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 authorisation 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 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 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).

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.

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When agreeing to take on shared care, the GP will need to be clear on the nature and responsibilities of each party of the shared care arrangement before transferring any care or prescribing. We will need to consider the following questions:

Do we feel that the prescribing and associated knowledge required falls within the scope of our team's professional competence?

Do we feel this falls within our team's workload capacity?

Are there adequate resources and sufficient capacity for the work of managing safe systems for monitoring and prescribing for this medication in our practice?

For NHS providers, are they locally commissioned or have they been approved by our ICB as working in line with UK best practice and local prescribing guidelines / shared care protocols?

For private providers are we satisfied that the provider is appropriately accredited, practicing in line with UK best practice and will prescribe and monitor patients in line with locally agreed pathways?

For those under private providers – has there been an agreement with the patient that prescribing will cease, if the patient for whatever reason, is unable to continue follow up with a private provider?

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 are 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 GPwSI (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.

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