HMP The Mount. Archway Contract

Archway Development and Consulting Contract: The first two years and the future.

Prison Medical Services are Primary Care Services

The prison population may have diseases in unusual proportions, but not dissimilar to any inner-city general practice. We see more patients with diseases associated with ethnic minorities. We see more hepatitis C and B, a few patients carrying HIV, and of course many more people with dependency personalities. There are a few patients with fully developed psychiatric disorders. There are a handful of schizophrenics, a few with endogenous depression, but nobody with mania. Now that personality disorder has come into the health remit, there are issues as to how we should treat and manage these people, but we have the same issues in the community as a whole. Dependency is linked to the personality disorder problems. Personality disorders are seen in general practice and make up a large proportion of our frequent attendees. The prison population seems to age faster than the rest of us, but otherwise the diseases and problems we see are those of any inner-city general practice. Prison medicine is general practice.

A prison G.P. is not be a G.P. with a special interest in Prison Medicine, as Prison Medicine is just General Practice with added security issues. The concept of Prison Medicine being a speciality was dismissed by the lead speakers at the BMA/DH conference in July 2004. G.P.s working in prisons may wish to develop special interests in subjects useful to the prison population, such as dermatology, liver diseases, GUM, mental health and drug dependency.

Staff should rotate with Primary Care outside. This has started with the doctors but should now include all other prison health staff and nurses.

Archway provides one of two doctors every morning, offering continuity of care with our third regular doctor covering leave. Archway is on call one in two nights and weekends (such contracts are outlawed in the hospital service). Sometimes doctors do not need to go in on Sundays or Christmas day. The Health Unit should be covered by nursing staff until 8pm, but the shortage of nursing staff has meant that on many occasions we have had to provide increased cover from 5pm, and be called by the mount during our evening surgeries, without warning.

The prison has not had to worry about cover for the morning surgeries since the contract started. The afternoon surgeries are also covered from time to time by Archway, always at very short notice.

The doctors work professionally and work beyond the hours contracted for, every day, especially on Mondays and Tuesdays. Wednesdays is often used for in-house informal training.

G.P. appraisals to date have included the work carried out by the doctors in the prison.

The Work to Date

The Segregation Unit Round.

This and other form filling in general had been perceived by many prison officers and staff as the sole task of the prison medical officer. A more general practice approach was quite shocking in the first few months.

We are still finding the seg round difficult to stop, since we need to do the "cc" algorithms and adjudication paperwork that takes us down there. Nurses as yet are not able to take this on fully. Systems so that the doctors see only those who are known to have problems does not work, so we end up wandering up and down the seg, and then miss those who later announce they must see the doctor. It remains quicker to walk round the lot at 8.30 am. Eventually the nursing staff will be able to take seg role on this role fully and bring problem patients up to health.

Avoidance of need to transfer to hospital.

Our Out of Hours cover has included out of hours procedures such as emergency suturing, saving many hospital trips.

Minor operations - Over 100 to date. 30 could have waited until the prisoners left, but will have avoided 70+ hospital outpatient and minor operation journeys.

Email "telemedicine" in dermatology reducing the need for 20 dermatology appointments.

We write letters on non-prison notepaper to make appointments for prisoners to attend hospitals after their discharge, so that while they remain in prison they are on the waiting list at another hospital, usually near their home. Most of these are in orthopaedics, which still has long waiting times. However should NHS waiting times go down, and Hemel is able to offer appointments within weeks in all specialties, this tactic may not be useful in the future. We will be obliged to offer the earliest appointment at Hemel even the prisoner has little time left in the Mount.

Cancelled hospital appointments

The pressure to avoid transfer to hospital because of staffing problems in the prison service (i.e. unable to offer escort) has to be resisted from time to time by the doctors. We assure ourselves that we need consultant opinion or operation before writing the referral letter. We expect those we refer to be seen. We remain dismayed by the number of cancellations of appointments by the prison service. The Mount is not alone in this practice. Some patients have had their appointments cancelled on multiple occasions. Patients are moved to different prisons days before a hospital appointment. The prisoners then have to have a further referral letter sent and join the back of the queue at the hospital local to their new prison. We know of prisoner whose appointment has been cancelled on five occasions. There is a system, of sorts, to red flag those who MUST have an appointment, but that implies the G.P.s know the likely diagnosis, and sometimes we do not, which is why we are seeking the second opinion in the first place. These cancellations remain an area of huge risk to both patients and the prison service.

Computer System

The clinical computer system was installed by Archway, and is operational with NHS Net connection. From August, Pathology Links are starting. We could do with three more terminal computers and a connection to the clinical system from reception, so the Nurses could put data on direct, and print out for the folders. Hopefully the PCT should fund this. The computer is fully NHS RFA accredited and supported. The computer generates legible letters containing all the details and some past history of the patients and their drugs, for hospital appointments and consultations. The new secretarial/reception staff will run off these letters. The doctors are doing them or printing out profiles to go with letters.

Computerised pharmacy dispensing, stock keeping and drug ordering is in place ready for the pharmacist, as that module is part of the clinical installed system.

Primary Care training of nursing staff.

Nurses are now visiting Archway Surgery, such that now there is a mood to use the computer fully at the prison.

Prescribing:

We have not had any details since December of our drug prescribing costs. Chelmsford Prison, The Mount's pharmacy suppliers, has not produced any data discs for me to put onto a spreadsheet since then.

We can report that the number of patients on medications containing codeine or related products was down to five in June 2004, and we only had one patient on prescribed diazepam or related products. Some ex-addicts remain on clonazepine, a valium like drug, as an anti-epileptic. This drug is hardly used "on the out", but somehow it seems the anti-epileptic of choice for the prison population with assumed epilepsy, and they come in on the medication. Changing or stopping clonazepam is fiercely resisted. We will need to consult with our local neurology department should this issue become more problematic.

One patient with severe aseptic necrosis of both hips was being prescribed Morphine drug as clinically indicated. (It took three attempts to have this man admitted by Hemel for his problems). We developed a positive approach to dependency issues. Our policy is well known to the prisoners and this is making life easier all round.

Olanzapine prescribing has stabilised or may have even fallen. We are waiting for Chelsmford data to confirm this. At one time 19 prisoners on this drug were consuming 40% of our drug expenditure. See prescribing report attached.

Prescribing Charts

There will be a big bang day in August when we move all prescribing over to the computer, but still printing details out on the cards. Computer system is in place for stock keeping and pharmacy ordering when the pharmacist arrives. The pharmacist will need to attend Microtest software house for training on the prescription module.

Psychiatry, CPN services, forensic psychiatry and recidivism and rehabilitation.
Whilst the numbers of patients with well defined psychiatric disorders are relatively few, there are many with complex psycho-social issues and many with personality disorders. The Mount's resources in this field have been limited and CPN services stretched. Since the Mount is often the last stop for prisoners before their discharge a more joined up approach may be indicated bringing health and prison services together. In an ideal world there would pre-discharge case conferences with the patient, involving the whole team, as occurs when discharging patients from psychiatric hospitals. Perhaps something like this already occurs, but we do not know of them nor have any input.

