February 2007

# Prescribing and the primary and secondary care interface

## Guidance for GPs

# Prescribing and the primary and secondary care interface

This guidance has been put together to clarify the role of GPs when prescribing in relation to secondary care, to provide examples of best practice and to thereby help LMCs negotiate with PCOs and secondary care colleagues on this issue.

Problems can exist between the primary and secondary care interface with prescribing for a variety of reasons however resource restrictions in secondary care will undoubtedly play their part. The key to successfully dealing with these problems are clear operating guidelines that are accepted across the local health care economy. This guidance should show how this can be done and encourages better communication between clinical colleagues.

There are various types of secondary care activity that can result in GP prescribing:

- In-patient discharge
- Out patient department requests or pro-formas
- Continuing care after consultant diagnosis
- Shared care agreements

In 1991 guidance on the responsibility for prescribing between hospitals and GPs was produced by the NHS and published with Executive Letter EL(91)127 (please see appendix 1). This is a valuable document for LMCs to keep on file and it has not so far been superseded. Unfortunately neither have the problems described within it. There are still hospital trusts and areas around the country where there are currently significant problems between the primary and secondary care interface.

## In-patient discharge and out-patient requests

Problems experienced with secondary care in relation to in-patient discharge and out-patient requests include patients arriving at the practice door with a badly scribbled note asking the GP to prescribe. No letter has been received to explain the patient's condition. This can happen after either in-patient stays or out-patient appointments. It is inconvenient for patients, who need to make a further visit to their GP practice, it can leave patients feeling anxious about the speed with which they can receive their medication and it presents a number of clinical governance issues. The doctor is put under both emotional and time pressure to prescribe a medication without full details of the patient's condition or hospital treatment and therefore they feel pushed into having to take responsibility for a prescribing decision that should have been fulfilled by the relevant consultant/hospital department.

Sometimes, the length of wait at the hospital pharmacy is so long, the patient leaves the hospital without their prescription being dispensed and takes it to the GP asking for the items to be reissued on an FP10.

LMCs have informed us that problems also exist with hospital pro-formas being automatically filled in by a consultant asking the GP to prescribe X drug, particularly in the areas of ophthalmology and dermatology. Other cases involve the faxing of abnormal results to GP practices sometimes with a scribbled note requesting the GP treat, others with no explanation of previous treatment.

**Clinical governance issues - an example from Cleveland**

Locally, we are seeing a rapid trend towards sending general practitioners pieces of paper recommending treatment. My experience of these so far is that they are clinically unsafe. Looking at the last six forms to arrive at the surgery, four contain significant errors.

- One recommends a drug for injection to a patient without a diagnosis covered by the product licence (licence covers prostate cancer and endometriosis, patient has undiagnosed pelvic pain)
- Another recommends the use of sustained-release tolteridine, which is not recommended for use in patients with impaired renal function (patients seen in urology clinic and has CKD3).
- The third recommended starting carbimazole, but the patient had not been counselled about potentially serious blood dyscrasias.
- The fourth requested a prescription for a chest infection that had been found during an outpatient visit to the chest clinic, despite the fact that the piece of paper on which the recommendation was written specifically indicated that the prescription could be issued within the next two weeks.

There are many reasons why these situations arise including a lack of any protocol defining what both sides are expected to do, failing to use FP10HPs where appropriate, and an attempt to shift prescribing costs from secondary to primary care. Hospital formularies also exist in Trusts and may be rigid. Recommendations can come from a hospital consultant to try an alternative medication which it then transpires is not on the hospital formulary, having been considered and rejected by their prescribing committee. Junior doctors are not always aware of the prescribing protocols (where they exist) between secondary and primary care.

**What should happen**

EL(91)127 is clear that for both in-patients and out-patient appointments patients should leave hospital with a minimum of 7-14 days worth of medication dispensed through the hospital pharmacy (7 days for in-patients 14 for out-patients).

Where this doesn't happen there is a need to raise this with the PCO prescribing leads or directly with the hospital.

In some instances, LMCs working through prescribing committees or forums are able to reach agreements that clarify what is expected of secondary care and what of primary care. This provides a local solution to the problem.

**An example from Wessex LMCs**

For many years we have agreed with hospitals the following:

1. If it is urgent to be prescribed that day the hospital should do so.

2. If the consultant wants to give advice on future treatment it should be included in the OPD letter.

3. If the consultant thinks the medication should be prescribed in the near future and does not wish it to be delayed until the OPD letter gets to the GP, they complete a pro-forma which contains the following:

Name of patient
Consultant whose care the patient is under
Name of doctor completing the pro-forma and their bleep number
Condition for which the drug is being recommended
The drug should be printed with dose.

