**Prescribing Policy on Shared Care**

GPs are often asked to prescribe medication that is not straightforward for a variety of reasons . This policy is intended as a guideline to cover some of these issues.

**1. Safety.**

GMC guidance on competency makes it clear there is an absolute and overriding duty on Doctors to make sure they are competent to safely prescribe safely. If they are unsure, they should not prescribe.

**2. Unlicensed medication**

Medication should usually be prescribed in accordance with the license issued. Prescribing medicines outside the recommendations of their marketing authorization alters and increases the prescriber’s professional responsibility and potential liability. The prescriber must be able to justify and feel competent in prescribing this way and also inform the patient or the patient’s carer that the prescribe medicine is unlicensed.

That said there are some drugs where the unlicensed (off-license) use is such well-established practice (amitriptyline for pain) that many GPs feel comfortable initiating this use and taking responsibility for it.

**3. Local guidelines.**

Many medications are restricted or prohibited under locally agreed guidelines. These restrictions have been agreed and approved under the guidance set out by NHS England by a representative local prescribing committee and save millions of pounds that is reinvested in the NHS every year. The savings are made when there are expensive drugs with unproven benefit or there is a cheaper and effective alternative. GPs locally have voluntarily signed up to these guidelines in order to save the NHS money. GPs have no financial incentive to refuse individual patients or drugs. The restriction on medications does not always apply to hospital doctors and the rules vary from one area to another which can lead to misunderstanding or confusion in patients. GPs frequently experience pressure to prescribe from patients who have been misled (unintentionally or otherwise).

Local Guideline Restrictions include:

* Restrictions on treatments of limited or unproven value.
* Restrictions on initiation of medication in primary care
* Restrictions on quantities of medication (e.g. Sildenafil generally restricted to 1/week)
* Absolute restriction of certain applications of treatment (e.g. Cialis for prostatic enlargement)
* Absolute restriction of expensive medication when an identical cheaper alternative is available
* Restriction of expensive medication until a after a cheaper alternative has been tried (e.g. Gabapentin before pregabalin, Ramipril before ARBs). In these situations it is reasonable to try the cheaper medication first.
* Absolute ban on medications or substances that it is felt it is reasonable for patients to supply themselves. For example nationally it is possible to prescribe Gluten Free products to sufferers of Coeliac disease but locally Coeliac sufferers have to purchase their own GF products from the supermarket despite being on the NHS tariff.

**4. Higher Risk Medications.**

In addition all medications have the potential for harm as well as therapeutic good. However, it is well recognised that “all medications are not equal”. Certain medications are regarded as straightforward and relatively low risk and conversely some are viewed as higher risk and prescribed with more caution. Reasons for increased caution include:

* New medication (Black triangle)
* Medication used in a new application – especially if it greatly widens its exposure increasing risks.
* Medication that potentially of higher toxicity in higher doses e.g. chemotherapy /Methotrexate
* Medication with many interactions e.g. Warfarin
* Medication with a narrow therapeutic window eg lithium
* Medication that requires monitoring (similar to examples above) with blood tests etc
* Medication that creates dependency or open to misuse e.g. Controlled Drugs (Opiates etc)
* Medication that is for severely ill patients – For example new treatments for severe heart failure – the patients are already very sick and often on multiple medications and have impaired liver or kidney function greatly altering pharmacokinetics and increasing the risk of prescribing

In these situations, GPs need to be familiar with the concerns around a particular medication and the processes and procedures in place to enable safe prescribing. As with prescribing off licence medication the responsibility remains with the prescriber. Unfortunately to complicate matters, experience has shown that medications previously considered low risk or “safe” turn out after extended use to have harmful effects. Examples such as PPIs now implicated in C Difficile infections and AKI show that any complacency in prescribing “safe medication” is misplaced.

