Prescribing responsibility

GPNI

22/9/22

HSS (OP1) 2/92

Management Executive
Operations Directorate

The General Manager of each
Health and Social Services Board
The General Manager,
Central Services Agency

18 November 1992

Dear Sir

SUPPLY OF MEDICINES AND OTHER PHARMACEUTICAL PRODUCTS - RESPONSIBILITY FOR PRESCRIBING BETWEEN HOSPITALS AND FAMILY PRACTITIONER SERVICES

Introduction

1. This circular sets out guidance on prescribing policy for prescribers, pharmacists and other health care personnel in hospitals and in the community. References in the Circular to "the supply of drugs" should be read as the supply of medicines, dressings and associated products.

2. The guidance should be brought to the attention of all general practitioners, hospital doctors, hospital pharmacists and community pharmacists. Supplies of the circular are being sent to Health and Social Services Boards and the Central Services Agency under separate cover.

Background

3. There has been very little guidance issued on prescribing policy or on the responsibility for prescribing at the hospital/GP interface where uncertainties can arise, causing difficulties for patients and doctors. The Northern Ireland Working paper, "The Implementation of the GP Indicative Prescribing Scheme", acknowledged that there might be occasions where doubt would exist as to which doctor had clinical responsibility. It was therefore important to consider the issue of interface prescribing with the aim of providing guidance for staff working in the health service.

4. In June 1990 the Department of Health, London, set up a working group of NHS professionals and managers with a knowledge of prescribing issues and charged it with examining current prescribing practices in relation to government health policy. The main issues that needed to be addressed were:

LH 88 Health and Personal Social Services Northern Ireland
Dundonald House, Upper Newtownards Road, Belfast BT4 3SF. Tel: 650111



Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

RESPONSIBILITY FOR PRESCRIBING BETWEEN PRIMARY AND SECONDARY /TERTIARY CARE SERVICES FOR THE SUPPLY OF MEDICINES AND OTHER PHARMACEUTICAL PRODUCTS

May 2022

30 years btw the 2 documents – what's changed?

Just a few things :

- Shipman
- The internet, social media
- Workload
- Patient expectation
- Society in general – less deferential
- Medicine – ICD10, DSM4. some commentators say "medicalisation ; overdiagnosis
- The role of ISPs (particularly in NI)
- A more proactive regulatory environment

30 years btw the 2 documents – what's not changed?

Professional duty to Rx safely

Noone has your back like you do

“Can’t I just rely on what my hospital colleagues tell me? “

Not 100% you can’t

Independent Neurology Inquiry Vol 1; pp 103-104; defence offered by Dr M Watt

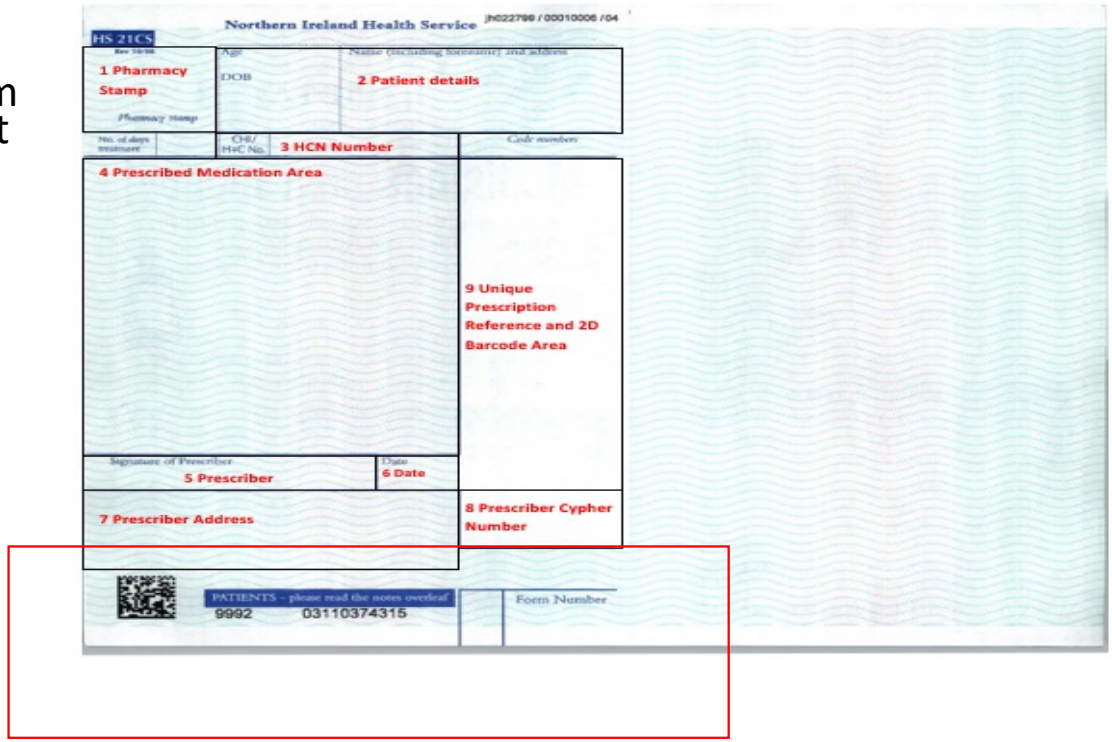
“(iii) The general practitioner is responsible for prescribing outside hospital, guided by the hospital consultants attended as an outpatient. …. (v) His treatment outside hospital is largely the responsibility of his GP shared to a degree by the specialists attended”

Case study 1 – patient found dead with alcohol, heroin and DZP on board

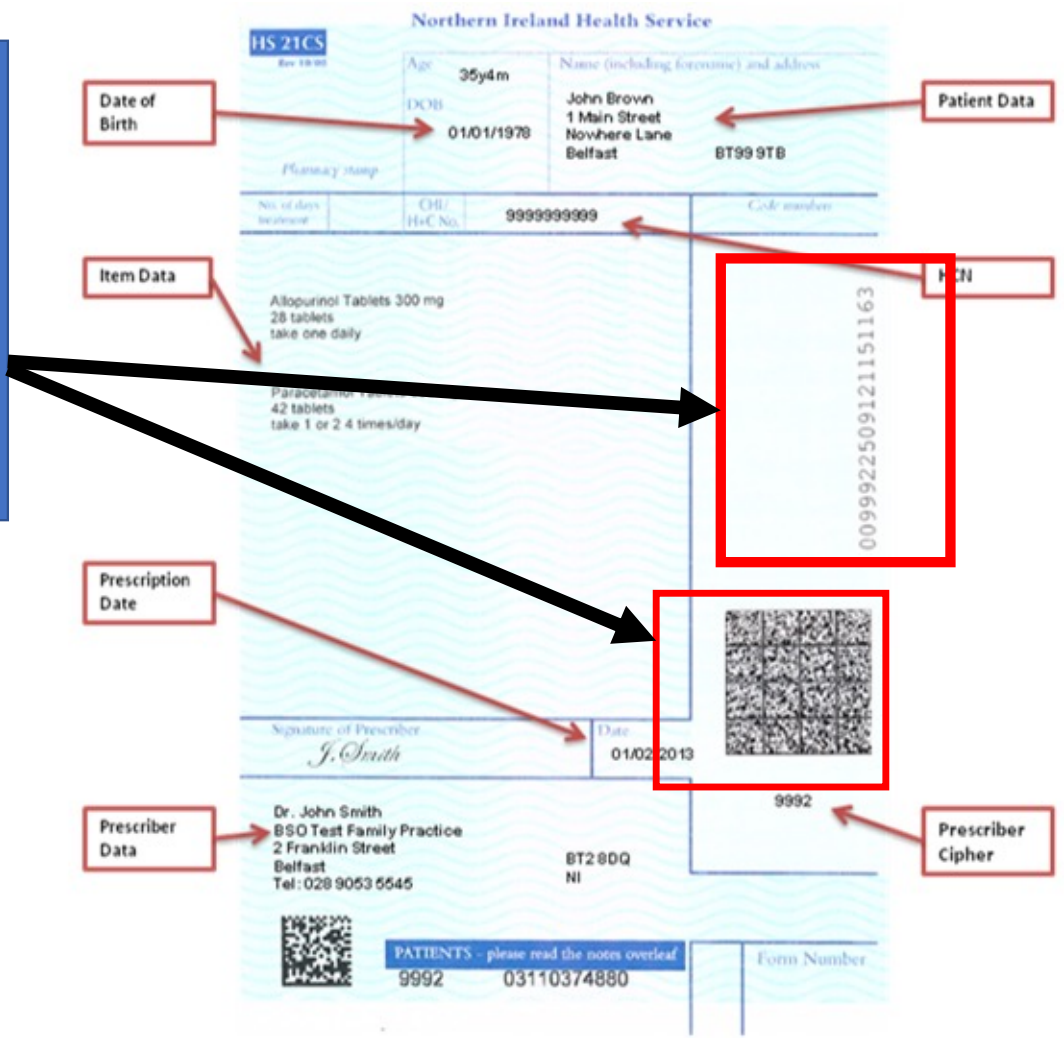
They won't find the dealer, they probably won't be sure whether the alcohol was from an off-licence or supermarket but they **will** be able to identify who prescribed the DZP-

