CLMC Briefing on Clinical Prescribing

We receive many queries into the LMC office about prescribing, particularly at the request of secondary care colleagues. This is an attempt to pull our advice together into a guidance document to support safe care within your clinical practice.

The Bottom Line – The decision to prescribe is yours alone. No-one can make you prescribe something that you feel is inappropriate.

GMC Guidance

As our regulators, the demands of the GMC trump any contractual considerations or local guidance. The full GMC guidance can be found here - Good practice in prescribing and managing medicines and devices - ethical guidance summary - GMC (gmc-uk.org) This guidance applies to **all doctors in all settings**. It is equally applicable to colleagues working in secondary care as it is to those of us working in general practice.

The key parts of this guidance are:

> ***You are responsible*** *for the prescriptions that you sign. You must only prescribe drugs when you have adequate knowledge of your patient's health. And you must be satisfied that the drugs serve your patient's need.*
>
> *If you prescribe based on the recommendation of another doctor, nurse or other healthcare professional,* ***you must be satisfied that the prescription is needed, appropriate for the patient and within the limits of your competence****.*

Our contractual requirements

The GMS contract has many pages dedicated to prescribing. These largely focus on the technicalities of prescribing, with a focus on electronic prescribing and repeat dispensing. GMS Essential Services require practices to provide services appropriate to meet the **reasonable needs** of its patients, including appropriate ongoing treatment and care, **in a manner determined by the practice**. CLMC interprets this clause to mean that the decision to issue a prescription at the request of another service is **entirely the decision of the practice**, assuming that you are meeting the reasonable needs of that patient.

There are no parts of our Local Incentive Scheme (LIS) that relate to the prescribing of any medications. The LIS supports safe monitoring of shared care drugs and the administration of some injectable medications, without mandating that the prescriptions are provided by practices.

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NHS England Guidance

This is a very helpful piece of general guidance on the interface between primary and secondary care - interface-between-primary-secondary-care.pdf (england.nhs.uk) CLMC notes that this was first published in July 2017; there has been plenty of time for secondary care colleagues to implement this. Key extracts from this document include:

> *For medication on **discharge following hospital admission**, the minimum period is seven days (unless a shorter period is clinically appropriate).*
>
> *Where a patient has an **immediate need** for medication as a result of **clinic attendance**, the provider must supply sufficient medication to last at least up to the point at which the clinic letter can reasonably be expected to have reached the GP and the GP can prescribe accordingly.*
>
> *The hospital must only initiate care for a particular patient under a **shared care protocol** where the individual GP has confirmed willingness to accept clinical responsibility for the patient in question. Where this is not the case, the ongoing prescribing and related monitoring will remain the responsibility of the secondary care team.*

CLMC have been working with hospital colleagues and the ICB to develop guidance for secondary care, which should be read alongside this guidance note.

Private Providers

With the lengthy waiting lists for NHS secondary care, we recognise that patients are increasingly accessing non-NHS services. Our recommendation is to treat prescribing requests from any private provider **in the same way** as you would if you were to receive it from a colleague within the NHS. The same clinical standards should be applied.

You should be mindful of any secondary care follow-up that may be needed, assuring yourself that the patient will be able to continue to fund this care. You can convert a private prescription into an NHS prescription if it is clinically appropriate for you to prescribe; this should not be done purely to reduce the cost to the patient of a private prescription.

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Local Formulary

The prescribing formulary is supportive guidance suggesting categories for medications. The categorisation can be different for different indications. Our Tees formulary is being combined to produce a regional formulary. CLMC has had input into formulary decisions for many years. The formulary **provides suggestions**, it does not compel you to prescribe or forbid you from prescribing. If you are acting outside of the formulary guidance, CLMC would recommend that you document the reasons for this decision.

The categories are:

- GREEN – can be initiated by any prescriber.
- GREEN+ – should usually be initiated by a specialist and can be safely maintained within general practice with minimal monitoring.
- AMBER Shared Care – suitable for prescribing within general practice only with a formal shared care agreement.
- RED – secondary care only to prescribe.
- NOT APPROVED – these medications are not recommended for prescribing, usually due to lack of evidence of effectiveness or cost effectiveness.

There is a formal process by which medications can be accepted into the formulary or by which the formulary status can be amended, which any prescriber is able to access.

Our current Tees formulary can be found here - Tees Guidelines - NECS Medicines Optimisation (necsu.nhs.uk) When the transition to a regional formulary is complete, it will be found here - NTAG – Northern Treatment Advisory Group

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CLMC recommended approach

We fully support that the default decision should be for practices to **issue a prescription at the request of secondary care**. This supports the patient in easily accessing medications and is the safest approach with regards to long term condition monitoring and drug interactions.

A decision to decline to prescribe should be unusual and made for good clinical reasons, such as:

- The medication is not licenced for this clinical indication.
- The medication is not recommended within any clinical guideline for this indication.
- There is good clinical evidence of lack of effectiveness for the medication.
- You do not believe that this medication is appropriate for this individual patient, for example:
    - Previous adverse reaction.
    - Previously not effective.
    - Significant drug interaction.
- The medication is not listed as GREEN or GREEN+ within our formulary.
- This is an AMBER shared care drug and the requirements of the shared care agreement have not been met.
- You feel this is outside of your competence as a GP.
- The workload associated with this request is excessive and/or inadequately funded, for example:
    - Frequent reviews to up-titrate a medication.
    - Frequent blood tests or other monitoring in the long-term.
    - Insufficient capacity to provide appointments for injectable medications.
    - No safe recall system.

If you decline to prescribe, it is essential that you document this decision and communicate this both to the patient and the responsible consultant.

We are always happy to discuss individual cases. Please email us on nencicb-tv.adminclmc@nhs.net being mindful to remove any patient identifiable information.

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