Primary Care Concepts. At the beginning we found that follow up and clinical medication reviews were not being undertaken; as for some time before, the service had had to run on a day-to-day crisis mode. Many of the nurses had come from hospital medicine had and little or no primary care experience. To our alarm 2.5 nurses have left to go into primary care; our championing of the Primary Care cause did have an effect!

We feel that there has been a change in attitudes towards the prisoners, and better understanding of confidentiality issues involved since we arrived. Of course other staff changes have also had a major influence in this. Follow-up and medication reviews will be much easier to maintain once we have all the current prescriptions computerised and used by all. Follow up remains weak, and prisoners have little influence on their appointment times, and have no easy mechanism to check on their own follow up arrangements.

Secondary/Primary Care divide in prisons.

There are visiting consultants in GUM and psychiatry. The normal Primary/ Secondary divide did not apply. We have attempted to reinstate it. All clinical problems "down below" were booked automatically into to the GUM doctor (even hernias), and if a prisoner could not sleep he was booked into to see the psychiatrist. The problem with this approach was that it overloaded the consultants.
The G.P.s were expected to take on the repeat prescribing without knowledge of the patient, nor having made the referral. This is medically unacceptable; it is the doctor who signs the prescription who takes on the responsibility, even if following a prescription of a colleague. It created difficulties for us with Olanzapine in particular. See the LMC document attached which outlines these issues in detail.

Number of appointments seen by doctors.

The G.P.s have not been able to handle or see as many patients as they could in the short times they are in the building. Support for the G.P.s attending had not been seen as a priority task in health. The health unit had, over the years, become unused to having doctors in the house. There were none of the support systems that are available in standard G.P. practices. There has been lack of equipment such as sphygmometers, spirometers, auroscopes and their sterile heads, ophthalmoscopes, batteries in the right place in the doctor's room, if anywhere. There is always a lack of correct forms in the room. The doctor is his or her own GOFER with the prisoner in train. We could seldom find any nurse free to delegate the work to or to follow up the patient. There has been no preparation for minor operations, nor aftercare and clearing up, so this was very much DIY surgery. All this made us very slow. Requests for blood tests would take weeks to be undertaken, and results not chased up. We found it better to take blood ourselves there and then, having walked about after the blood letting equipment to do so. There has been a lack of secretarial support. These issues are all now being addressed.

Quality and Outcome Frameworks and NSFs

Reports in these areas depend on data getting onto the computer systems. Turnover is high and age group relatively young. The number of patients with the chronic diseases of the GMS contract is relatively small, and the prisoners do not stay long enough to collect the indicators. More relevant outcome measures should be applied for this population. The standard new GMS reports will not make sense: it will not be able to give figures of cholesterol every 15 months as prisoners move on. Targets on Hepatitis B and C status would be more useful, and forms of prescribing monitoring.

Critical Incidence Reporting

We have instigated this and now Gill Salsbury has formally taken this over. We have had a handful of clinical scrapes which can be boiled down to lack of follow up systems, failures of chronic disease management and cancelled appointments. We have rescued the situations on all occasions, but need to work on prevention.

Death in custody.

This has been subject to formal reports. Patient found dead from a myocardial infarction a day after arrival in the Mount. It is unlikely that any interventions at reception could have prevented this, although it is making us consider how to improve the reception procedures, which are not normally part of Archway's contract.

The Next Stages

Archway Priority: Staff usage of Computer: Starting August

Archway Priority 2: Appointments

Move to full appointment system with slots available on the day. A suggestion already made is that Prisoners could ring in to speak to the staff for results, make enquiries and be able to book appointments, as occurs in outside G.P. surgeries. We could start with the enhanced wings first. We are puzzled by waiting lists to attend us are maintained on the wings. Using the computer for appointments would highlight defaulters and enable follow up of critical conditions.

Out of Hours Cover

Harmoni are taking over NHS Out of Hours in Dacorum from 1st October 2004. NHS G.P.s will no longer be responsible for the care of their practice patients between 6.30pm to 8am and all weekends and bank holidays. Dr Khan has used Primecare Out of Hours services to cover when he is away, and Primecare doctors do visit the prison. Both of us have used Primecare as the last stop should there have been difficulties getting to HMP. We have discussed the Harmoni contract with the PCT. We understand that Harmoni is contracted to offer Out of Hours services for the entire population in Dacorum and this includes the prison.

Harmoni could take and vet the calls, acting as an answering service at the very least. This would solve the Mount's problem of finding and ringing the right telephone number. Harmoni could not cope, nor can any Out of Hours service, with the current contractual arrangement in which the Governor on duty can demand that a doctor attends whether clinically indicated or not. For this reason Drs Bulger and Khan will have to remain on call, hopefully as second on call, until new contracts in 2005. There may be a need to develop an on-call service that can provide minor in-house minor injury services such as burns, assessment of bony injuries (X-rays are available on site twice weekly) and to perform suturing out of hours. This may still be cheaper for the prison than escorting patients to hospital for minor injuries.

Review of Current Contract Price for this year and our final year.

We never heard any further about increasing the current contract price. We have already put in a bid for a further £10,000 per annum to bring us somewhere towards current G.P. rates for the work we currently do and our current work-time commitment.

Long Term Plan

At one time Archway considered putting in a bid to run more of the Mount's Health service, starting with pharmacy services, as if we were a dispensing practice with a pharmacist. This was not taken up.

The PCT wishes to take over the Archway Prison Contract by April 2005.
We have not heard if the PCT intends to take over Dr Khan's afternoon and alternate night cover contract. It would seem odd if they take over one contract but not the other. Archway did consider and discuss with Dr Khan the idea of employing Dr Khan as part of our contract, but his pension arrangements prevented that occurring.

Archway's current contract with HMP ends in September 2005. Dr Bulger and Crabtree are keen to continue with their prison work.

We understand that the PCT is considering a full review of prison provision with a view to offering tenders for a complete service. That approach, on its own, could perpetuate the isolation of prison medical services from Primary Care. On the other hand prisoners cannot come onto a practice's list. Prisoners NHS notes would be called up from their G.P.s. If prisoners were on practice's lists prescribing costs would go up as FP10 prescribing is much more costly than in house dispensing (no dispensing fees and drug cost mark-up). Prisoners could then demand a choice of doctor or practice.

An approach the PCT may consider is that the PCT take over the contract for Prison Services and then enter into a single joint Prison and Archway/Surgery PMS contract as a single entity.

A further development on that line is that it became a single PCT PMS project. The surgery and prison services could be integrated as a PCT Primary Care Service/PMS project, with staff moving freely between the two parts. The doctors and surgery staff would be in the direct employ of the PCT (salaried) as would be the prison healthcare staff. This would ensure that modern primary care standards pertain to both the Prison and to Archway Practice. It would also help with recruitment and prevent professional isolation. We could lease back the archway surgery building and contents. Dr Bulger could take on a more part-time role if the PCT so desired.

A Surgery/Prison Health/PCT merger under PCT management would also help cement the relationship between the Mount and local community. I have no doubt that it would have the enthusiastic approval of the DH.