NI GPSoC Requirement for Prescriptions Version 4

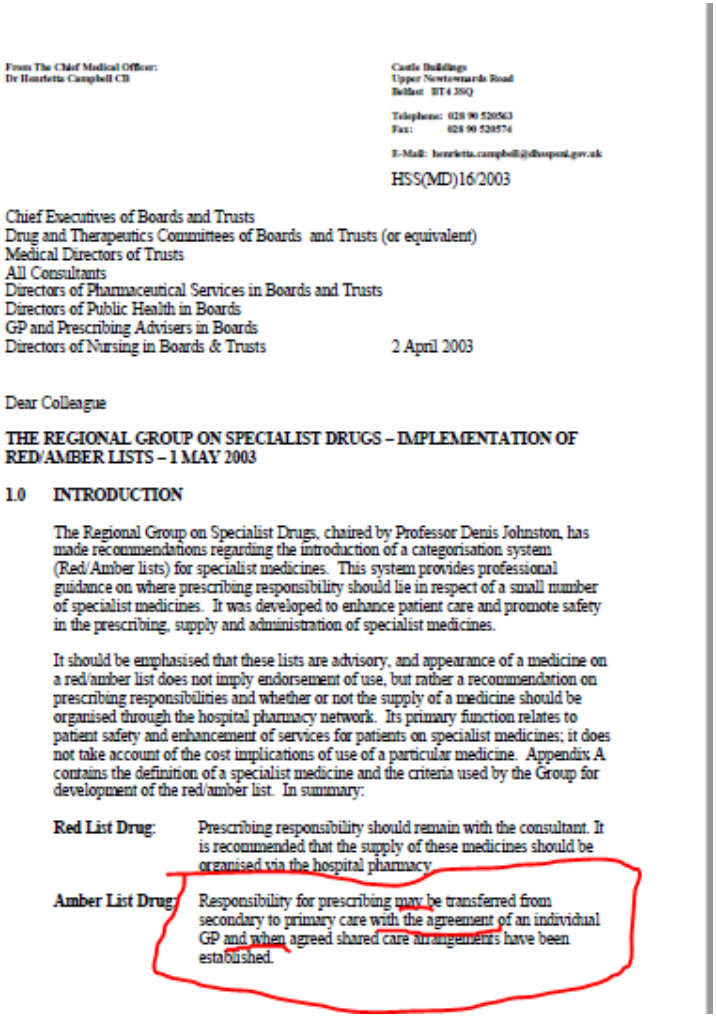
October 2017



Data added at time of script generation



shared care. CMO HSS MD 16/2003



From The Chief Medical Officer:
Dr Henrietta Campbell CB

Castle Buildings
Upper Newtownards Road
Belfast BT4 3SQ

Telephone: 028 90 520563
Fax: 028 90 520574

E-Mail: henrietta.campbell@dhsspsni.gov.uk

HSS(MD)16/2003

Chief Executives of Boards and Trusts
Drug and Therapeutics Committees of Boards and Trusts (or equivalent)
Medical Directors of Trusts
All Consultants
Directors of Pharmaceutical Services in Boards and Trusts
Directors of Public Health in Boards
GP and Prescribing Advisers in Boards
Directors of Nursing in Boards & Trusts

2 April 2003

Dear Colleague

THE REGIONAL GROUP ON SPECIALIST DRUGS – IMPLEMENTATION OF RED/AMBER LISTS – 1 MAY 2003

1.0 INTRODUCTION

The Regional Group on Specialist Drugs, chaired by Professor Denis Johnston, has made recommendations regarding the introduction of a categorisation system (Red/Amber lists) for specialist medicines. This system provides professional guidance on where prescribing responsibility should lie in respect of a small number of specialist medicines. It was developed to enhance patient care and promote safety in the prescribing, supply and administration of specialist medicines.

It should be emphasised that these lists are advisory, and appearance of a medicine on a red/amber list does not imply endorsement of use, but rather a recommendation on prescribing responsibilities and whether or not the supply of a medicine should be organised through the hospital pharmacy network. Its primary function relates to patient safety and enhancement of services for patients on specialist medicines; it does not take account of the cost implications of use of a particular medicine. Appendix A contains the definition of a specialist medicine and the criteria used by the Group for development of the red/amber list. In summary:

Red List Drug: Prescribing responsibility should remain with the consultant. It is recommended that the supply of these medicines should be organised via the hospital pharmacy.

Amber List Drug: Responsibility for prescribing may be transferred from secondary to primary care with the agreement of an individual GP and when agreed shared care arrangements have been established.

Beware:

1. "Informal" SCAs- check Interface Pharmacy website as source of truth
2. Beware discharged/ DNA /"advice"- melatonin
3. Care with ISP shared care - review dependent on self-funding ; contactability if there are problems

PAEDIATRIC ENDOCRINOLOGY AND DIABETES

Consultant Paediatric Endocrinologists
Dr Nolina Abid

Secretary
Ms Tracy Greer
028 90756452

Endocrine Nurse Specialists
Jackie McNabbe &
Angela McCormick

SHARED CARE GUIDLEINES FOR THE USE OF GnRH ANALOGUES IN ADOLESCENT GENDER DYSPHORIA

Introduction

This shared care guidance is regarding GnRh analogues and the shared care with GPs. This forms part of wider psychological pathway by Tavistock Gender Identity Development Service. This has been modified for use by Northern Ireland Adolescent Gender Dysphoria service (KOI).

Indications

GnRH Analogue is indicated when all the following criteria are satisfied:

The young person has been assessed and referred by KOI to the Paediatric Endocrinology Clinic.

The young person has been presenting with long term and persistent gender dysphoria and the intensity and distress has increased with puberty.

There is on-going local CAMHS support.

The young person is consenting – in line with consent to Treatment Guidance and Age related.

There is support from the family and social network.

In some cases, the referral to the Paediatric Endocrine Clinic is made for the purpose of physical assessment e.g. to exclude intersex or other endocrine conditions, or for educational purposes e.g. information about physical development. This assessment may allay some anxieties about physical development in the adolescent and in the family and be a containing measure.

The young person continues to attend appointments at CAMHS/KOI in conjunction with recommendations from The Tavistock Centre London alongside attendance at the clinic.

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN
E.TRIAGE FOR PAEDIATRIC MEDICINE / RAPID RESPONSE CLINIC

Dr Mary Claire McGovern / Dr Sara Lawson / Dr Sarah Kapur
Specialist Nurse – Lauren Legge

Ellen Waring / Sonia McGinney – Admin Support: Tel 02895 041 919
Email: DL-PMed-RBC-Admin@belfasttrust.hscni.net

Hospital Ref: [redacted]
H&C No: [redacted]

Date dictated: 23.08.2022
Date Typed: 23.08.2022

PRIVATE & CONFIDENTIAL

[redacted]

BELFAST

[redacted]

Dear [redacted]

Many thanks for referring [redacted] Paediatric Medicine. In the first instance, we would advise Melatonin 2mg once daily, increased to 4-6mg once daily if required. Max dose 10mg/day as per BNFc. Take medication 30-60 minutes before bed. We have not routinely listed [redacted] for appointment at this time however if things do not settle, please do not hesitate to get in contact.

Yours sincerely

[redacted]

On behalf of [redacted]
Paediatric Medical E.Triage Team

CC: Parents/Guardians

Template for amber abN; decl shared care

Warning – don't google paracetamoxyfrusebendroneomycin in polite company

ELMWOOD MEDICAL PRACTICE
Dr J. Logan, Dr L. Agnew, Dr D. MacDonagh,
Dr M. Finnegan, Dr F. McCann, Dr J. Burnett, Dr M. Oliver
Tel 02896941594

16-Sep-2022

REQUEST BY INDEPENDENT SECTOR PROVIDER FOR GP TO PRESCRIBE "AMBER-LIST" MEDICATION

FAO Dr Richey, The Till on the Hill

Regarding Miss MOUSE, Minnie (Miss) ; 14-Oct-1977 ; 987 654 3210

Dear Richey
The practice has received a request for us to prescribe ~~Paracetamoxyfrusebendroneomycin~~** This is an "amber-list" medication. GPs are not obliged to prescribe amber-list meds without assurances about follow-up. Regrettably ther practice has seen occasions where follow-up in the private sector has not occurred as planned leaving GPs in a very difficult position.
We will consider all requests but we must be clear about next planned review interval. Additionally in order that we can maintain the same standard of governance where either (1) a patient's monitoring results become abnormal or (2) where a patient does not attend for monitoring we require to have a mobile number for contacting the private specialist responsible for the amber list recommendation

If this is not possible the practice is unlikely to be able to consider the requirements for a shared care agreement are met. The choices for private Drs are then either

- **Issue a private prescription themselves mindful of the need for repeat prescriptions in some instances OR**
- **Refer the patient to themselves or a colleague under the NHS (the DHSSPSNI guidance is clear that there is no probity issue with this)**

We hope that this clarifies matters for private Drs and will help to avoid confusion for patients.
We have attached some appendices for further reading

