally accountable for their judgment in doing so and may be called upon to justify their actions
- prescribers must give patients (or their carers) sufficient information about the proposed course of treatment, any common side effects, and the reasons for prescribing an unlicensed medicine (or the off-label use of a medicine) to enable the patient (or carer) to make an informed decision

An example of where an unlicensed or off-label medicine is prescribed may be a medicine that is licensed for use in adults, but there is a clinical need for prescribing for children.

6.1. Use of licensed medicines in an unlicensed manner

In some cases it may be deemed preferable to give a licensed product via an unlicensed route (e.g. an injection given orally, crushing/dispersing tablets in water or opening capsules), rather than to use an unlicensed product.

Where the use of a licensed product in an unlicensed manner is necessary, further information can be obtained from the following sources:

- NEWT Guidelines for the administration of medication to patients with enteral feeding tubes or swallowing difficulties[12]
- Handbook of Drug Administration via Enteral Feeding Tubes[13]
- British National Formulary (BNF) for Children
  Individual manufacturer's medicines information departments may be able to provide advice on their products

[11] General Medical Council. Good practice in prescribing medicines, 2013 http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

[12] The NEWT Guidelines for the administration of medication to patients with enteral feeding tubes or swallowing difficulties. Smyth J; Betsi Cadwaladr University Health Board, Second Edition May 2010.

[13] White R and Bradman V. The Handbook of Drug Administration via Enteral Feeding Tubes; Pharmaceutical Press, September 2010.

6.2. Special order products

Medicines not commercially available in liquid formulations may be obtained as special order products or extemporaneous preparations. Special order products ('specials') and extemporaneous preparations are unlicensed and should only be considered for prescribing when a patient's needs cannot be met by licensed medicines.

Special order products may have a short shelf-life compared with licensed preparations and may require fridge storage.

Special order products are expensive, sometimes many times the cost of equivalent licensed medicines. A number of specials have been included in Part VIIIB of the Drug Tariff from November 2011 however these remain significantly more expensive than licensed formulations.

7. Prescribing Outside Guidance

National and local guidance will often clarify what practitioners should do for identified individuals. Prescribers may make a decision, on a case-by-case basis, to prescribe outside of guidance provided there is a compelling clinical reason to do so. It would be good practice to make a record of such clinical justification as part of the consultation notes.

8. Travel Abroad

8.1. NHS patients traveling for 3 months or less

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 the European Union (EU) should be advised to carry the European Health Insurance Card (EHIC) at all times; this gives entitlement to local health care arrangements. Patients are advised to check specific entitlements and appropriate health advice prior to travel and obtain adequate holiday insurance cover. If a person is travelling outside the EU, they should check whether they can get their medication in the countries they plan to travel to. They can contact each country's embassy or high commission for advice.

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) then this should be issued, providing it is clinically appropriate. A Home Office License to travel into or out of the UK with less than 3 months prescription is not required (laws in country of entry will vary), but it is advised a letter is obtained from the prescribing practitioner confirming the carrier's name, travel itinerary, names of prescribed controlled drugs, dosages and total amounts of each to be carried.

GPs are not required to provide prescriptions for medication which 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). Such items may be issued via a private prescription or the patient can be advised to purchase these items locally prior to travel. Such advice is available from community pharmacists if required. For conditions unresponsive to self-medication, the patient should normally seek medical attention abroad.

8.2. NHS patients living or travelling abroad for more than 3 months of the year

For longer visits abroad, the patient should be advised to register with a local practitioner 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. It is also worth advising that medicines can be purchased without a prescription from pharmacies in some countries.

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[14].

8.3. Immunisation for travel abroad

Some vaccinations are available free of charge on the NHS for overseas travel (see also Appendix 2).

This depends of the risk of developing the medical condition e.g. due to where the individual is travelling to and what they are planning to do on their trip. The following vaccines may be free of charge:

- Cholera
- Meningitis C
- Diphtheria
- Tetanus booster.
- Hepatitis A
- Typhoid
- Poliomyelitis

The following are not usually available free of charge on the NHS for overseas travel:

- Hepatitis B
- Tuberculosis
- Rabies
- Yellow fever
- Japanese encephalitis
- Tick-borne encephalitis

[14] NHS Choices. Healthcare abroad.
http://www.nhs.uk/NHSEngland/Healthcareabroad/Pages/Healthcareabroad.aspx

- Other Meningococcal vaccines.