Comparison costs:

Archway Surgery, covering over 2,600 patients (2,800 a year allowing for turnover) has a budget, including drugs and buildings of about £500,000. The Mounts' health budget for 750+ patients (1,200+ a year) is nearly £1,000,000 excluding buildings. There are huge opportunities to use these funds more effectively if the service was run more on primary care/PCT lines. Prison care will always be more expensive because of the security issues, and prisoners do have special needs. They cannot access OTC medicines, nor can they simply turn up in casualty, and they require more extensive psycho-social care.

Addenda

Drug and Therapeutics HMP The Mount

GB Memo January 2004

HMP The Mount has a relatively low turnover of inmates amongst prisons.
The focus of our activities is the management of chronic diseases, personality disorder and dependency syndromes. Actively treating patients may help reduce recidivism.

Pressures on Prescribing:

Age Distribution
21-24 21 %
25-34 48 %
35-44 24 %
45-54 5 %
55-64 1.5% (24 during 2002-2003)
65-74 0.5% (6 during 2002-2003)

The NHS uses "ASTRO P.U.s to calculate a prescribing list size based on the number of temporary residents, as a reflection of turnover, and on the age profile. Over 65s count as 3 younger patients as far as NHS drug costing are concerned. We do not have and ASRO PU figure for the Mount. We do not have any of the standard Prescription Pricing Authority reports that G.P. have been receiving since the 1980s. These reports can be broken down to every tablet dispensed. G.P.s are used to this monitoring and had incentives based on the PPA reports. Secondary care, hospital and psychiatric services do not have such systems in place.

The Mount, being close to London has a large proportion of black and Asian prisoners. This raises the prevalence of hypertension, diabetes, heart disease. We will also have increase in other more unusual associated diseases such as sickle cell disease and sarcoidosis.

Diabetics (10 patients) and hypertensives (30) require polypharmacy under modern guidelines.

60% of prisoners screened in health are smokers.
58% of those screened in health have or had a drug problem. (The attendance rates of such people makes it seem much more!)

The incidence of psychiatric diseases is high in accordance with national studies.

Prisoners arriving here should have been detoxified by the time they get to us.
Patients with major schizophrenia are in the main housed elsewhere. We have seen a change in the personality types coming here over the last year which has put a major strain on our psychiatric services

The G.P.s employed are obliged to work to the National Service Frameworks and Quality Standards. We are to apply the same principles as we apply to our GMS/PMS contracts. This not only generates work in data gathering but is bound increases the numbers of problems found.

We are prescribing something to 40% of our prison population. Over 40% of the patients at Archway surgery have had a prescription within 3 months. Archway is a low prescribing practice (17% below National Average).

Primary care takes on the responsibility of prescribing as we have to offer the 24/7 cover and do much of the repeat prescribing. The legal responsibilities between primary and secondary care are outlined in the Local Medical Committee Document which is given below.

Systems we have in place for review of repeat prescribing is weak. That is one of the imperatives for introducing the pharmacist and to use the computerised prescribing system and dispensing as occurs in the rest of primary care.

Risk Prescribing

Overdose is an unusual method of suicide in the prison service. However the Pharmacy Service in Prisons document suggest we should move to original pack dispensing, which for the most part is monthly supplies.

Only one was recorded in the report on prison suicides, and he used amitriptyline. Ian Huntley used the same drug. This is the most risky drug we dispense. In the Seg there was a prisoner who had collected 120 tablets, to sell rather than take. Last year in one month we prescribed enough to kill 29 people. These are useful drugs for chronic pain, and for that matter depression. We could move to lofepramine and to the SSRIs and restrict the rest to short supplies. Chronic neuropathic pain can be treated expensively with gabapentin and with (cheaper) carbamazepine.

Paracetamol is risky. As few as 15 taken at once could kill but normally it takes 150mg/kg is dangerous. It is easy to collect large quantities of that drug.

The staff should have access to a ranking of other drugs in order of risk. I have not found a simple list, but it would be useful.

We have a murderer who has some extremely effective poisons in his cell used for his severe rare condition, we hope.

Response to overdose is usually to send the patient to hospital as we can never be certain that nothing else was taken, especially paracetamol or a tricyclic such as amitriptyline.

Prescribing and The Dependency Personality

At the Mount the prisoners should be clean and detoxified. We are left some patients on diazepam. There are no indications for long term diazepam and all should be slowly withdrawn. We have a protocol to do this. Long term Diazepam causes aggression. It does not have a role in backache. Since we have such a large number of patients who have dependency disorders there are huge risks in starting it, or rather restarting it, with any patient. There is a market for the drug in the prison.

Codeine Drugs and Co-Proxamol,

In the syndrome of Chronic Daily headache, it is analgesics, particularly codeine has been shown to cause and perpetuate the condition. This effect may occur with backache. Long term use of these drugs is not indicated. The St. Thomas' hospital team managing chronic pain syndromes stop ALL medication. Our favoured combination drugs (co-proxamol) are labelled "less suitable for prescribing" in the BNF. We should resist prescribing "Co"-anything and avoid codeine and DF118. *(These products are hardly ever used now 4/2004)*

Doctors find themselves perpetuating the dependency syndrome with various prescriptions. We should avoid all prescribing to remove the belief that something taken will resolve the prisoner's problems. The converse is true. We just give them another problem, the tablet. Sometime our prescribing must be frustrating to the CARATS team who expect their clients to be drug free. Their dependency is still evident if we are prescribing. We need to be humane in how we withdraw long term drugs, especially in the case of diazepam which can take weeks to remove.

For severe pain, such as necrosis of the hip the use of a narcotic patch e.g. (Fentanyl) treatment may be a sensible but expensive option. The patch is stuck on in health and the old one patch returned before the next is stuck on 72 hours later.

Schizophrenia

We have relatively few of these patients, and the new atypical drugs are such as Olanzapine. NICE has specific guidelines on the use of these drugs. They are not indicated for general anxiety or for personality disorder of for the dependency personalities. Fortunately the drug seems to have got a little cheaper recently, and now only takes a third of our drugs budget on just 29 patients (November 2003)

Personality Disorders

"Personality disorder: No longer a diagnosis of exclusion". The implication of that document is that the prison becomes a therapeutic centre. There is little positive evidence on what really works in treating this varied group. If anything Carbamazepine may be the drug of choice.