Yours Sincerely
MACDONAGH, Donagh (Dr)

https://www.bnsa.org.uk/media/1563/bnsa-prescribing-in-general-practice-april-2018.pdf
If a patient has been seen privately in secondary care and is given a private prescription, is it acceptable for them to come to their GP and ask for it to be converted to an FP10?
--
If a GP receives a letter from a private consultation advising/suggesting a course of action then it may be appropriate for a script to be issued on an [HS21] if the GP agrees with the advice. The prescriber takes clinical responsibility for monitoring, so the GP must ensure that they are able to accept this responsibility. If the drug is one that a GP would not normally initiate, then it may be prudent to await a full communication from the private consultant. Even then, replacement of the private prescription with a (HS21) may not be appropriate and the patient may need to be advised of this.
Can my GP refuse to give me a prescription that my consultant asked them to provide?
Yes, your GP may refuse because the person who signs the prescription is legally liable for the prescribing and the consequent effects of that drug. Some drugs which may be very familiar to consultants in a specialised area of medicine can be potent drugs of which a GP will have little experience (for example many cancer drugs or specialised treatment for diseases such as rheumatoid arthritis – the group called 'biologicals'). Where a GP considers that it is inappropriate for them to issue a prescription on the advice of a third party, responsibility for provision will rest with the doctor making the recommendation.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/code-contact-private-practice2003.pdf
Referral of Private Patients to HPSS Lists
2.12 Patients who choose to be treated privately are entitled to HPSS services on exactly the same basis of clinical need as any other patient.
2.13 Where a patient wishes to change from private to HPSS status, consultants should help ensure that the following principles apply:
• any patient seen privately is entitled to subsequently change his or her status and seek treatment as a HPSS patient;
• any patient changing their status after having been provided with private services should not be treated on a different basis to other HPSS patients as a result of having previously held private status;

http://www.ipnm.hscni.net/download/document-library/HSSMD1603.pdf
THE REGIONAL GROUP ON SPECIALIST DRUGS – IMPLEMENTATION OF RED/AMBER LISTS – 1 MAY 2003 Amber List Drug:
Responsibility for prescribing may be transferred from secondary to primary care with the agreement of an individual GP and when agreed shared care arrangements have been established.
AMBER LIST
It is recommended that amber list drugs are appropriate for shared care, responsibility for prescribing may be transferred from secondary to primary care when agreed shared care arrangements have been established. The GP would normally undertake prescribing responsibility provided he/she was content that sufficient information was available to do so.
Concern about the prescribing/monitoring of a specific product should be discussed between parties.
It is recommended that shared care agreements should be drawn up following
local discussion and agreement by prescribing parties.
Criteria for products which may become part of shared care agreements (Amber List): Circumstances which meet all of the following criteria may allow a product to be used as part of a shared care arrangement, following agreement by both prescribing parties involved.
1. A shared care proposal has been drawn up following joint discussions of the parties.
2. The shared care agreement:
- provides a comprehensive summary of treatment.
- defines the responsibility of the consultant and GP for monitoring and adjusting treatment.
- defines the referral procedure from hospital to GP.
- defines the back-up facilities available to the GP from the hospital with which the agreement is made.
3. The GP is satisfied that he/she has all the information and support needed to prescribe and to monitor the patient.
4. If a product is not licensed for the proposed indication, full justification for its use is given by the consultant to the GP.

What to do if not happy with a HCP's Treatment Advice Note ?

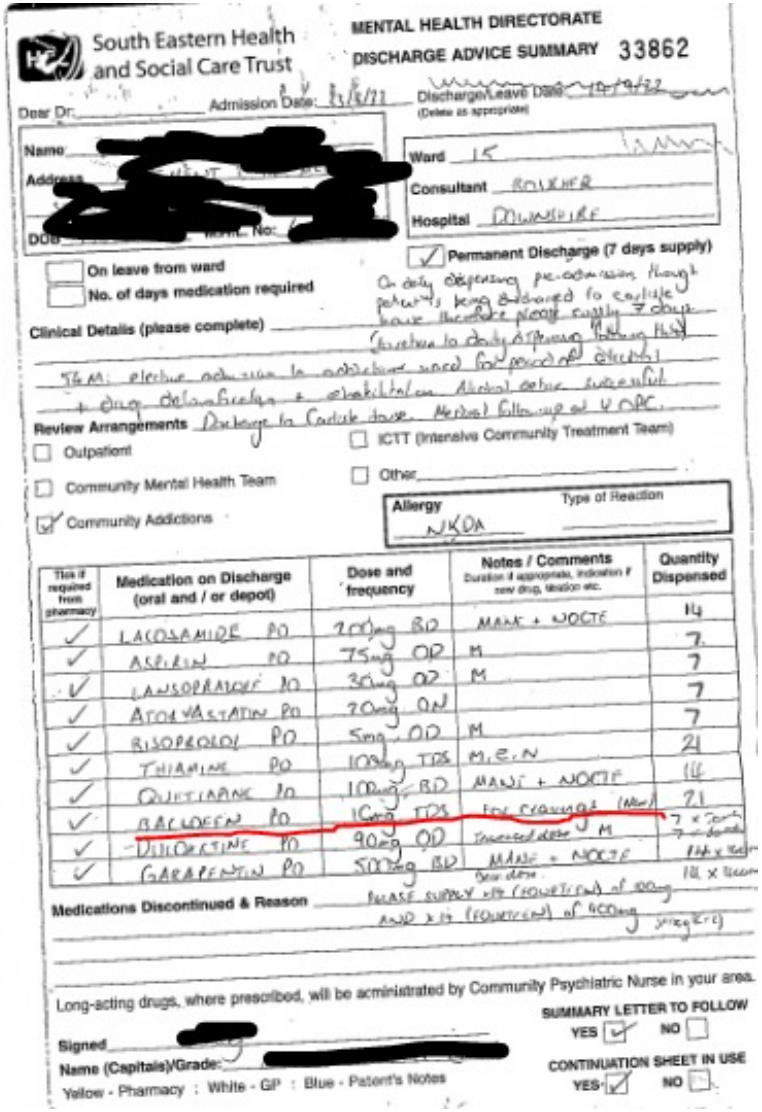
Ensure early that pt is aware that it isn't going to be issued or will be delayed pending further info – avoids conflict at reception – tel call, AccuRx

Repatriate the request back to Trust / ISP for them to make own dispensary arrangements

** be aware of contractual assurance A8.14; one has 48hrs to Rx/ decide not to Rx**



	A	B
		Education and training
9		Clinical staff have Training/updating in basic life support skills every 18 months as a minimum
10		The practice reviews their prescribing data compared with other practices and actions any findings appropriately
11		The practice complies with relevant legislation and considers guidance and alerts issued by the Board and the Department.
12		The Practice reports Complaints and Adverse Incidents as required by the HSCB. The practice undertakes regular significant event analysis and an annual review of patient complaints. Learning points are shared with the team.
		Practice Systems
13		The practice offers a range of appointment times of reasonable length on at least 5 mornings and 4 afternoons per week.
14		The number of hours from requesting a prescription to availability for collection is 48 hours or less (excluding weekends and bank holidays).
15		The practice has a system to alert the out of hours service or duty doctor to patients dying at home and a system for transferring and acting on information about patients seen by other doctors out of hours.



South Eastern Health and Social Care Trust

MENTAL HEALTH DIRECTORATE

DISCHARGE ADVICE SUMMARY 33862

Dear Dr: Admission Date: 13/8/22 Discharge/Leave Date: 10/9/22 (Delete as appropriate)

Name: [redacted]
Address: [redacted]
DOB: [redacted] Hosp. No: [redacted]

Ward: 15
Consultant: BOLKHER
Hospital: MUNSTER

☐ On leave from ward
☐ No. of days medication required

☑ Permanent Discharge (7 days supply)

Clinical Details (please complete): On daily dispensing pre-admission though patient's being advised to collect have therefore please supply 7 days. Elective to daily ATMosing taking PLAN TGM: elective admission to ambulance ward for period of detoxification + drug detoxification + rehabilitation Alcohol detox successful

Review Arrangements: Discharge to Carlisle house. Medical follow up at YPAC.

☐ Outpatient
☐ Community Mental Health Team
☑ Community Addictions
☐ ICTT (Intensive Community Treatment Team)
☐ Other

Allergy: NKDA Type of Reaction:

This if required from pharmacy	Medication on Discharge (oral and / or depot)	Dose and frequency	Notes / Comments Duration if appropriate, indication if new drug, titration etc.	Quantity Dispensed
✓	LACOSAMIDE PO	200mg BD	MANE + NOCTE	14
✓	ASPIRIN PO	75mg OD	M	7
✓	LANSOPRAZOLE PO	30mg OD	M	7
✓	ATORVASTATIN PO	20mg ON		7
✓	BISOPROLOL PO	5mg OD	M	7
✓	THIAMINE PO	100mg TDS	M, E, N	21
✓	QUETIAPINE PO	100mg BD	MANE + NOCTE	14
✓	BACLOFEN PO	10mg TDS	FOR CRAVINGS (NEW)	21
✓	DILTIAZEM PO	90mg OD	Increased dose M	7 x 4 + 7 x 3
✓	GABAPENTIN PO	500mg BD	MANE + NOCTE Increased dose	14 x 4 + 14 x 3

Medications Discontinued & Reason: PLEASE SUPPLY 14 (FOURTEEN) of 100mg AND x 14 (FOURTEEN) of 400mg (NEW)

Long-acting drugs, where prescribed, will be administrated by Community Psychiatric Nurse in your area.