**5. Initiation or continuation of medication in primary care.**

There are some situations where the diagnosis and assessment of a condition and the initiation of treatment is very properly that of a hospital specialist. However once treatment has been safely commenced GPs may take on the ongoing maintenance treatment. Examples would include Zoladex or Prostap injections for ongoing treatment of prostate cancer. Often it is necessary to have a shared care arrangement in place to do this.

**6. Shared care arrangements**

Shared care arrangements are where the prescribing of specialist medication is taken on by GPs for the convenience of patients. The Department of Health has advised in its guidelines on shared care between hospitals and GPs that the legal responsibility for prescribing lies with the doctor who signs the prescription. Therefore, a shared arrangement is not just a letter from a hospital issuing guidance or advice on prescribing but one that has been previously agreed in full by both parties.

**7.Private prescriptions**

The first prescription given from a private consultation is issued as a private script, whilst the consultant is the one in control of the patient’s care. This should then not be converted to an NHS script by the GP until the patient has been discharged to GP care/responsibility, which may take a bit of time.

If however, private prescriptions are for off licence medications not usually prescribed by NHS Consultants or GPs, we will then direct the patient back to their consultant to have this prescription provided.

If a new patient transferred to us is already taking medication prescribed by another general practice which is unlicensed, issued privately and not usually prescribed by NHS Consultants or GPs, we will consider this on a case by case basis, although we may have to direct the patient back to their consultant to have this prescribed.

A patient may need a prescription for medication during a period of post-operative recovery or as part of a longer term medication regime. It is the patient’s responsibility to obtain private prescriptions from the consultant in charge of their care. The patient will be responsible for paying the drug costs even though they may hold an exemption based upon medical or age grounds.

We aware that Private consultants are increasingly requesting patients to have tests done through their GP on the NHS with a request that the results are forwarded to the Private sector. If private blood test monitoring is needed, this had to be done by the private specialist.

There are two problems with this.

* 1. The requestor of the test is not receiving the result directly, and the GP is being involved in a loop they should not be involved in. This is inefficient and leads to confusion as to who should be managing the result. There are clear GMC guidelines that the person requesting a test should be following up a result and this is a safety issue for patients as they are unclear as to who is responsible.
* 2. There is an issue with probity, as the NHS should not be funding the investigations for Private consultations.

**8. GPs with specialist knowledge**

Some GPs develop highly specialist knowledge in a particular field. In some areas this training is formalised as a GPSI (GP with special interest) but often the expertise can be just appropriate knowledge and experience recognised and accredited by those in the field. Here it would be entirely appropriate for them to initiate medication that most GPs would feel is beyond their competency. Examples would include initiating methadone for drug misuse patients or Denosumab for osteoporosis. In these situations it is important that GPs work within their competency.

**9. Ethical consideration**

GPs or other HCPs (Health Care Professionals) may have an ethical concern about prescribing certain medications or treatments. For example offering the morning after pill or contraception. In line with GMC guidelines the HCPs should discuss this with the practice to ensure the impact on the patient is minimised and that alternative provision is made available.

**10. Medications that GPs may not prescribe.**

There are some situations or medications that GPs should not or simply cannot prescribe. This is for a variety of reasons that are not always understood by other professionals

* 1. Because local guidelines prohibit their use.
* 2. Because they are not on the National Formulary list that can prescribed list for GPs (e.g. Roaccutane – a pharmacist could not dispense a prescription) and so only a specialist can prescribe.
* 3. Because the NHS has blacklisted them – e.g. Valium (Branded version) – sometimes these could be prescribed privately if the GP has expertise.
* 4. Because they are not safe or because the GP does not have the expertise to prescribe in this area.

**11. Where hospital services are not available for patients:**

There is a responsibility to treat patients in a timely way and not to delay treatment. But where other NHS services are delayed or restricted this is not an excuse or reason to endanger patients by working outside one’s competency and taking on secondary care or a specialist prescribing role. GPs have a duty to alleviate suffering but the overriding duty of safety remains. Any potential harm that arises in this situation from GPs going beyond their competency would be indefensible.

In this situation we should make the needs known to the relevant commissioning authority.