The pro-forma makes it clear to patients they should take it to their practice, that the prescription is a recommendation and it is up to the GP to decide on treatment, they would need to leave 2 working days to pick up a prescription.

The system works well. Most of the time I prescribe and get my receptionists to contact the patient to pick up the prescription. Occasionally I decline and will contact the patient by phone to explain. On very rare occasions I will contact the patient to make an appointment to discuss the treatment etc at greater length.

I believe I am generally in charge of coordinating the care for my registered patient. I am asking a hospital doctor for their opinion, I will then make a judgement if I wish to follow that advice, with consultation with the patient.

The solution in Wessex was reached by chairing a committee that included both hospital doctors and GPs who discussed this issue. In Coventry a similar accommodation has been reached with the LMC having designed the form that is used by the outpatient department.

When negotiating on this issue the following may prove helpful:

NHS guidance on this is clear - EL(91)127
GPs should not have to medico-legally compromise themselves because of hospital bad practice
Write to the clinical director of the hospital trust if you feel that prescribing practice has become unsafe
Patient care should not be compromised or inconvenienced as a result of a breakdown in the primary-secondary care prescribing interface
Involve the PCO prescribing advisors where you can – they should want to ensure there is best prescribing practice across both primary and secondary care
Hospital doctors are equally concerned to ensure their patients get the appropriate medication in the appropriate way, Area Prescribing Committees or their equivalent can play a vital role in ensuring harmonious relationships between colleagues and good safe patient care.
Hospital pharmacies are there to meet the needs of patients passing through hospitals – some secondary care doctors are also able to use an FP10HP to prescribe drugs from community pharmacies
This issue has been resolved in many areas – GPs need to hold firm to their principles and to communicate well with colleagues.

## Continuing care after consultant diagnosis

This is linked to and leads on from the in-patient and out-patient discharge problem. This issue relates to the type of drugs being prescribed – not just the manner in which the GP is being asked to prescribe.

Any doctor who prescribes a drug must take responsibility for that prescribing decision. It doesn't matter whether or not a consultant advised it, if something goes wrong it is the prescribing doctor who will have to answer for their decision.

Problems GPs experience around this include being asked to prescribe a drug which is not regularly used in primary care and for which the GP feels they do not have the relevant experience or confidence to prescribe. This puts GPs in a difficult position when they have a patient in front of them for whom they are not prepared to prescribe. It also strains relations between GP and consultant colleagues.

There is also the issue of GPs being asked to prescribe a drug for a condition that is outside those for which that drug is licensed.

**What should happen**

Because of the important medico-legal aspects of prescribing, LMCs and PCOs can find ways of ensuring that all colleagues within the health service are aware of the boundaries between what is and is not acceptable primary care prescribing.

This can be done by setting up a 'traffic light' system or accessing specific, area-wide prescribing guidance. PCO Prescribing committees or forums are often the most appropriate environment for GPs and secondary care colleagues to work out what is appropriate for them locally and to draft protocols signalling what drugs are considered 'red' (i.e.: for hospital prescribing only) what are 'amber' (appropriate for shared care arrangements subject to clinical agreement) and what are 'green' (appropriate for primary and secondary care prescribing.) An example of a traffic light policy is attached at Appendix 2.

**An example from Worcestershire LMC**

We find MTRAC – Midland Therapeutic Review and Advisory Committee, very helpful. The West Midlands Regional LMC was instrumental in starting this organisation which continues to be funded by the PCTs and provides very useful documents entirely with a GP focus. These are frequently used to clarify the point with consultants as we can send the documents back to the hospitals saying that we have been advised not to prescribe. We are very keen to enhance and continue the role of MTRAC. It is very heavily GP oriented and carries a great deal of weight in the West Midlands.

MTRAC
http://www.keele.ac.uk/schools/pharm/MTRAC/
http://www.ukmicentral.nhs.uk/pressupp/sd.asp

When the drugs involved relate to a condition for which that drug is not licensed then in most cases, this should stay with the consultant, and in places where traffic light systems are in place they would fall into the red category – for hospital prescribing only. There may be a few cases, in particular with paediatric drugs (many of which are necessarily prescribed outside of their licence) where a GP may agree to a shared care agreement.