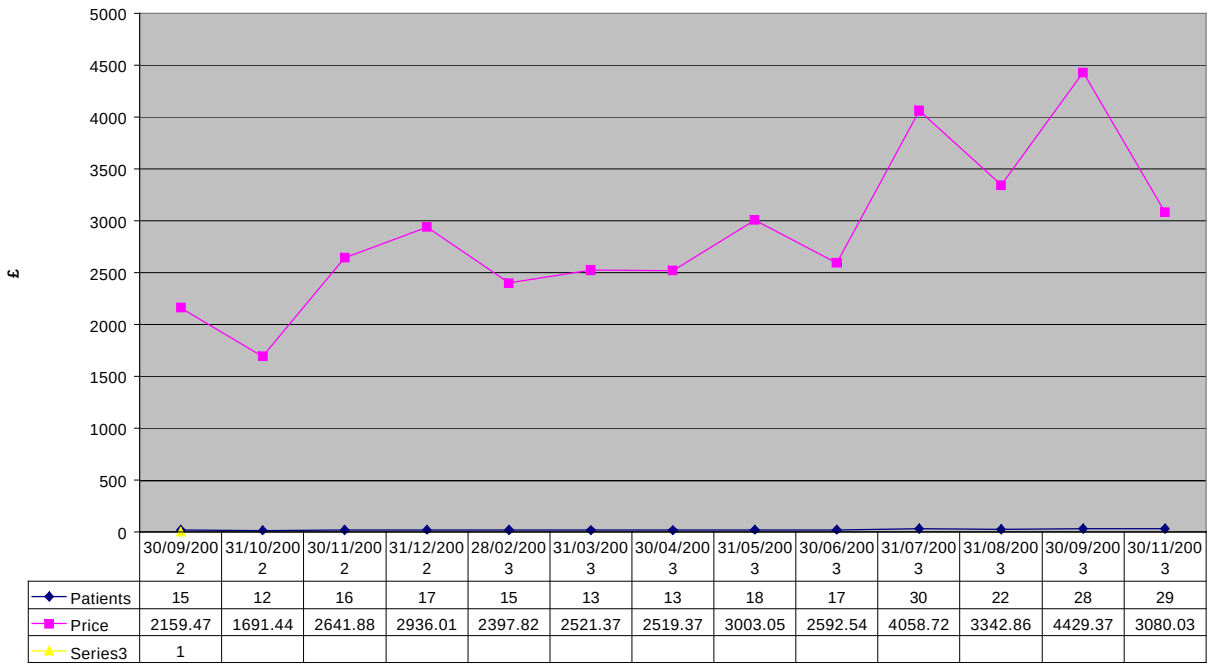
Prevalence of psychiatric disorder and self-harm in sentenced prisoners			
Singleton N, Meltzer H, Gatward R, Coid J, Deasy D. Psychiatric Morbidity of Prisoners in England and Wales. London: ONS, 1998 Aimed to provide baseline information about the prevalence of psychiatric disorders in prisons in order to inform policy decisions about services			
Disorder or condition	**Population**	**Prevalence of men (%)**	**Prevalence of women (%)**
Any schizophrenic or delusional disorder (b)	studied 1121 men and 584 women aged 16-64 years in a random, national sample of all prisons	6	13
Affective psychosis (b)		1	2
Neurotic disorders		40	63
Personality disorder (b)		64	50
Alcohol dependence (a)		30	19
Drug dependence (opiates, stimulants or both)		34	36
Suicide attempt in the last year		7	16
Self-harm (not a suicide attempt) in the current prison term		7	10
a Measured as AUDIT = 30.			
b Prevalence of schizophrenic or delusional disorders, affective psychosis and personality disorder was made from a combined sentenced and remand female sample.			

Addenda

Most Expensive "Patients" November 2003

THE MOUNT STOCK	1044.59)			
(Blank)	735.75)	=	1780.34	19.2% of our cost not identified to patients
M1	381.94			
M 2	297.29			
M 3	293.08			
M 4	250.93			
M 5	243.08			
M 6	206.8			
M 7	205.54			
M 8	200.12			
M 9	196.85			
M 10	195.92			
M 11	195.52			
M 12	189.84			
M 13	176.02			
	155.89			

Olanzipine Costs



	30/09/2002	31/10/2002	30/11/2002	31/12/2002	28/02/2003	31/03/2003	30/04/2003	31/05/2003	30/06/2003	31/07/2003	31/08/2003	30/09/2003	30/11/2003
Patients	15	12	16	17	15	13	13	18	17	30	22	28	29
Price	2159.47	1691.44	2641.88	2936.01	2397.82	2521.37	2519.37	3003.05	2592.54	4058.72	3342.86	4429.37	3080.03
Series3	1												

Table of All prescribing by Cost November 2003

Sum of £ Cost November 2003	
Drug name	Total
OLANZAPINE(ZYPREXA) 10MG TABLETS	2663.66
MIRTAZAPINE(ZISPIN) 30MG TABLETS	337.53
FENTANYL(DUROGESIC) 50 5mcg PATCH	325.86
ROFECOXIB(VIOXX) 12.5MG TABLETS	305.32
RISPERDAL 3MG TABLETS	302.3
SENNA(SENOKOT) SYRUP 100ML	295.4
OLANZAPINE(ZYPREXA) 7.5MG TABLETS	293.08
OMEPRAZOLE(LOSEC) 20MG CAPSULES	260.6
RISPERDAL CONSTA 25MG INJECTION	249.99
GABAPENTIN(NEURONTIN) 300MG CAPSULES	248.74
CUP VENDING DISP.	228.9
SIMVASTATIN(ZOCOR) 20MG TABLETS	180.14
DIAZEPAM 5MG/5ML SYRUP 100ML	162.7
LANSOPRAZOLE(ZOTON) 30MG CAPSULES	134.28
OLANZAPINE(ZYPREXA) 5MG TABLETS	123.56
ZOVIRAX 5% CREAM 2G	109.8
QUETIAPINE(SEROQUEL) 100MG TABLETS	95.4
ROSIGLITAZONE(AVANDIA) 4MG TABLETS	80.6
SALBUTAMOL INHALER 100mcg 200 DOSE	77.42
IBUPROFEN 400MG TABLETS	75.7
TAMSULOSIN HCL(FLOMAX) MR CAPSULES	68.13
AMISULPRIDE(SOLIAN) 200MG TABLETS	62
CITALOPRAM HYDROBROMIDE(CIPRAMIL) 20MG	60
LIQUIBAND TISSUE ADHESIVE 0.5G	56.21
LOSARTAN POTASSIUM(COZAAR) 50MG TABLET	52.49
PARAMAX TABLETS	50.43
AMOXIL 250MG CAPSULES	50.32
SERTRALINE(LUSTRAL) 50MG TABLETS	49.4
LEVETIRACETAM(KEPPRA) 500MG TABLETS	46.6
AMITRIPTYLINE 50MG TABLETS	44.83
NALTREXONE(NALOREX) 50MG TABLETS	42.91
ORLISTAT(XENICAL) 120MG CAPSULES	41.56
TRAZODONE HCL(MOLIPAXIN) 100MG CAPSULE	40.83
IBUPROFEN 400MG S/C TABLETS	39.66
CHLORAL HYDRATE 500MG/5ML SYRUP	38.67
LOFEPRAMINE 70MG TABLETS	37.6
ETHILON P NEEDLE CURVE CUT 16mm W1616T	36.88
AMLODIPINE BESYLATE(ISTIN) 5MG TABLETS	36.75
BECLOMETHASONE 100mcg INH	36.6
TRAMADOL HCL(ZYDOL) SR 100MG TABLET	34.88
ATORVASTATIN(LIPITOR) 10MG TABLETS	32.36
AMLODIPINE BESYLATE(ISTIN) 10MG TABLET	31.78
ADVANTAGE II GLUCOSE TESTING STRIPS	30.84
DOVONEX OINTMENT 120G	29.16
SEREVENT 25mcg INHALER 120 DOSE	29
VENLAFAXINE HCL(EFEXOR) 75MG TABLETS	28.17
TINADERM CREAM 15G	28.16
DIHYDROCODEINE(DHC) CONTINUS M/R 60MG	27.56
CANESTEN CREAM 20G	26.48
E45 CREAM 500G	26.4
TRAZODONE HCL(MOLIPAXIN) 150MG TABLETS	25.96
LOCERYL NAIL LACQUER 5ML	25.4
HYDROXYUREA(HYDREA) 500MG CAPSULES	24.22
QUINODERM CREAM 25G	24.2
PANTOPRAZOLE(PROTIUM) 40MG E/C TABLETS	24.05
IBUPROFEN(IBULEVE) GEL 30G	23.58
GLIMEPIRIDE(AMARYL) 3MG TABLETS	23.08
PARACETAMOL 500MG TABLETS	22.96
PROCTOSEDYL OINTMENT 30G	22.59
ZINERYT LOTION	22.47
SUTURE PACK DISP.	20.74
ERYTHROMYCIN 250MG E/C TABLETS	20.63
GAVISCON 250 TABLETS LEMON	19.52
PULMICORT INHALER 200 DOSE	19.4
PEPPERMINT OIL(COLPERMIN) CAPSULES	19.22
ERYTHROMYCIN 250MG E/C F/C TABLETS	18.96
SODIUM VALPROATE 200MG TABLETS	18.42
CHLORPROMAZINE 100MG TABLETS	18.26
BONJELA GEL 15G	18.08
DICLOFENAC 50MG TABLETS	18.05
CELECOXIB(CELEBREX) 100MG CAPSULES	18
MED CUPS	17.98
OMEPRAZOLE(LOSEC) 10MG CAPSULES	17.42
GLICLAZIDE(DIAMICRON) 80MG TABLETS	17.2
DIAZEPAM 10MG TABLETS	17.15
AMITRIPTYLINE 25MG TABLETS	17.09
ESCITALOPRAM(CIPRALEX) 10MG TABLETS	16.43
CO-PROXAMOL 32.5/325MG TABLETS	16.35
PROCYCLIDINE HCL(ARPICOLIN) 5MG/5ML SY	16.31
PROCYCLIDINE 5MG TABLETS	15.94
ECONACORT CREAM 30G	15.9
CYMEX CREAM 5G	15.68
FLUPENTHIXOL DECAN'T(DEPIXOL-CONC) 50M	15.48
NAPROXEN 500MG TABLETS	15.42
LODINE 600MG S/R TABLETS	15.26
ANUSOL SUPPOSITORIES	15.04
MEDISENSE G2 GLUCOSE TEST STRIP	14.54
SOFT WHITE PARAFFIN BP 500G	14
AMITRIPTYLINE 50MG/5ML SYRUP	13.9
SULINDAC(CLINORIL) 200MG TABLETS	12.5
LANSOPRAZOLE(ZOTON) 15MG CAPSULES	12.41
CLEMASTINE(TAVEGIL) 1MG TABLETS	12.27
DIORALYTE SACHETS PLAIN	12.16
ANUSOL CREAM 23G	11.62
TERBUTALINE SULPH(BRICANYL) INHALER	11.52
LYCLEAR DERMAL CREAM 30G	11.44
NIZORAL 20MG/ML SHAMPOO 120ML	11.12