Vaccines prescribable under the NHS:	Vaccines requiring a private prescription:
• Hepatitis A • Typhoid • Combined hepatitis A/ typhoid • Combined hepatitis A/ hepatitis B* • Cholera (but only for those at absolute risk as described on TRAVAX) • Diphtheria/ tetanus/ polio *if the traveler requires protection against both hepatitis A and hepatitis B, then this combined vaccine can be used. Remember that at least 2 doses of this vaccine are required before the hepatitis A protection is sufficient cover for a year. This vaccine contains fewer antigens than Havrix Monodose.	• Japanese encephalitis • Tick-bourne encephalitis • Yellow fever (at a registered centre where a certificate is given) • Rabies (unless the person is at occupational risk e.g. bat handler or is having post exposure prophylaxis, in which case this is provided under the NHS) • Influenza if given for travel and the traveler is not in an immunisation target group as defined in the DH Green Book
The following travel immunisations that can be given as either NHS or as a private service: • Hepatitis B (single agent) any dose • Meningitis ACWY (quadrivalent meningococcal meningitis vaccine; A, C, Y and W135)	

8.4. Malaria prophylaxis

In 1995, the Department of Health (DH) issued guidance that medication for malaria prophylaxis may not be reimbursed under the NHS. Instead, prescription-only medicines for malaria prophylaxis should be prescribed privately and other medications can be purchased via a local community pharmacy. The practitioner may also make a charge for the consultation and supplying the prescription if they wish[15]. Some practices stock these items and may provide them directly to the patient for a fee.

Local community pharmacists also have access to up to date advice regarding appropriate prophylactic regimes and can advise travellers accordingly.

8.5. Controlled drugs: implications for patients

DH guidance recommends that, in general, prescriptions for controlled drugs should be limited to a supply of up to 30 days treatment.

A Home Office License to travel into or out of the UK with less than 3 months prescription is not required (laws in country of entry will vary), but it is advised that a letter is obtained from the prescribing doctor confirming the carriers name, address and date of birth and also destination, dates of outward and return travel, a list of the drugs the patient will be carrying, including dosages and total amounts. A charge may be made for supplying a letter.

[15] The National Health Service (General Medical Services Contracts) Regulations 2015. http://www.legislation.gov.uk/uksi/2015/1862/contents/made

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.

Persons travelling abroad (or visitors travelling to the UK) in excess of three months and carrying controlled drugs will require a personal export or import license[16]. A personal license 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[17].

Anyone staying outside of their home country for longer than three months should make suitable arrangements with a doctor in the country they are visiting for the purpose of receiving further prescriptions.

9. 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. Prescribing of borderline foods and dietary products should comply with the recommendations of the ACBS.

Prescriptions for such products on FP10s are regarded as drugs for the treatment of specified conditions. Prescribers should satisfy themselves that the products can safely be prescribed, that patients are adequately monitored and where necessary, that expert hospital supervision is available.

A complete list of conditions can be found in the BNF or the Drug Tariff.

Prescribers are strongly advised not to prescribe dietary products for patients (including in nursing or residential homes) outside the local guidance, or for use as an alternative to liquidising/purchasing appropriate food.

10. Complimentary Medicine and Alternative Therapies

Evidence suggests that there are large numbers of complementary medicines and alternative therapies available that have not been subject to the type of trials used to establish the effectiveness of conventional clinical treatments. It is for this reason and lack of established evidence that such therapies are generally not used by the NHS. They are occasionally used as part of a mainstream service care plan (e.g. as part of an integrated

[16] UK Government. Travelling with controlled drugs. July 2015 https://www.gov.uk/travelling-controlled-drugs
[17] Controlled drugs: licences, fees and returns
https://www.gov.uk/guidance/controlled-drugs-licences-fees-and-returns

multidisciplinary approach to symptom control by a hospital – based pain management team) and as such will be used as part of an existing contract where these are in place.

11. Minor Ailments

The General Medical Council (GMC) advises that practitioners should only prescribe drugs to meet the identified needs of patients and never for their own convenience or the convenience of other healthcare professionals[18]. Declining patient requests from the outset may deter patients from making similar future demands (for example requests for simple analgesia or for antibiotics for viral infections).

12. Fertility Treatment

12.1. Background

The Clinical Guideline on fertility assessment and treatment was published by National Institute for Care and Excellence (NICE) in February 2013[19] and covers all clinical procedures/pathways relating to fertility assessment and treatment.

Over 80% of couples in the general population will conceive within 1 year if:

- the woman is aged under 40 years and
- They do not use contraception and have regular sexual intercourse (every 2 – 3 days).

Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate over 90%). [NICE 2004, amended 2013]

The estimated prevalence of infertility is one in seven couples in the UK. A typical Clinical Commissioning Group (CCG) can expect about 230 new consultant referrals (couples) per 250,000 head of population per year (NICE CG11, 2004).

All couples are eligible for consultation and advice from the specialist service.

12.2. Definitions

12.2.1. Definition of infertility

A woman of reproductive age, who has not conceived after 1 year of unprotected vaginal sexual intercourse, in the absence of any known cause of infertility, should be offered further clinical assessment and investigation along with her partner. In Vitro Fertilisation (IVF) will only be funded after at least 2 years of unexplained infertility.

[18] General Medical Council. Good practice in prescribing medicines, 2013 http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

[19] NICE guidelines [CG156] Fertility problems: assessment and treatment, February 2013 https://www.nice.org.uk/guidance/cg156

Offer an earlier referral for specialist consultation to discuss the options for attempting conception, further assessment and appropriate treatment where:

- the woman is aged 36 years or over
- there is a known clinical cause of infertility or a history of predisposing factors for infertility

12.2.2. Definition of a full cycle

This term is used to define a full IVF treatment, which should include 1 episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s).

12.3. NHS prescription costs

Please refer to your local value based commissioning policy for IVF for details and eligibility criteria for NHS funded infertility treatment.

If couples are eligible for NHS-funded IVF treatment, they will still have to pay prescription charges for fertility medicines, unless they are exempt from prescription charges.

12.4. Private fertility treatment costs

Couples who are not eligible for NHS treatment may consider paying for private fertility treatment. Ensure choice is from a clinic licensed by the Human Fertilisation and Embryology Authority (HFEA)[20].

The HFEA does not regulate the cost of treatment set by private UK fertility clinics. Private clinics set their own prices for treatment – and these do vary from clinic to clinic. Some may include consultation fees and any recommended tests in their overall price, others may not. Some clinics may offer some free counselling, and others may charge for this. Fertility drugs are usually an extra cost and can be very expensive and should be provided privately by the specialist clinic and not at the expense of the NHS. Up until the point the individual is discharged, this remains an episode of care. In this case, the medication should be continued to be supplied privately and a practitioner may refuse to prescribe on the NHS in such a situation as they do not have the clinical responsibility for managing that particular condition.

13. Treatment of Erectile Dysfunction (ED)

Drug treatments for erectile dysfunction may only be prescribed on the NHS under the following circumstances for men who:

- have diabetes, multiple sclerosis, Parkinson's disease, poliomyelitis, prostate cancer, severe pelvic injury, single gene neurological disease, spina bifida, or spinal cord injury
- are receiving dialysis for renal failure

[20] Human Fertilisation and Embryology Authority. Accessed 09/2019 http://www.hfea.gov.uk

- have had radical pelvic surgery, prostatectomy (including transurethral resection of the prostate), or kidney transplant
- were receiving Caverject®, Erecnos®, MUSE®, Viagra®, or Viridal® for erectile dysfunction, at the expense of the NHS, on 14 September 1998

The prescription must be endorsed 'SLS'. Any patient who is not eligible under the above criteria may have the treatment prescribed privately, but no fee may be charged.

13.1. Recommended quantities

The DH has advised prescribers that one treatment per week is appropriate for most patients treated for erectile dysfunction. If the GP, in exercising clinical judgement, considers that more than one treatment a week is appropriate, it should be prescribed on the NHS. The practitioner should not write a private prescription; if a greater supply is deemed necessary, this should be prescribed on the NHS.

Prescribers may also wish to bear in mind that some treatments for impotence have been found to have a 'street value' for men who consider, rightly or wrongly, that these treatments will enhance their sexual performance. Excessive prescribing beyond the DH recommendations could therefore lead to unlicensed, unauthorised and possibly dangerous use of these treatments.

13.2. Generic sildenafil

The restrictions on NHS prescribing of generic sildenafil were lifted in August 2014, extending its availability on the NHS to many patients who had previously been prescribed it privately because they fell outside the 'SLS' criteria.

This only applies to prescriptions for generic sildenafil. Prescribing restrictions are still in place for other ED treatments.

As a result of this patients who have been prescribed sildenafil privately because they did not previously meet the SLS criteria will now be eligible to be prescribed generic sildenafil on the NHS. NHS prescriptions for generic sildenafil no longer require the 'SLS' annotation.