**Shared care agreements**

Shared care agreements cover a range of drugs that are often initiated in secondary care but where primary care doctors may chose to be involved in the continuing care and monitoring of the patient with referral back to secondary care at agreed intervals. Shared care agreements relate to patients on specialised drugs which often have significant potential side

effects and they are out with the essential and additional services of the new GMS contract. There already exist two National Enhanced Services specifications that deal with anti-coagulant monitoring and near-patient testing. Shared care agreements often cover those Amber drugs that appear on a 'traffic light' list. They may, in specific circumstances, relate to drugs being used outside of the terms of that drug's licence.

GPs may sometimes feel under pressure to be involved in the shared care of a patient. It is generally more convenient for a patient to receive as much care in the primary care setting as possible, cutting down on visits to the hospital. Shared care agreements can enable this to happen but there are some key questions a GP will want to ensure are addressed before involving themselves in shared care.

**An example from Morganwwg LMC**

This list was drawn up to aid GPs when considering working to a shared care agreement.

**Elements of a Shared Care Scheme**

**Clinical**

- What is the condition?
- It is the condition suitable for shared care?
- Is the patient's condition stable?
- Does the GP should have full knowledge and experience of any drug to be prescribed?

**Resources**

- Who provides the service at present?
- What are the human resources required to provide the service?
- Are there any other human resources that could be used?
- Does the general practitioner have adequate human resources to deliver shared care?
- Does the general practitioner have adequate human resources to deliver shared care?
- Does the general practitioner have adequate equipment and access to investigations to deliver shared care?

**Finance**

- What are the financial resources required to provide the service?
- What will it cost to provide a shared care service?
- Are there any other financial resources which could be used?
- Does the general practitioner have an adequate drug budget to pick up the costs of any prescribing involved?

**Agreement**

- Who will produce the guidelines?
- Who will approve the guidelines?
- Is the GP prepared to accept responsibility for the appropriate level of shared care?

**Communications**

- Are there adequate communications between the consultant and the GP to ensure safe management of the patient?

**Responsibility**

- Do the GP and Consultant both agree as to who carries the day to day responsibility and the ultimate responsibility for the management of patient should a problem arise?

**Safety**

- Is there a fast-track referral back to the consultant should problems arise?

**Review**

- How will the scheme be reviewed?

Depending on the degree of work and number of patients involved it is reasonable to negotiate a local enhanced service to cover a practices participation in shared care agreements. Such a LES may often cover a list of drugs and the GP will be expected to take part responsibility for the continuing care and monitoring of all patients on those drugs. An example of a shared care agreement local enhanced service is attached at Appendix 3.

## Issues with colleagues

LMCs can sometimes be presented with the problem that their constituents are their own worst enemies when they continue to prescribe drugs in a way the LMC would advise against. In areas where there are difficulties between secondary and primary care it is harder for an LMC to negotiate change if colleagues are continuing to work to a system that is unsatisfactory. In such cases, it is worth stressing the medico-legal aspect and encouraging colleagues, as you see fit, to contact their MDO for clarification.

When there is a traffic light system, or agreed area protocols, there may still be colleagues who do not wish to prescribe certain drugs. Generally, it is hoped that there will be a professional consensus on a traffic light system or local protocols; however, individual GPs are allowed to refuse to take prescribing responsibility for drugs they are unhappy to prescribe. There are possible solutions to such a situation.

**An example from Beds and Herts**

There is a local Prescribing Committee on which at least one LMC rep sits, as well as various PCT prescribing advisors and consultants. The committee draws up 'shared care' protocols which are reviewed on a regular basis and updated when necessary. These Shared Care protocols are sent to GPs from time to time, but are also held on our website for easy access. Once in a while we get complaints from GPs saying they don't agree with the protocol or aren't willing to prescribe and our policy then is to say that the GP must refer the patient to a GP who is willing to adhere to the protocol and will prescribe. This can be a little harsh on single-handers but it seems to work locally.

In general, the GPC would advise that where there are agreements drawn up with a professional consensus, that all practices should eventually be involved in prescribing these drugs. It is reasonable that colleagues are given sufficient time to acquire the skills and knowledge to prescribe drugs on a shared care list.

Thank you to all the LMCs who have contributed to this guidance and provided the GPC secretariat with information on this issue.

Thank you to Shaun Green, Pharmacy Advisor, Somerset PCT for the traffic light scheme in Appendix 2.

Thank you to Diane Adams, Chief Pharmacist, Richmond and Twickenham PCT for the LES in Appendix 3.