DALACIN T TOPICAL LOTION 30ML	10.96	ACICLOVIR 200MG TABLETS	5.4
DOXAZOSIN(CARDURA) 1MG TABLETS	10.96	TOT PLASTIC	5.32
PROCTOSEDYL SUPPOSITORIES	10.86	RANITIDINE 150MG TABLETS BP	5.27
ELOCON OINTMENT 30G	10.56	PROPRANOLOL LA (HALF) 80mg CAP	5.26
METFORMIN 500MG TABLETS	10.53	OILATUM GEL 125G	5.24
BETNOVATE SCALP APPLICATION	10.38	METRONIDAZOLE 200MG TABLETS	5.22
PAROXETINE(SEROXAT) 20MG TABLETS	10.33	ZOPICLONE(ZIMOVANE) 7.5MG TABLETS	5.11
SODIUM BICARBONATE EAR DROPS 10ML	10.26	FAST-AID WASHPROOF PLASTERS ASSORTED	4.91
PURIFIED WATER BP	10.2	PIZOTIFEN(SANOMIGRAN) 1.5MG TABLETS	4.68
CITALOPRAM 10MG TABLETS	10.04	ASPIRIN 75MG DISPERSIBLE TABLETS	4.67
PIZOTIFEN(SANOMIGRAN) 500mcg TABLETS	10	SUDOCREM CREAM 25G	4.6
RAMIPRIL(TRITACE) 5MG CAPSULES	9.95	MOVELAT GEL 100G	4.54
GAVISCON 250 TABLETS PEPPERMINT	9.76	DICLOFENAC (VOLTAROL) 75MG/3ML INJ	4.53
FLUOXETINE(PROZAC) 20MG CAPSULES	9.73	BECLOMETHASONE 50mcg AQUEOUS NASAL SPR	4.41
TYLEX 30/500MG CAPSULES	9.6	GAVISCON ADVANCE LIQUID 500ML	4.2
FLUPHENAZINE(MODECATE) 100MG/ML CONC 1	9.5	GLICLAZIDE(DIAMICRON) MR 30MG TABLETS	4.16
PLASTIC BOTTLE 500ML	9.45	FAST AID BLUE EYETECH 2.5X7.6	4.05
NAPROXEN 250MG TABLETS	9.42	BETNOVATE-C CREAM 30G	3.84
AZITHROMYCIN DIHYDRATE(ZITHROMAX) 250M	9.35	ASPIRIN 75MG E/C TABLETS	3.82
SCHOLL SOFTGRIP CL2 B/K CT SAND MED	9.17	CARNATION CORN CAPS	3.78
SYNALAR GEL 30G	8.91	AMOXYCILLIN 3G POWDER S/F	3.75
LACTULOSE SOLUTION BP	8.9	ALPHOSYL HC CREAM 100G	3.62
COMBIVENT MDI 200 DOSE	8.8	T-GEL SHAMPOO 125ML	3.58
B-D PEN NEEDLES MICRO-FINE 8mm	8.67	CLONIDINE HCL(CATAPRES) 100mcg TABLETS	3.54
CETIRIZINE(ZIRTEK) 10MG TABLETS	8.55	HYDROCORTISONE 1% CREAM 30G	3.36
TRAMADOL HCL(ZYDOL) 50MG CAPSULES	8.33	DEXAMETHASONE(ALCON) MAXIDEX EYE DROPS	3.35
CHLORPHENIRAMINE 4MG TABLETS	8.25	SERTRALINE(LUSTRAL) 100MG TABLETS	3.24
EMLA CREAM DRUG TARIFF PACK 5G TUBE	8.2	DOXYCYCLINE 100MG CAPSULES	3.21
SOFTCLIX(=ACCU-CHEK) LANCETS	8.09	ALLOPURINOL 300MG TABLETS	3.2
EMULSIFYING OINTMENT 500ML	7.9	FLUCLOXACILLIN(FLUCLOXIN) 250MG CAPSUL	3.2
BENDROFLUAZIDE 2.5MG TABLETS	7.32	FLUCLOXACILLIN 500MG CAPSULES	3.19
AQUEOUS CREAM BP 100ML	7.18	OILATUM EMOLLIENT 250ML	3.15
SELSUN DANDRUFF TREATMENT 100ML	7.05	DIAZEPAM 5MG TABLETS	3.09
MINOCYCLINE(MINOCIN) MR 100MG CAPSULES	6.99	LOPERAMIDE 2MG CAPSULES	3.09
CARBAMAZEPINE(TEGRETOL) 200MG TABLETS	6.8	CALCICHEW 500MG CHEWABLE TABLETS	3.01
KETOPROFEN GEL 100g	6.65	VITAMINS CAPSULES BPC	2.97
GLYCERYL TRINITRATE(GLYTRIN) SPRAY	6.6	AMOXYCILLIN(AMOXIL) 500MG CAPSULES	2.96
SOFT PARAFFIN BP 15G	6.44	WATER FOR INJECTIONS 5ML	2.96
CANESTEN-HC CREAM 30G	6.26	LISINOPRIL(ZESTRIL) 2.5MG TABLETS	2.9
ETODOLAC 300MG CAPSULES	6.19	BISOPROLOL FUMARATE(MONOCOR) 5MG TABLE	2.87
AQUEOUS BP CREAM 500G	6.12	TRIMETHOPRIM 200MG TABLETS	2.82
MOUTHWASH EFFERVESCENT TABLETS	6	SODIUM CHLORIDE EYE DROPS 0.9% 10ML	2.81
FLUPENTHIXOL DECAN'T(DEPIXOL) 40MG/2ML	5.86	DIPROBASE CREAM PUMP DISPENSER 500G	2.76
DIHYDROCODEINE 30MG TABLETS	5.84	PREDNISOLONE 5MG TABLETS E/C	2.74
POLYTAR LIQUID/SHAMPOO 150ML	5.82	CUPLEX GEL 5G	2.63
CALCICHEW-D3 FORTE TABLETS CHEWABLE	5.72	HYPROMELLOSE BPC 0.3% EYE DROPS 10ML	2.52
CAPASAL THERAPEUTIC SHAMPOO	5.68	MEBEVERINE 135MG TABLETS	2.5
ATENOLOL 50MG TABLETS	5.6	METRONIDAZOLE 400MG TABLETS	2.49
FLUPHENAZINE DECANOATE 25MG/1ML INJECT	5.58	DOMPERIDONE(MOTILIUM) 10MG TABLETS	2.44
INFLUENZA VACCINE(INFLUVAC) DISPOSABLE	5.48	METHOTREXATE 2.5MG TABLETS	2.39
DOTHIEPIN HCL 75MG TABLETS	5.46	PROCHLORPERAZINE 5MG TABLETS	2.33
PROPRANOLOL 40MG TABLETS	5.43	SALACTOL WART PAINT 10ML	2.33