14. Doctors Prescribing for Themselves or Their Families

The GMC recommend that wherever possible, doctors must avoid prescribing for themselves or anyone with whom they have a close personal relationship[21].

It is good practice for doctors and their families to be registered with a GP outside the family who takes responsibility for their health care. This gives the doctor and their family member's access to objective advice and avoids the conflicts of interest that can arise

[21] GMC. Good Practice in Prescribing and Managing Medicines and Devices, 2013 http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

when doctors treat themselves or those close to them. Ideally, doctors, family and staff from a practice should be registered with, and treated by, another practice.

It is difficult to form an absolute rule: it may be sensible for a doctor to treat minor ailments, or take emergency action where necessary; however, they should avoid treating themselves or close family members wherever possible. This is a matter of common sense as well as good medical practice.

15. Visitors from Overseas

Patients entitled to NHS treatment in primary care, including the provision of any necessary prescriptions, are as follows:

- A person intending to be resident in this country for six months or more (registration with a practice is necessary)
- Patients from within the European Economic Area (EEA) in possession of an European Health Insurance Card (EHIC)
- Patients who require immediate, essential treatment, which the treating doctor deems cannot reasonably be delayed until the patient returns home (EHIC not required)
- Patients holding S2 (formerly E112) for specific treatment of a particular condition (and prescriptions for this condition only)
- Patients holding E128
- Refugees (those whose applications to reside in this country have been approved) and asylum seekers (those who have submitted an application and are awaiting a decision)

This list contains the most common categories, but please check an individual's situation before providing or declining NHS care as special conditions may apply.

GP services are excluded from the overseas visitor regulations, however, the guidance on the implementation of the regulations sets out the current situation:

- GPs have discretion to accept any person, including overseas visitors, to be either fully registered as a NHS patient, or as a temporary resident if they are to be in an area between 24 hours and three months. There is no minimum period that a person needs to have been in the UK before a GP can register them. Furthermore, GPs have a duty to provide free of charge treatment which they consider to be immediately necessary or emergency, regardless of whether that patient is an overseas visitor or registered with that practice.
- Being registered with a GP, or having a NHS number, does not give a person automatic entitlement to access free NHS hospital treatment.
- However, GPs should not be discouraged from referring their patients to the relevant NHS body. It is the relevant NHS body's duty, not the GP's, to establish entitlement for free hospital treatment. Furthermore, neither relevant NHS bodies

nor anyone acting on their behalf should imply that a particular patient should not be registered with a GP practice as that is exclusively a matter for that GP.

- GPs are able to offer treatment to overseas visitors on a private basis but can also accept anyone as an NHS patient.

Further information is available from the Overseas Visitors section of the DH website. https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme#resources-for-health-professionals.

16. Items for Occupational Health Purposes

16.1. Immunisations

Immunisation against infectious disease – The Green Book[22] gives clinical recommendations for the use of vaccines, but does not identify those which are recommended to be NHS funded (see Appendix 2). Where no remuneration is available from either the GMS contract or Local Enhanced Service for individual vaccines, NHS prescribing is strongly discouraged.

An individual sent by an employer to request occupational health immunisations should be advised that this is not the responsibility of the practice[23]. The employer (not the individual) will have to make private arrangements with a practice or occupational health provider to administer the vaccine(s).

The same applies for students (including healthcare students) who often request a Hepatitis B immunisation prior to, or on entering, a course. Universities and Medical Schools are legally responsible for providing a full occupational health service to their students (which should include appropriate training e.g. in risk reduction and coping with needle stick injuries). By providing a Hepatitis B immunisation, a practitioner could place inexperienced healthcare students at risk by providing a false sense of security and potentially exposing them to clinical risk of other blood borne infections including HIV and Hepatitis C before they have received appropriate training.

16.2. DVLA and diabetes monitoring

The Driver & Vehicle Licensing Agency (DVLA) has updated its licensing information for Group 2 drivers with Diabetes treated with medication which carries a risk of inducing hypoglycaemia, this includes sulphonylureas and glinides. This criterion also applies to drivers of C1 vehicles (medium sized goods vehicles 3.5 – 7.5 tonnes MAM) treated with insulin.