Signed: [redacted]
Name (Capitals)/Grade: [redacted]

SUMMARY LETTER TO FOLLOW YES ☑ NO ☐

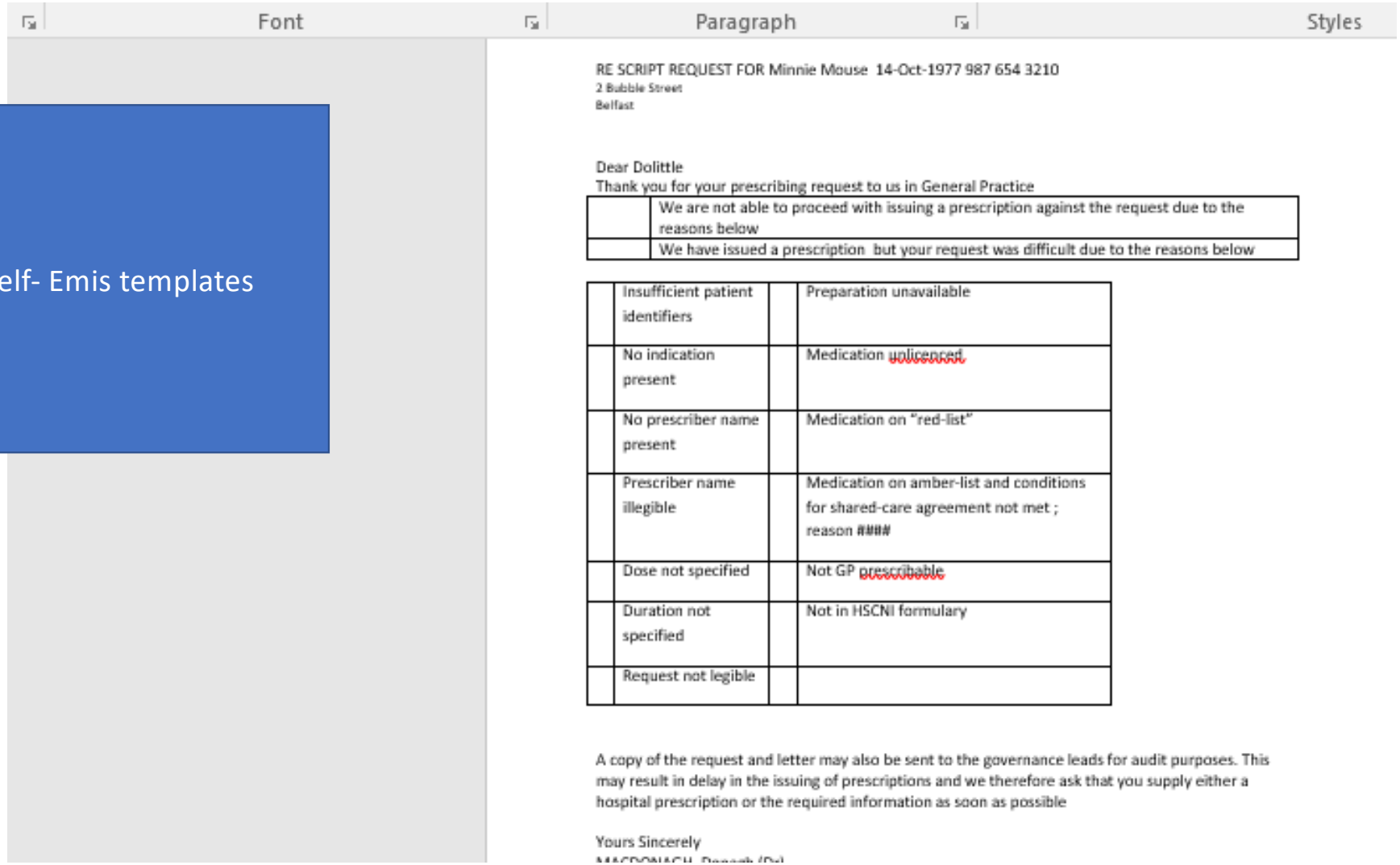
CONTINUATION SHEET IN USE YES ☑ NO ☐

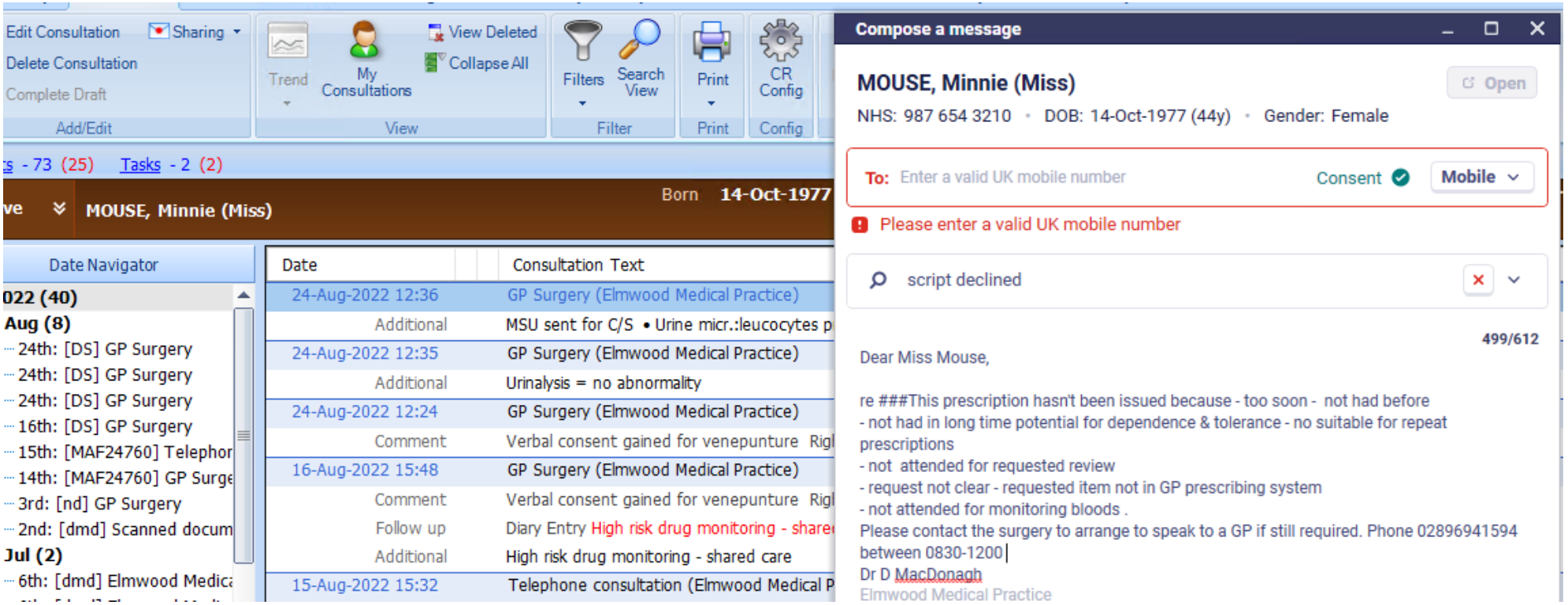
Yellow - Pharmacy : White - GP : Blue - Patient's Notes

[Baclofen | Drugs | BNF | NICE]

- Pain of muscle spasm in palliative care
- Hiccup due to gastric distension in palliative care
- resulting from disorders such as multiple sclerosis or traumatic partial section of spinal cord
- Severe chronic spasticity unresponsive to oral antispastic drugs (or where side-effects of oral therapy unacceptable) or as alternative to ablative neurosurgical procedures (specialist use only)

Protect yourself- Emis templates




Edit Consultation
Sharing
Delete Consultation
Complete Draft
Add/Edit
Trend
My Consultations
View Deleted
Collapse All
View
Filters
Search View
Filter
Print
Print
CR Config
Config
- 73 (25)
Tasks - 2 (2)
MOUSE, Minnie (Miss)
Born 14-Oct-1977
Date Navigator
022 (40)
Aug (8)
24th: [DS] GP Surgery
24th: [DS] GP Surgery
24th: [DS] GP Surgery
16th: [DS] GP Surgery
15th: [MAF24760] Telephor
14th: [MAF24760] GP Surge
3rd: [nd] GP Surgery
2nd: [dmd] Scanned docum
Jul (2)
6th: [dmd] Elmwood Medica
Date
Consultation Text
24-Aug-2022 12:36
GP Surgery (Elmwood Medical Practice)
Additional
MSU sent for C/S • Urine micr.:leucocytes p
24-Aug-2022 12:35
GP Surgery (Elmwood Medical Practice)
Additional
Urinalysis = no abnormality
24-Aug-2022 12:24
GP Surgery (Elmwood Medical Practice)
Comment
Verbal consent gained for venepunture Rigl
16-Aug-2022 15:48
GP Surgery (Elmwood Medical Practice)
Comment
Verbal consent gained for venepunture Rigl
Follow up
Diary Entry High risk drug monitoring - share
Additional
High risk drug monitoring - shared care
15-Aug-2022 15:32
Telephone consultation (Elmwood Medical P
Compose a message
MOUSE, Minnie (Miss)
Open
NHS: 987 654 3210 • DOB: 14-Oct-1977 (44y) • Gender: Female
To: Enter a valid UK mobile number
Consent
Mobile
Please enter a valid UK mobile number
script declined
499/612
Dear Miss Mouse,
re ###This prescription hasn't been issued because - too soon - not had before
- not had in long time potential for dependence & tolerance - no suitable for repeat prescriptions
- not attended for requested review
- request not clear - requested item not in GP prescribing system
- not attended for monitoring bloods .
Please contact the surgery to arrange to speak to a GP if still required. Phone 02896941594 between 0830-1200
Dr D MacDonagh
Elmwood Medical Practice

Who do I ask if I amn’t sure ?