LACRI-LUBE OPHTHALMIC OINTMENT 3.5G	2.3
PROMETHAZINE HCL(PHENERGAN) 25MG TAB	2.28
PARAFFIN LIQUID/SOFT WHITE 50%	2.27
FERROUS SULPHATE 200MG TABLETS	2.2
PEN TORCH	2.14
VERNAID STERILE DRESSING PACK	2.12
CALAMINE AQUEOUS CREAM BP	2.1
CO-CODAMOL 8/500MG TABLETS	2.06
SENNA(SENOKOT) TABLETS	1.98
MICRO GREEN 21Gx1.5" 304432	1.95
BETNOVATE CREAM 30G	1.94
NASEPTIN CREAM 15G	1.88
NEBULISER KIT	1.8
BATTERY MN1400	1.72
PREDSOL EYE/EAR DROPS 10ML	1.71
CO-DYDRAMOL 10/500MG TABLETS	1.7
ATENOLOL 25MG TABLETS	1.68
ETHILON SUTURE N/AB STER POLY W320	1.48
ETHILON NEEDLE CURVE REVERSE 19mm W319	1.41
SYRINGE 5ML	1.2
B-D SINGLE USE INS SYR 1ML U100	1.18
OXYTETRACYCLINE 250MG TABLETS	1.16
CARBAMAZEPINE(TEGRETOL) RETARD 200MG T	1.06
BATTERY AA MN1500	1
SYRINGE 2ML	1
BUTTERFLY BLUE	0.92
BUTTERFLY GREEN	0.92
AMITRIPTYLINE(TRYPTIZOL) 10MG TABLETS	0.9
ATENOLOL 100MG TABLETS	0.87
DOTHIEPIN 25MG CAPSULES	0.85
GLIBENCLAMIDE 5MG TABLETS	0.84
TONGUE DEPRESSOR	0.83
AMOXYCILLIN 250MG CAPSULES	0.77
LISINOPRIL(ZESTRIL) 5MG TABLETS	0.68
ISOSORBIDE MONONITRATE 20MG TABLETS	0.66
ORPHENADRINE HCL(DISIPAL) 50MG TABLETS	0.57
DIAZEPAM 2MG TABLETS	0.47
Grand Total November 2003	9259.85

Reading:

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5. The Prison Medical Service in England and Wales. In: Recruitment and training of doctors. London: Home Office and Department of Health, 1989.
6. Royal College of Physicians, Royal College of General Practitioners, Royal College of Psychiatrists.
7. Report of the working party of three medical royal colleges on the education and training of doctors in the Health Care Service for prisoners. London: Home Office, 1992.
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9. Joint Prison Service and National Health Service Executive Working Group. The future organisation of prison healthcare. London: Department of Health, 1999.
10. Department of Health. Report of the working group on doctors working in prisons. London: Department of Health, 2001.
11. Department of Health. Nursing in prisons. Report by the working group considering the development of prison nursing, with particular reference to health care officers. London: Department of Health, 2000.
12. Department of Health. Changing the outlook. A strategy for developing and modernising mental health services in prisons. London: Department of Health, 2001.
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14. Safer Prisons 2003: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness:
15. Beds and Herts Local Medical Committee: Prescribing. Letter to Consultants.
16. Select Committee on Home Affairs Second Special Report 2002
17. Professor C Heath Ashton Newcastle University Diazepam withdrawal (email) 2003/4
18. British National Formulary 2003
19. Luke Birmingham, senior lecturer in forensic psychiatry BMJ papers 2000-2003
20. Department of Health: Drug Misuse and Dependence – Guidelines on Clinical Management
21. NIMHE Personality disorder: No longer a diagnosis of exclusion 2003
22. Prescription Pricing Authority Data systems: http://www.ppa.org.uk/index_noflash.htm
23. http://www.benzact.org/crime.htm http://www.benzo.org.uk/manual/index.htm

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Diazepam and other related drugs called Benzodiazepines.

There is no medical reason for long term diazepam and their like. This is stated in all medical references. Diazepam does not work for anxiety in the long term and it does not work to relieve backache spasm. We do not use diazepam that way on the outside in our GP practices. These tablets cause harm to patients, quite apart from the drug's habit forming potential.

If you have been on diazepam long term your agitation and anxiety state is now likely to be DUE to the drug. Diazepam could be making you aggressive.