[22] Public Health England. Immunisation against infectious disease. 2013. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

[23] BMA General Practitioners Committee. Focus on hepatitis B immunisations. Guidance for GPs. August 2012. http://www.bma.org.uk/support-at-work/gp-practices/focus-hepatitis-b-immunisations

From 15/09/2010 drivers who wish to hold a group 2 license are required to satisfy the following criteria as stipulated in the new European Commission (EC) Directive. If they cannot meet these criteria they will not be eligible to hold a group 2 license:

- No episode of hypoglycaemia requiring the assistance of another person has occurred in the preceding 12 months
- Has full awareness of hypoglycaemia
- Regularly monitors blood glucose at least twice daily and at times relevant to driving
- Must demonstrate an understanding of the risks of hypoglycaemia
- There are no other debarring complications of diabetes such as a visual field defect[24]

This has obvious implications for the use of products utilised to self-monitor blood glucose. As this is a perceived occupational need rather than a general health need such additional items should be provided via private prescription.

17. Disposal of Pharmaceutical Waste

Pharmaceutical waste includes all liquid medicines in their bottles, tablets loose or in foils, unopened medicines vials and non-hazardous nebulisers.

All GP practices are required to have a contract in place for the disposal of clinical and pharmaceutical waste.

17.1. Controlled drugs (CD)

CDs should be disposed of through a process of denaturing using special kits. Denaturing kits can be obtained from your usual waste contractor.

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

If you have controlled drugs requiring destruction in the presence of an authorised witness, please contact the North of England Commissioning Support (NECS) Medicines Optimisation Team:

Cumbria	Durham, Darlington and Tees	North and South of Tyne
Telephone: 01228 603050 Email: england.cntw-cds@nhs.net	Telephone: 01642 746903 Email: necsu.ddtcontrolleddrugs@nhs.net	Telephone: 0191 217 2983 Email: england.cntw-cds@nhs.net

For Yorkshire & Humber areas the proforma is available by this link – https://secure.yhcs.org.uk/soft-intelligence/nelccg/downloads/controlled-drugs-destruction-proforma.doc

[24] Accessed from DVLA website 09/2019 https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide- for-medical-professionals

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Appendix One: Abbreviations

Abbreviation	Definitions
BMA	British Medical Association
NHSBA	NHS Business Services Agency
BNF	British National Formulary
EU	European Union
EHIC	European Health Insurance Card
DH	Department of Health
ACBS	Advisory Committee on Borderline Substances
GMC	General Medical Council
NICE	National Institute for Care and Excellence
CCG	Clinical Commissioning Group
IVF	In vitro fertilisation
HFEA	Human Fertilisation and Embryology Authority
ED	Erectile Dysfunction
SLS	Selective List Scheme
EEA	European Economic Area
EHIC	European Health Insurance Card
DVLA	Driver & Vehicle Licensing Agency
EC	European Commission
CD	Controlled Drugs
NECS	North of England Commissioning Support Unit

Appendix Two: Vaccines and NHS Provision

Travel immunisations that must be given as part of NHS provision:

- Part of additional services under GMS and PMS Regulations
- No fee may be charged by the contractor to a registered patient

Vaccination	Dosage
Hepatitis A (infectious hepatitis)	First and second / booster dose (6 – 12 months after first dose
Combined Hepatitis A and B	All doses
Typhoid	First and any boosters
Combined Hepatitis A and Typhoid	First dose (second dose is with Hepatitis A alone)
Tetanus, Diphtheria and Polio	As given in the combined Td/IPV vaccine
Cholera	

Travel immunisations that cannot be given as an NHS service

- Not remunerated by the NHS as part of contracted services:
  - Yellow Fever
  - Japanese encephalitis
  - Tick borne encephalitis
  - Rabies
- Patients are charged:
  - Private prescription
  - Or charged for stock purchased
  - And administration of the immunization
- Practices may determine their own price for these services.

Travel immunisations that can be given as either NHS or as a private service

- Not remunerated by the NHS as part of contracted services
- Practice discretion as to whether they levy a charge or not
- Regulations do not impose any circumstances or conditions
- Practice must have a consistent approach and provide the service as either fully NHS or entirely private.
  - Note that provision of an NHS service may also follow assessment that there is a clinical risk e.g. following exposure to someone in the family/ house that has hepatitis B.

Vaccination	Dosage
Hepatitis B (single agent)	Any dose
Meningitis ACWY	Quadrivalent meningococcal meningitis vaccine; A, C, Y and W135

- Providing as an NHS service:
  - Prescribe using FP10 or from purchased stock and claim reimbursement
  - No charge for administration of the vaccine
  - Confirmatory certificate can be charged for
- Providing as a Private service:

- Vaccine can be charged on a private prescription or as supply from practice stock
- A charge may be made for administration of the vaccine