Peer GPs

PBP

MMA

MDO

LMC

** performance concerns**

Belfast Health and Social Care Trust
caring supporting improving together

Acute Services,
Department of Neurology,
Level 6, Wing C, Outpatients,
Royal Hospitals,
Grosvenor Road,
Belfast, BT12 6BA.

Direct Line: 028 90634589

TIA CLINIC

Hospital Ref.: [redacted]
H&C No.: [redacted]

Date Typed: 15/05[redacted]
Clinic Date: 08/[redacted] (Appt. Type: REV)
Date Dictated: 14/[redacted]

[redacted]
THE HEALTH CENTRE
[redacted]
BELFAST
BT9 7HR

Dear DR [redacted]

RE: [redacted]

Her MS has been reasonably stable. In the past year she has lost a couple of stone in weight and her chest has been giving her quite a bit of bother. I have arranged a chest x-ray and I have also given her a private prescription for Sativex oral mucosal cannabis extracts spray which might help her to stop smoking. She recently started back on the cigarettes having been off them for quite a few years. I will see her again in about a year.

Yours sincerely

Electronically checked and signed

[redacted]
Consultant Neurologist

Circumstances where people commonly report unease

Periprocedural meds- synacthen, bowel prep, DZP, pre-MCUG Abio ppx , pre-cardiac BB

Rx for use by another HCP – private Mirena

Non-EBM : T3

Superspecialist meds- GID , part paeds

Unlicenced meds

MHRA safety alerts- domperidone (cardiac), metoclopramide (neuro)

Ambers without formal SCAs – EPO, ketamine

Asked to Rx for tests that someone else has done –** ANC UTI-ASB **

From the Chief Pharmaceutical Officer
Mrs Cathy Harrison

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont
Belfast
BT4 3SQ

Tel: 028 90 523219
Email: cathy.harrison@health-ni.gov.u
Date: 4 May 2021

Dr Donagh MacDonagh
e-Health lead, HSCB
By email: Donagh.MacDonagh.200140@gp.hscni.net

Dear Donagh,

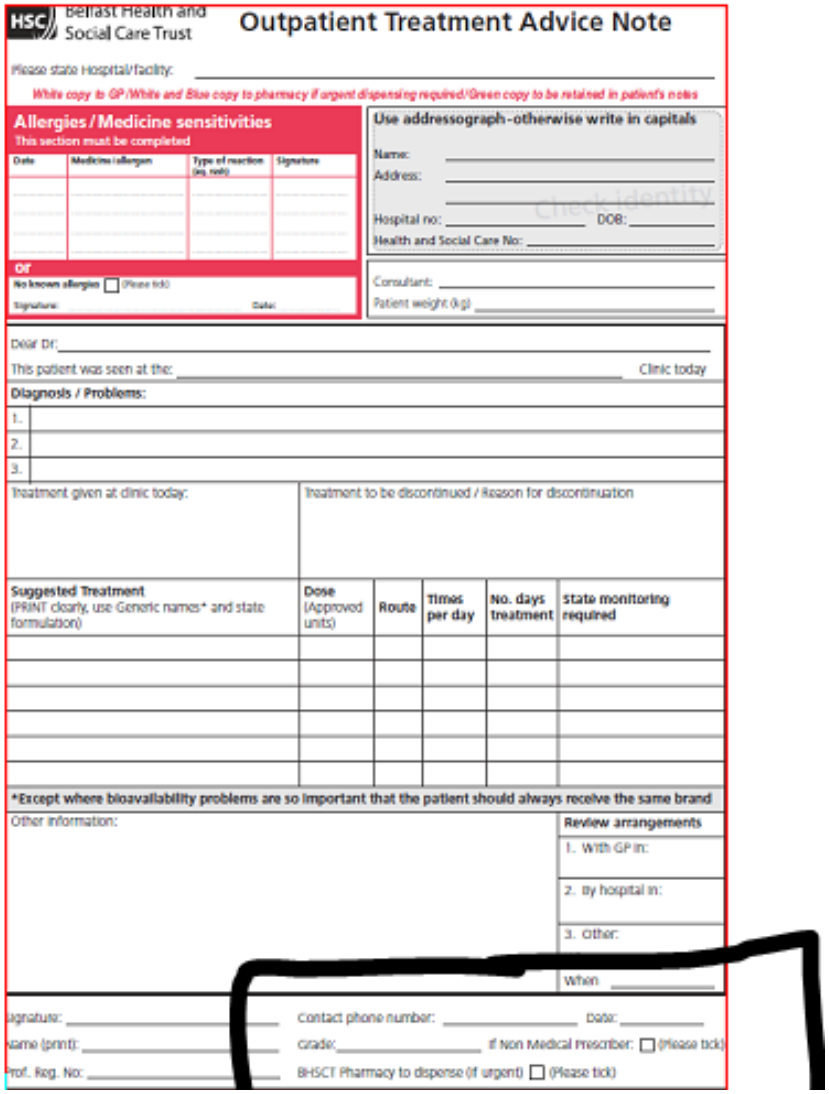
Thank you for your letter of 9 April highlighting your concerns about current arrangements for the transfer of information between HSC Trusts and general practice and the supply of new and urgent medication by secondary care providers.

As you will be aware, the Department is currently finalising preparations to undertake a formal public consultation on revised guidance on the responsibilities of primary and secondary care services for the prescribing and supply of medicines, and it is anticipated that this will progress to consultation in the next few weeks, subject to the Minister's approval. This updated guidance will replace the extant guidance in HSS(OP1) 2/92 and will reflect the changed landscape of HSC service provision in the intervening years since first publication, including utilisation of non-medical prescribers and collaborative working between sectors as part of HSC transformation and rebuilding.

Both the current 1992 guidance and the draft update are clear on the extant responsibilities of secondary care providers to ensure that when patients are treated in inpatient, outpatient or day-case settings that an appropriate supply of any new and urgently required medication is made by the secondary care provider in order to facilitate the smooth transition of prescribing responsibility to primary care. All HSC Trusts have the capability to supply new and urgent medication from the hospital pharmacy, and I am engaging with HSC Trusts to identify and address any barriers that may impact this in practice.

All Trusts **must** have dispensary arrangements

if you feel unease, don't allow emotional blackmail "GP best placed" and don't get drawn into consequentialist debates



Belfast Health and Social Care Trust

Outpatient Treatment Advice Note

Please state Hospital/Facility: _____

White copy to GP/White and Blue copy to pharmacy if urgent dispensing required/Green copy to be retained in patient's notes

Allergies / Medicine sensitivities

This section must be completed

Date	Medicine / allergen	Type of reaction (eg. rash)	Signature

Or

No known allergies ☐ (Please tick)

Signature: _____ Date: _____

Use addressograph-otherwise write in capitals

Name: _____

Address: _____

_____

Check Identity

Hospital no: _____ DOB: _____

Health and Social Care No: _____

Consultant: _____

Patient weight (kg) _____

Dear Dr: _____

This patient was seen at the: _____ Clinic today

Diagnosis / Problems:

1. _____
2. _____
3. _____

Treatment given at clinic today:	Treatment to be discontinued / Reason for discontinuation

Suggested Treatment (PRINT clearly, use Generic names* and state formulation)	**Dose** (Approved units)	**Route**	**Times per day**	**No. days treatment**	**state monitoring required**

***Except where bioavailability problems are so important that the patient should always receive the same brand**

Other information:

Review arrangements

1. With GP in:
2. By hospital in:
3. Other:

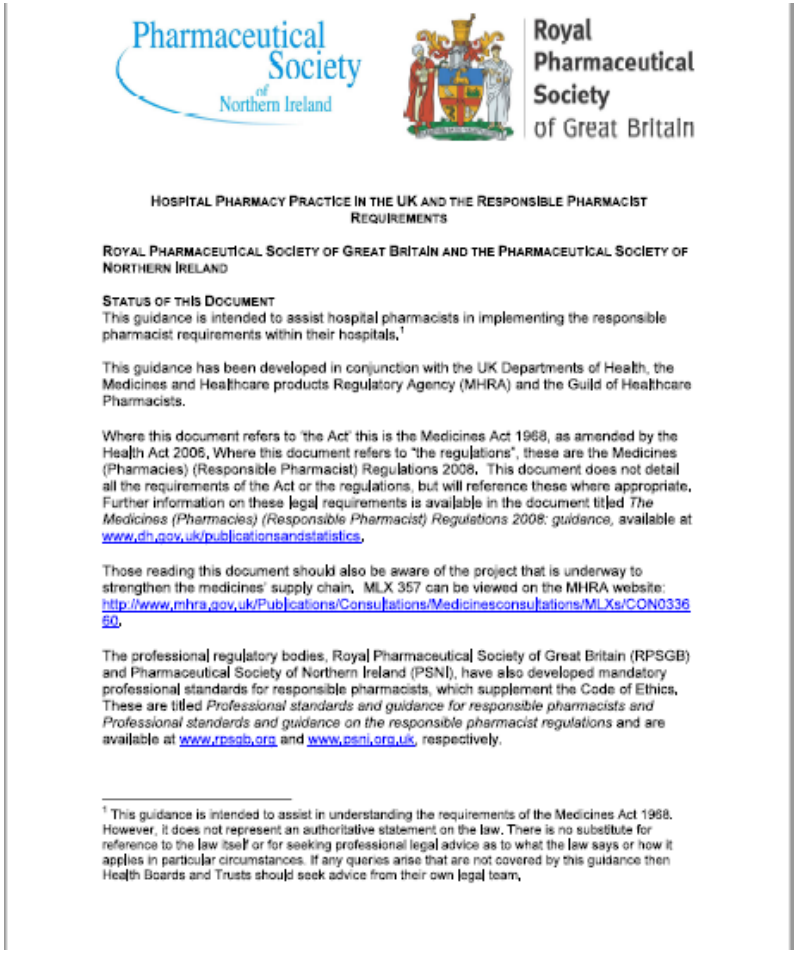
When: _____

Signature: _____ Contact phone number: _____ Date: _____

Name (print): _____ Grade: _____ If Non Medical Prescriber: ☐ (Please tick)

Prof. Reg. No: _____ BHSCT Pharmacy to dispense (if urgent) ☐ (Please tick)

There isn't currently cross-Trust recognition of each other's Treatment Advice Notes (but it has been pointed out that it should happen)



Pharmaceutical Society of Northern Ireland

Royal Pharmaceutical Society of Great Britain

HOSPITAL PHARMACY PRACTICE IN THE UK AND THE RESPONSIBLE PHARMACIST REQUIREMENTS

ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN AND THE PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND

STATUS OF THIS DOCUMENT

This guidance is intended to assist hospital pharmacists in implementing the responsible pharmacist requirements within their hospitals.[1]

This guidance has been developed in conjunction with the UK Departments of Health, the Medicines and Healthcare products Regulatory Agency (MHRA) and the Guild of Healthcare Pharmacists.

Where this document refers to 'the Act' this is the Medicines Act 1968, as amended by the Health Act 2006. Where this document refers to "the regulations", these are the Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008. This document does not detail all the requirements of the Act or the regulations, but will reference these where appropriate. Further information on these legal requirements is available in the document titled *The Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008: guidance*, available at www.dh.gov.uk/publicationsandstatistics.

Those reading this document should also be aware of the project that is underway to strengthen the medicines' supply chain. MLX 357 can be viewed on the MHRA website: http://www.mhra.gov.uk/Publications/Consultations/Medicinesconsultations/MLXs/CON033660.

The professional regulatory bodies, Royal Pharmaceutical Society of Great Britain (RPSGB) and Pharmaceutical Society of Northern Ireland (PSNI), have also developed mandatory professional standards for responsible pharmacists, which supplement the Code of Ethics. These are titled *Professional standards and guidance for responsible pharmacists and Professional standards and guidance on the responsible pharmacist regulations* and are available at www.rpsgb.org and www.psni.org.uk, respectively.

[1] This guidance is intended to assist in understanding the requirements of the Medicines Act 1968. However, it does not represent an authoritative statement on the law. There is no substitute for reference to the law itself or for seeking professional legal advice as to what the law says or how it applies in particular circumstances. If any queries arise that are not covered by this guidance then Health Boards and Trusts should seek advice from their own legal team.

“the private sector” – friend or foe of GPs?

Health and Social Care Board

Directorate of Integrated Care
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : 028 9536 3926
Fax : 028 9536 3126
www.hscboard.hscni.net

8th May 2017

For Action:
Providers of Private Medical Treatment

For Information:
General medical practices
Community pharmacies
HSC Trust Chief Executives for onward cascade

Dear Colleague(s)

Reminder: Interface between Private and HSC treatment and supply of medications

We have previously highlighted the issue of inappropriate requests from private providers to GPs to issue HSC prescriptions for medications which run contrary to HSCB prescribing guidance[i]. It is apparent from ongoing complaints from GP colleagues that such recommendations and requests continue to be made by a number of providers.

A number of recent examples have been brought to our attention where a GP was asked to prescribe inappropriately:

- A GP was presented with an ‘advice note’ from a private provider asking for Mirena® intrauterine system to be prescribed on HSC prescription. The GP practice in question did not provide IUS contraceptive insertion and therefore insertion of the device would be carried out by the private provider. The GP did not wish to accept clinical responsibility and appropriately did not issue a HSC prescription
- A patient’s partner presented an ‘advice note’ on a Friday afternoon to a GP to obtain a HSC prescription for tramadol in advance of the patient’s discharge over the weekend following surgery. In this case and under duress the GP did supply a prescription as it would not have been in the patient’s best interest to refuse.
- GPs have been advised, that in line with the NI Formulary, levothyroxine is the treatment of choice for hypothyroidism. We have been advised that patients unwilling to accept this treatment have seen private providers for prescription of liothyronine. Where this occurs, private providers should not be referring patients back to their HSC GP for a prescription for liothyronine under the Health Service. We expect the private provider to issue a private prescription and manage this treatment privately.
- A patient presented a GP with a discharge note for ongoing supply of enoxaparin following a hip replacement having received an initial 5 day supply from the private hospital. Enoxaparin is classed an ‘amber drug’[ii] and GPs are not obliged to prescribe in the absence of a Shared Care Arrangement with private providers outlining prescribing and monitoring responsibility.

Where a GP considers that a privately recommended treatment is clinically appropriate and does choose to prescribe then under the HSC terms of service they can issue an HSC prescription. However, the GP is accepting clinical responsibility for this decision. They will be held accountable for the prescribing by HSCB should this fall outside accepted recommendations for the health service, i.e. the Northern Ireland Formulary [iii]. Private providers are asked not to recommend treatments which are not considered appropriate under the HSC and which are without robust clinical evidence for the GP to make a decision on.

The purpose of this letter is to clarify expectations on the responsibility of prescribing by private healthcare providers as follows:

1. Sufficient post-op medication including analgesia, anticoagulation etc. is provided at discharge following procedures provided by private healthcare without reference for GP prescription
2. Where procedures are being provided on behalf of HSC Trusts, up to 28 day supply of medication is provided by private healthcare
3. Where patients elect to seek alternative treatment from a private provider, the prescription of any medicines linked to this treatment is managed by the private provider
4. Where a procedure is being undertaken by a private provider, any medicine or appliance is prescribed / supplied from the private provider and not sought from the GP practice.
5. GPs are not asked to provide prescriptions for Amber List drugs in the absence of a Shared Care Arrangement outlining ongoing prescribing and monitoring arrangements

Action for Private Healthcare Providers
We would be grateful for confirmation by Private Healthcare providers that they will advise staff of the requirements, review and update their procedures in light of the letter, and confirm that their procedures have been updated.

Please contact Mr Matthew Dolan (matthew.dolan@hscni.net) with responses and/or if there are any queries.

Yours sincerely,

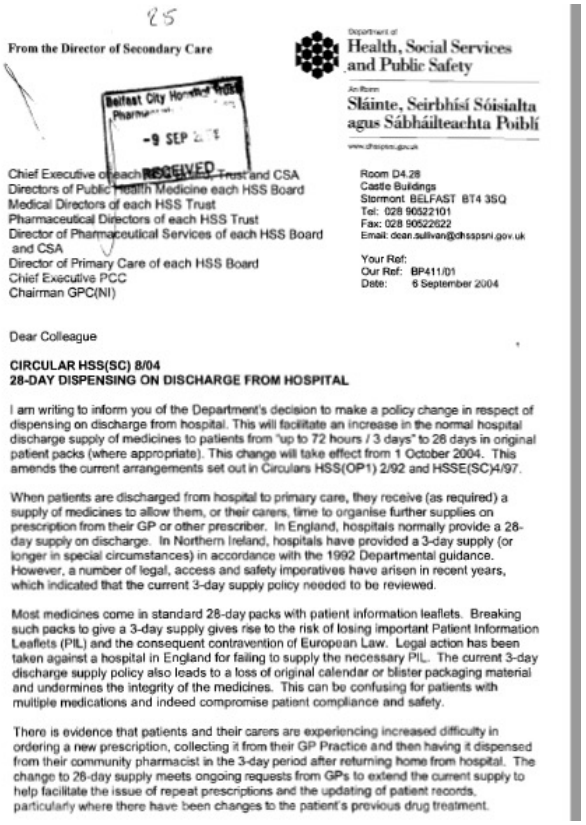
Dr Margaret O’Brien
Head of General Medical Services