Coming off the drug is difficult. The Health Care Team will be working with you to come off diazepam. Do not panic; there is not going to be any sudden withdrawal of the diazepam. We shall take this slowly.

Liberating you from this drug will enhance your life on the outside. Currently you will find that your problems are ignored while everyone fusses about the diazepam. Get you off that drug and you can be seen for the problems and difficulties you faced, which may have got you on the drug in the first place.

After taking a Diazepam tablet, the levels in the blood take 200 hours, over 8 days, to fall to half its the peak. Diazepam lasts so long in the blood that it makes no sense to take the medication 3 times a day. Firstly get onto a single daily dose. Part of your addiction ritual is to believe that you need a dose at specific times. It is not working like that.

The Regime is a modified version of Professor C Heath Ashton's regime, Newcastle University. Much of below is taken from her web site

Firstly we would get you onto daily prescribing. We could even try a slightly increased dose if you find it uncomfortable, but usually a lower dose is required.

The larger the dose you are taking initially, the greater the size of each dose reduction can be. You could aim at reducing dosage by up to one tenth at each decrement.

40mg diazepam equivalent you would reduce at first by 4mg every week or two. When you are down to 20mg, reductions could be 2mg weekly.

When you are down to 10mg, you go down in 1mg steps.

We will be flexible and to be ready for your schedule to be adjusted to a slower (or faster) pace at any time, but remember you are coming off Diazepam and no step will last more than two weeks. Neither of us will go backwards. You don't want to back over ground you have already covered.

Avoid finding extra in times of stress. Learn to gain control over your symptoms. This will give you extra confidence that you can cope without benzodiazepines. Avoid compensating for benzodiazepines by increasing your intake of alcohol, cannabis or non-prescription drugs. Do not take the sleeping tablets such as zopiclone as they have the same actions as benzodiazepines.

Getting off the last dose:
Stopping the last few milligrams is often viewed as particularly difficult. This is mainly due to fear of how you will cope without any drug at all. In fact, the final parting is surprisingly easy. People are usually delighted by the new sense of freedom gained. 1mg diazepam per day which you are taking at the end of your schedule is having little effect apart from keeping the dependence going. Do not be tempted to spin out the withdrawal to a ridiculously slow rate towards the end. Take the plunge when you reach 0.5mg daily; full recovery cannot begin until you have got off your tablets completely. Do not become obsessed with your withdrawal schedule. Let it just become a normal way of life.

AGGRESSION, VIOLENCE AND BENZODIAZEPINES

1980 - A woman stabbed her husband to death after taking prescribed doses of diazepam (Valium). After hearing expert medical evidence from Professor Michael Rawlins that diazepam induces aggressive outbursts, the jury acquitted the defendant completely.

"Those taking benzodiazepines may show 'paradoxical behavioural responses such as increased aggression and hostility, uncharacteristic petty criminal activities such as shoplifting, sexual improprieties or offences such as importuning or self-exposure, and excessive emotional responses such as uncontrollable weeping or giggling."
Professor Malcolm Lader
Consultant Psychiatrist, Royal Madsley Hospital.
(C) Drug Notes, ISDD, 1993
Aggression and violent behaviour: induced by prescribed benzodiazepine use is well documented and widely reported.

Crime and benzodiazepines: Reports of a link between Benzodiazepines and crime are growing. Reports from drug misuse agencies of BDZs used specifically when committing crimes are described as "cloak of invisibility" or similar. due to their behavioural effects.

34% of arrestees tested positive for benzodiazepines: A recent ADAM(Arrestee Drug Abuse Monitoring),pilot study monitoring drug use in arrestees
in the Strathclyde and Fife areas of Scotland revealed high levels of **BDZ use(33%)**, second only to cannabis **(52%)**. Alcohol:**(32%)**, opiates: **(31%)** and methadone:**(12%)** .

Prisons report increased aggression:

1975, Canada 81% of inmates involved in aggressive incidents had taken diazepam (Valium) and 3.6 times as many acts of aggression occurred in inmates while on these drugs.

1978, Utah A high level of riots, stabbings, cuttings, murders, self mutilation attempted suicide were attributed, at least in part to high consumption of BDZs in a Utah State prison.

1995,Australia (New South Wales) Restriction of clonazepam(a BDZ) prescription was implemented by the Corrections Health Service of New South Wales due to it causing emotionally reactive and aggressive behaviour with self-harm and suicide attempts in inmates.

1995, UK (Parkhurst). Tranqilliser prescription (mostly BDZs) was reduced from 3.5 Kgs PA in 1990/91, to 0.15 Kgs in 1994/95, correspondingly physical assaults by inmates on another person reduced from 5 in 1990 to 0 in 1995.

"Professor Michael Rawlins said that he believed the tragedy [murder] was probably precipitated by the excessive amount (30mg) of diazepam which the defendant had consumed in the preceding twelve-hour period before her husband's death"
The Law Society Gazette, 22 July, 1987.

B.N.F: "A paradoxical increase in hostility and aggression may be reported by patients taking benzodiazepines. The effects range from talkativeness and excitement, to aggressive and antisocial acts."
British National Formulary, 2001.

"The implications of the combination of anti-anxiety agents and aggressiveness are astounding."
D.G. Cunningham, D.G.Workman.
Canadian Family Physician, Nov. 1975.

"Paradoxical aggressive outbursts are a recognised adverse effect of diazepam; they are probably caused by the suppression of mechanisms which normally inhibit aggressive outbursts."
Professor Michael Rawlins,
medical expert in court, 1980.

" Aggressive behaviour towards self and others may be precipitated".
Berk Pharmaceuticals,
ABPI Data sheet re: Diazepam, 1991.

Technical details of NHSNet Connection at Mount Prison. GVB 23/2/2004

The connection arrangements are for limited clinical functions. Mostly these occur in the background and are not used directly by the staff: Automated updates of the clinical system, pathology links and maintenance of the software. Some limited access to the internet is allowed for educational and for find NHS management documents

The clinical system is a NHS accredited system. It uses its own wiring and the computers do not touch the prison system at all. There is no connection between the two whatsoever. Thus "air gapped".

The clinical system runs Sophos antivirus software which is updated daily. The clinical system server is SCO Unix. It runs Windows client authentication using visionfs (SCO's brand of Samba).

Zyxel ISDN routers at Archway Surgery and The Mount make the connection.
The Mount router is set up as follows: The only incoming call the Mount router will accept is from the ISDN telephone number of the Archway Surgery router. The prison router drops the call and dials the surgery router back. This is a security feature and also logs all calls in and out and puts them on the one bill. Outgoing calls can only be made to the surgery router telephone number (CLI). No other connections are possible. All calls use CHAPs protocol encrypted passwords (challenge handshake, the password itself does not traverse the telephone line). The router has a firewall. The Mount router has only one route between the two networks. There is no route to the internet or anywhere else.

At The Mount the clinical client machines do not have a direct connection to the internet, nor to the router, but run NHSNet web page and internet web page requests through a proxy server that does have a route to the router. (This approach also helps reduce false dialups caused by windows packets seeking the outside world) The proxy server can list all connection made to the internet, and we view these to show that there is no abuse.

The proxy server at the Mount is restricted and will not pass many internet protocols such as chat, messaging and messenger alerts. It will not pass video streams. This will not affect the legitimate uses of the service. The proxy server at the mount passes the web requests to another proxy server at Archway Surgery (apache on SCO Unix). That proxy server passes to web requests out to the NHS BT managed fire walled router out to NHSNet.

The NHS Net connection is behind a class b address and NAT. No connections whatsoever can be made to that router by anyone on the internet. The only addresses that can access the network are the accredited software supplier within the NHSnet. BT NHS Net team can access the router only. I have no access to that router.

NHS Net email uses 128 encryption so will be safe for passing clinical details between The Mount and hospitals and G.P.s.

ADDENDA

LMC GUIDANCE ON GPS' PRESCRIBING RESPONSIBILITIES

This summarises some of the problems which GPs encounter with prescribing requests made to them by hospital colleagues, and sets out GPs' prescribing responsibilities including the legal aspects

The Local Medical Committee, which is the statutory body representing all local NHS GPs has prepared this guidance so that there can be clarity about prescribing at the hospital/general practice interface. We hope that this may be of use to you and may help resolve prescribing problems in the best interest of our shared patients.

Common problems encountered by GPs at the primary/secondary prescribing interface include:-

- Receiving limited/inadequate information from the hospital about the patient's medication and its management.
- Being asked to prescribe new drugs and 'black triangle' drugs where the CSM requests that all suspected reactions should be reported. The medication may be outside the GP's current clinical experience.
- Being asked to prescribe a medication which is well understood, but which requires monitoring, and where the GP is not kept updated about the results of monitoring.
- Being asked to prescribe unlicensed drugs where the prescription is not within the licensed indications for the product e.g. Domperidone to promote lactation.
- Being asked to prescribed dosages which are outside the licensed range.
- Being asked to prescribe drugs, which are specifically noted in the BNF as prescribable under supervision of a specialist.
- Inconvenience to patients and GPs when the hospital does not provide the length of prescription set out in its current contract specification with the PCT.
- Inconvenience to patients and GPs where the medication requires specialist prescription, but consideration has not been given to using a hospital (FP10 (HP)) prescription which can be dispensed in any community pharmacy, in order to prevent unnecessary trips to the hospital by the patient.

Legal and contractual aspects of prescribing at the primary/secondary interface

This guidance is derived from the following documents:
i) EL (91) 127 "Responsibility for prescribing between hospitals and GPs". Reinforces that the doctor who has clinical responsibility for the patient should undertake the prescribing.
ii) Core Services. General Medical Services Committee of the BMA 1996.
iii) HSC 1998/113. Clinical governance with regard to prescribing practice.
iv) EL(95)5 Prescribing High Tech Care for patients at home.
v) The new GMS contract, National Enhanced Services specifications for near patient testing.

1 Prescriptions for unlicensed medications or the use of licensed products outside licensed conditions:

- If the use of a medication is outside the product's licensed indications, the responsibility should remain with the hospital specialist responsible for initiating and monitoring the treatment and this is reflected in the PCT contract with the Trust.
- If, rarely, an individual GP considers that they have the appropriate specialist expertise to undertake the clinical and legal responsibility to prescribe a medication outside its licensed indications, then they should discuss the implications of prescribing with their Medical Defence Organisation before prescribing.
- Informed consent should always be obtained from patients before prescribing under these circumstances.

2 Prescriptions for new licensed specialist drugs or licensed drugs for specialist conditions:

- Prescribing responsibility should remain with the hospital clinician.
- Where a GP has the specialist expertise to undertake the prescribing of a newly licensed or specialist drug, or licensed drug for specialist conditions, and wishes to take clinical and legal responsibility for prescribing, a patient specific shared care protocol should be developed.
- The GP is responsible for the clinical and legal consequences of so prescribing, even if this is undertaken within a shared care protocol.

- The patient specific shared care protocol should include the roles and responsibilities of each prescriber, how the patient will be monitored and the circumstances in which treatment will be adjusted and stopped.
- Shared care protocols which include near patient testing by GPs will, from April 2004, need to be commissioned by PCTs as an enhanced service which the practice may choose to provide (see 4).
- Shared care does not necessarily mean that the GP will prescribe, but that they will offer routine care to the patient. The GP's agreement must be sought before any transfer of care takes place.
- The General Practitioners Committee recommends that GPs who consider that they have this degree of expertise should have the skills to monitor, modify and terminate the treatment.
- If the prescribing of a medication requires interpretation of monitored results with which the GP is unfamiliar, [eg oxygen saturations for premature babies receiving oxygen at home] then the GP should not prescribe.
- The Bedfordshire and Hertfordshire Strategy & Priorities Group for New Medicines & Therapies will consider the introduction of new pharmacological treatments in Bedfordshire and Hertfordshire.
  Three committees (Bedford Therapeutics Committee, E&N Herts NHS Trust Drugs & Therapeutics Committee and West Herts Medicines Management Committee) feed into the Beds & Herts Strategy & Priorities Group and will be responsible for implementation. We expect that newly licensed drugs, introductions of drugs recommended by NICE etc, will be discussed and agreed at these committees so that there is clarity as to prescribing responsibility.

3 <u>Prescriptions for recently introduced and 'black triangle' drugs where reporting of adverse effects to the CSM is required:</u>

- All new drug treatments should be considered and approved by the appropriate Drug and Therapeutics Committee (see above).
- Hospital clinicians should not ask GPs to prescribe drugs which have not been approved by the relevant Drug and Therapeutics Committee.
- GPs who undertake these prescriptions should have sufficient knowledge to undertake full clinical and legal responsibility for the consequences of their prescribing.

4 <u>GPs' Provision of Blood test Monitoring (Near Patient Testing)</u> from April 2004

The new GMS contract provides for all GPs to choose whether to provide an enhanced service for blood test monitoring for named medications used in rheumatology. These include Penicillamine, Auranofin, Sulphasalazine, Methotrexate and Sodium Aurothiomalate. These are national arrangements and the list of medications to be monitored will be amended by national negotiation. Each PCT can decide whether to commission these enhanced services from GPs, based on a national specification of services to be provided and national minimum rates of payments to practices which choose to undertake this work.

GPs who sign an enhanced services contract with their PCT must demonstrate that they have the necessary training and competence and must be regularly appraised for these. Other GPs should not undertake this work.

5 <u>Medications prescribed within clinical trials:</u>

- GPs should be informed if a patient is participating in a clinical trial in order to respond appropriately to suspected adverse events.
- All studies should have been subject to ethical committee scrutiny.
- Prescribing should remain within the specialist centre with the facilities and staff to monitor appropriately.
- Patients should be made aware that there is no guarantee that the drug will be continued at the end of the trial.

6 <u>Medications for High Tech care for patients at home:</u>

- In line with EL95(5), the prescription of drugs and equipment for high tech treatments at home should remain with the hospital specialist. These would include medication such as Total Parenteral Nutrition (TPN) and Desferrioxamine, which usually require specialist monitoring.

Taken from LMC web site Dr Judy Gilley FRCGP Chief Executive October 2003