Mr Joe Brogan
Assistant Director of Integrated Care
Head of Pharmacy and Medicines Management

Cc Dr Sloan Harper
Dr Carolyn Harper
Mrs Mary Hinds
Mr Dean Sullivan
Dr Lourda Geoghan (RQIA)

[i] Letter from HSCB July 2013 www.hscboard.hscni.net/our-work/integrated-care/pharmacy-and-medicines-management/correspondence-pharmacy-medicines-management/
[ii] www.ipnsm.hscni.net/red-amber/
[iii] Northern Ireland Formulary niformulary.hscni.net

Private sector (2) – HSC rules don't apply



25

From the Director of Secondary Care

Department of Health, Social Services and Public Safety

An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Belfast City Hospital Trust Pharmacy
-9 SEP 2004
RECEIVED

Chief Executive of each HSS Trust and CSA
Directors of Public Health Medicine each HSS Board
Medical Directors of each HSS Trust
Pharmaceutical Directors of each HSS Trust
Director of Pharmaceutical Services of each HSS Board and CSA
Director of Primary Care of each HSS Board
Chief Executive PCC
Chairman GPC(NI)

Room D4.28
Castle Buildings
Stormont BELFAST BT4 3SQ
Tel: 028 90522101
Fax: 028 90522622
Email: dean.sullivan@dhsspsni.gov.uk

Your Ref:
Our Ref: BP411/01
Date: 6 September 2004

Dear Colleague

CIRCULAR HSS(SC) 8/04
28-DAY DISPENSING ON DISCHARGE FROM HOSPITAL

I am writing to inform you of the Department's decision to make a policy change in respect of dispensing on discharge from hospital. This will facilitate an increase in the normal hospital discharge supply of medicines to patients from "up to 72 hours / 3 days" to 28 days in original patient packs (where appropriate). This change will take effect from 1 October 2004. This amends the current arrangements set out in Circulars HSS(OP1) 2/92 and HSSE(SC)4/97.

When patients are discharged from hospital to primary care, they receive (as required) a supply of medicines to allow them, or their carers, time to organise further supplies on prescription from their GP or other prescriber. In England, hospitals normally provide a 28-day supply on discharge. In Northern Ireland, hospitals have provided a 3-day supply (or longer in special circumstances) in accordance with the 1992 Departmental guidance. However, a number of legal, access and safety imperatives have arisen in recent years, which indicated that the current 3-day supply policy needed to be reviewed.

Most medicines come in standard 28-day packs with patient information leaflets. Breaking such packs to give a 3-day supply gives rise to the risk of losing important Patient Information Leaflets (PIL) and the consequent contravention of European Law. Legal action has been taken against a hospital in England for failing to supply the necessary PIL. The current 3-day discharge supply policy also leads to a loss of original calendar or blister packaging material and undermines the integrity of the medicines. This can be confusing for patients with multiple medications and indeed compromise patient compliance and safety.

There is evidence that patients and their carers are experiencing increased difficulty in ordering a new prescription, collecting it from their GP Practice and then having it dispensed from their community pharmacist in the 3-day period after returning home from hospital. The change to 28-day supply meets ongoing requests from GPs to extend the current supply to help facilitate the issue of repeat prescriptions and the updating of patient records, particularly where there have been changes to the patient's previous drug treatment.

The move to 28-day original patient pack dispensing on discharge is part of the overall modernisation approach as advocated in the Audit Commission Report 2001: "A Spoonful of Sugar". This indicated that although original pack dispensing can lead to larger supplies of medicine being taken home, it can also yield savings, reduce waste and improve continuity of treatment. In May 2002 the Minister agreed to the Department's recommendation that hospitals should be encouraged to dispense in original patient packs on discharge from hospital to improve the continuity of care from secondary to primary care.

Allied to the provision of 28-day supply at discharge has been the development of modern medicines management systems as exemplified by the 'Integrated Medicines Management' (IMM) project. IMM seeks to maximise health through the optimal use of all aspects of medicines management. It targets the three main phases of a patient's stay in hospital – to ensure that a comprehensive accurate patient medication history is taken on admission, a full medication record and review during the patient's stay, and the preparation and dispensing of the discharge prescription in a 28-day original patient pack in liaison with the doctor. The development of IMM is also one of the recommendations of "Making it Better – A Strategy for Pharmacy in the Community", launched by Minister Angela Smith in February 2004.

The Department will make the appropriate funding adjustments to account for the transfer of medicines costs from primary care to secondary care based on the costing analysis that formed the evidential base for the policy change.

Yours sincerely

Dean Sull.

DEAN SULLIVAN
Director of Secondary Care

NORMAN MORROW
Chief Pharmaceutical Officer

Private sector (3)- but there are other rules AKA everyone is accountable to someone

March 22, 2022

To Elmwood Medical Practice,

I am writing in regards to a request I have regarding an upcoming appointment with an ADHD clinic concerning ADHD medication prescriptions.

Please see a copy of the email and letter I have received from the ADHD clinic. You can see the confirmation they require regarding my GP's willingness to prescribe ADHD medication on their recommendation of such.

I understand from my phone calls with Elmwood that a prescription of ADHD medication would be considered based on the recommendation from the clinic, before a prescription is to be made. I am hoping to get this statement in a letter from Elmwood, so I can bring that letter to my appointment on Saturday 26th of March 2022. I would greatly appreciate it if I could get this letter by this Friday.

If you wish to discuss this further, please don't hesistate to contact me. My number is [redacted]

Kind regards

[redacted]

BELFAST ADULT ADHD CLINIC

Referral & Treatment Process

Musgrave House
10 Stockman's Lane,
Belfast, BT9 7JA
Telephone: 02895 212294

1. We accept patients aged from 18 years to 65 years.

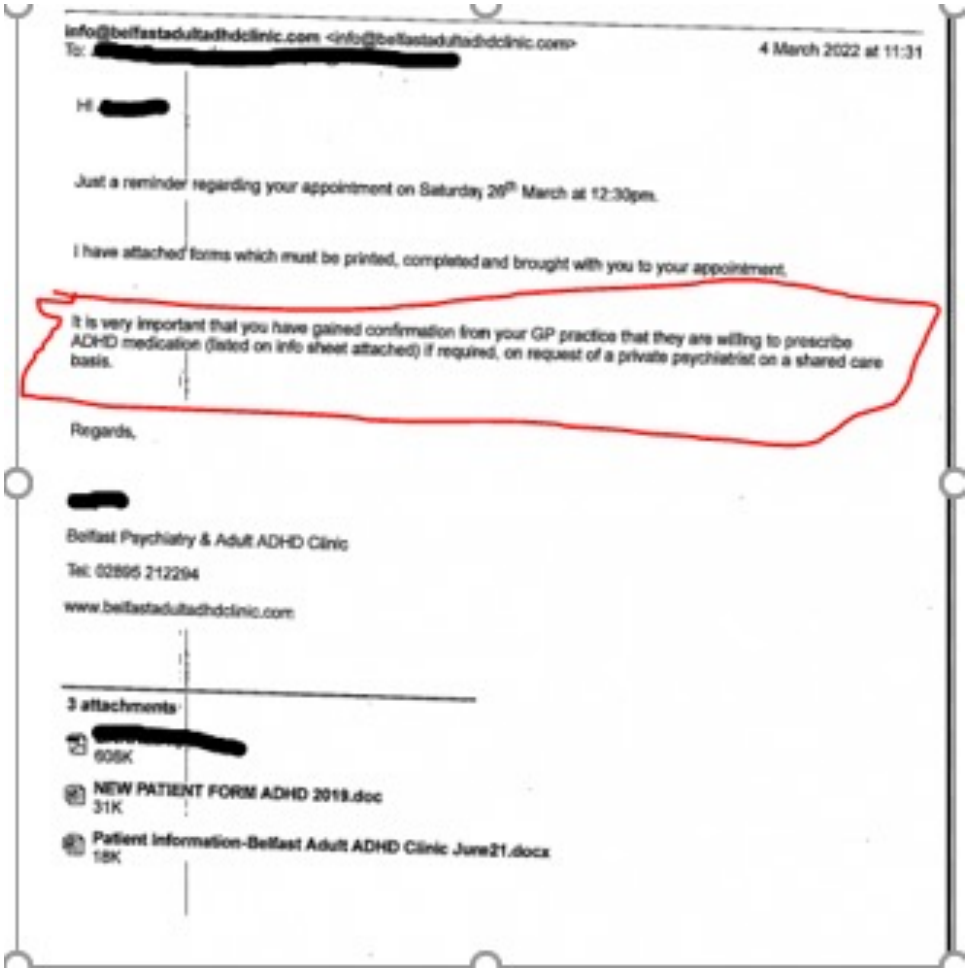
2. Initially we will require a referral from your General Practitioner together with any previous reports and/or assessments if possible.

When you are discussing the referral with your GP, it is important that they are willing to prescribe ADHD medication (Methylphenidate, Lisdexamfetamine, Atomoxetine) for you on request of a private psychiatrist under a Shared Care Agreement (if this is required). Not all GP's are prepared to do this so it is vitally important to establish this before referral. We will ask for confirmation of this from you before offering an appointment.

3. On receipt of referral we will be able to offer an appointment.

4. The assessment will be carried out over the course of two appointments. The first appointment will last for approximately two hours and is with a Consultant Psychiatrist and a Clinical Psychologist. The second appointment will last approximately one hour. It is at the second appointment that you will receive a diagnosis and treatment plan (if applicable). The first appointment will cost £450 and the second £200, each to be paid on the day of appointment by Credit/debit card or cash. Any subsequent reviews will cost £140 each.

5. We treat on a shared care basis i.e. we recommend medication which is then prescribed by your own GP. We will need to conduct regular reviews the frequency of which will be decided by your consultant. Your GP will only continue to prescribe your medication if you have attended your review.



info@belfastadultadhdclinic.com <info@belfastadultadhdclinic.com>
To: [redacted]
4 March 2022 at 11:31

Hi [redacted]

Just a reminder regarding your appointment on Saturday 26th March at 12:30pm.

I have attached forms which must be printed, completed and brought with you to your appointment.

It is very important that you have gained confirmation from your GP practice that they are willing to prescribe ADHD medication (listed on info sheet attached) if required, on request of a private psychiatrist on a shared care basis.

Regards,

[redacted]

Belfast Psychiatry & Adult ADHD Clinic

Tel: 02895 212294

www.belfastadultadhdclinic.com

3 attachments

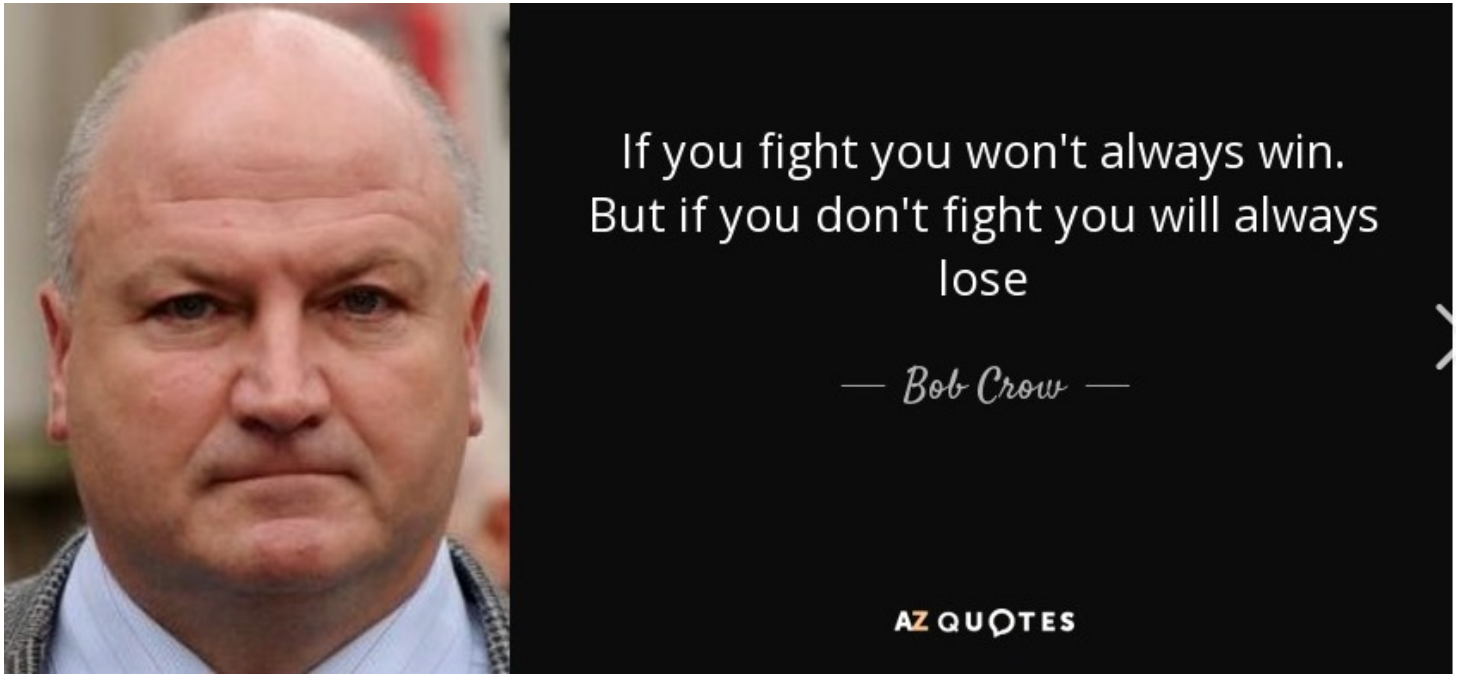
[redacted]
606K

NEW PATIENT FORM ADHD 2019.doc
31K

Patient Information-Belfast Adult ADHD Clinic June21.docx
18K

Private clinic looking for assurance that GP ~~would act as community SHO~~ do scripts in advance of private appt

RQIA unimpressed …


If you fight you won't always win. But if you don't fight you will always lose
— Bob Crow —
AZ QUOTES



https://www.health-ni.gov.uk/articles/pharmaceutical-non-medical-prescribing

Department of Health | An Roinn Sláinte | Männystrie O Poustie

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Prescribing by Non-Medical Healthcare Professionals

Topics: Pharmacy , Pharmacy and medicines policy

It is the Department's policy to extend prescribing responsibilities to a range of non-medical professions.

Non-Medical Prescribing

Prescribing responsibilities include:

- improve patient care without compromising patient safety
- make it easier and quicker for patients to get the medicines they need
- increase patient choice in accessing medicines
- make better use of the skills of health professionals

On this page

- Non-Medical Prescribing
- Three types of non-medical prescribing
- What can Non-Medical Prescribers Prescribe?
- Controlled Drugs
- Information about training as a n
- A fo



HS21H

In other 3 home nations there exists a FP10H which a 2ary care HCP can issue for dispensing in a community Pharmacy
Pre-2019 Trusts could only dispense from Trust sites and GPs thru comm pharmacy or own dispensing pharmacy
Community Geriatrics and the “workarounds” 2015 – taxis & bags

New Models of Prescribing & pilot areas – CCFNs, BT-HTT, care home dieticians, Physio IPs lymphoedema

Lessons learnt:

1. IP is hard
2. Prescribing doesn’t sit in isolation – diuretics
3. Handovers

ETP

Deferred for 3 years

Scope – 2ary care included/ not included?

Some large IT config changes reqd (cipher system, validation, CP IT landascape)

CDs

Merit their own mention (if not seminar)

Post-Shipman

Practitioners as well as practices can be inspected (includes locums & NMPs)

Avoid the pain or at least minimise it

IN THE CROWN COURT IN NORTHERN IRELAND
CRIMINAL JUSTICE (NORTHERN IRELAND) ORDER 1996 (ARTICLE 10)
PROBATION ORDER
Re XXXXX
DOB: XX XXXX 19XX
Defendant

WHEREAS the defendant who resides at XX, XXX, BTXX XXX was on the XX Sep 20XX convicted by XX Crown Court sitting at Belfast of the following offences:
Counts 1,6,8,12,16 Theft contrary to Section 1 of the Theft Act (Northern Ireland) 1969
Counts 4,7,14 Possessing Class B Controlled Drug contrary to Section 5(2) of the Misuse of Drugs Act 1971
Counts 5,10,11,15 Possession Of Class C Controlled Drug contrary to Section 5(2) of the Misuse of Drugs Act 1971
Counts 9,13 Possession Of Class A Controlled Drugs contrary to Section 5(2) of the Misuse of Drugs Act 1971

AND on the XX November 20XX this court having obtained and considered a pre-sentence report for the purpose of determining the most suitable method of dealing with the defendant and being of the opinion that the supervision of the defendant is desirable for securing the rehabilitation of the defendant.

AND the court has explained in ordinary language to the defendant:

(a) why it is making the order;
(b) the effect of this order and its requirements;
(c) the consequences which may follow if he fails to comply with any of the requirements of the order (including the fact that he will then be liable to be re-sentenced for the offence in respect of which the order is made); and
(d) that the court has power to review the order on the application of either the defendant or of the officer responsible for his supervision.

IT IS ORDERED that the defendant, who will reside in the area of XXX be required for the period of 3 years ; concurrent on each count and with each other,next ensuing to be under the supervision of a Probation Officer appointed for or assigned to that area and it is further ordered that the defendant shall during the said period comply with the following requirements:-
Defendant shall keep in touch with the Probation Officer in accordance with such instructions as may from time to time be given,
Defendant shall notify the Probation Officer of any change of address;
And the defendant has expressed willingness to comply with the said requirements.
Dated XX Nov 20XX at XXX Crown Court sitting at Belfast
Richard Crossthwaite
On behalf of Chief Clerk



Apologies to younger viewers: Sgt Esterhaus in Hill St Blues

Aphorisms or trueisms ?

1. Life is fraught with difficulty
2. no good turn goes unpunished (Tamiflu)
3. today's favour is tomorrow's duty

But a GP's defences are

1. Collegiality – ask your peers , ask pharmacist . Ask!
2. Knowing the score – e-mail blizzard but keep the important ones
3. Never be rushed
4. Using IT – templates . Exporting/ sharing resources