**APPENDIX 1**

NHS Management Executive

To: Regional General Managers
District General Managers
FHSA General Managers
SHA General Managers
NHS Trust Chief Executives

*Department of Health*
*Richmond House*
*79 Whitehall*
*London SW1 A 2NS*
*Telephone 071-2103000*

EL(91)127
1 November 1991

Dear Colleague,

**Responsibility for prescribing between hospitals and GPs**

1. Guidance on the responsibility for prescribing at the hospital/GP interface is attached as an annex to this letter.

2. The guidance, which should be brought to the attention of all prescribing doctors:

- reflects the recommendations of a working group of NHS professionals and managers set up by the Department in June 1990;
- reinforces the basic premise that it is for the doctor who has clinical responsibility for a patient to undertake the prescribing;
- focuses on the concept of shared care and emphasises the need for proper hand-over procedures from hospitals;
- specifies a minimum amount of out-patient prescribing to be provided by hospitals in routine cases;
- cancels circular DA(87)10, issued in February 1987.

3. Any enquiries about this letter should be addressed to:
Richard Walsh, Department of Health, HCD(SD), Room 429 Portland Court, 158-176 Gt Portland St, London WIN STB. Tel: 071-972 8273.

Yours sincerely,

*Diana Walford*

Dr Diana Walford Director of
Health Care/ Medical Director
NHS Management Executive

This letter, but not the attached guidance, will be cancelled on
31 October 1992

**APPENDIX 1**

EL(91)127 Annex

## Responsibility for prescribing between hospitals and GPs

Introduction

1. On 25 February 1987 Sir Leonard Peach, the then acting Chairman of the NHS Management Board, issued guidance on prescribing policy. The guidance indicated that it was for the doctor who had clinical responsibility for a patient to undertake the necessary prescribing. The guidance in the letter ceased to be operational on 1 March 1991 and is superseded by this guidance which, however, preserves its basic principles.

Background

2. The previous guidance referred to cases where hospitals inappropriately transferred prescribing responsibility to GPs. This practice still occurs and causes difficulty to patients, GPs and consultants.

3. With this in mind, and the introduction of indicative prescribing amounts from 1 April 1991, it was important to reconsider the issue of interface prescribing with the aim of providing updated guidance to the NHS. In June 1990, the Department of Health set up a working group of NHS professionals and managers operating prescribing policy day-today and charged it with examining current prescribing practices in relation to government health policy. The main issues that needed to be addressed were:

- **GPs' concerns over taking responsibility for unfamiliar treatment.** GPs were worried about their potential liability for a patient's treatment and there was genuine professional concern over whether it was appropriate for them to take on this prescribing, either wholly or on a shared-care basis;

- **GPs' concerns over taking additional responsibility for expensive treatment.** With the advent of the indicative prescribing scheme, many GPs were concerned about the effect of out-patient prescribing on their prescribing costs;

- **consultants' concerns** about prescribing drugs for which there was not budgetary cover;

- **lack of consultation between professionals over the transfer of prescribing responsibility.** GPs often felt that they had been improperly forced into taking on out-patient prescribing. If they refused, patients may have been denied necessary treatment;

- patients who are caught in the middle of a professional dispute were worried about the **continuity of their treatment** and the threat that they may be denied treatment, particularly where expensive drugs were involved;

- **hospitals providing insufficient quantities of drugs on discharge or following an out-patient/casualty visit**, to allow patients time to obtain follow-on treatment from GPs;

- patients having the **additional inconvenience of obtaining prescriptions via their general practitioner,** rather than directly from hospital, immediately after a hospital visit.

4. The deliberations of the Working Group were enhanced by a study[1] conducted by a research team from St. George's Hospital Medical School.

5. The NHS Management Executive, having considered the helpful views and advice provided by the Working Group, has produced the following guidance to address the above concerns. The guidance re-affirms the policy that prescribing responsibility will continue to be based on clinical responsibility. This is good medical practice and is in the best interests of the patient.

**The Indicative Prescribing Scheme**

6. The guidance given below sets out the basis on which prescribing responsibility should be determined and, where appropriate, transferred. General practitioners should note that the operation of the indicative prescribing scheme does not in any way inhibit them financially from accepting prescribing responsibility under these guidelines.

1 *Prescribing at the Hospital/General Practice Interface:Current Hospital Dispensing Policies* in *England and their impact on Hospital Chief Pharmacists, General Practitioners Hospital Consultants and Community Pharmacists* - Anderson, Freeling, Rafferty, Sibbald, Wilkie. April l991.

**APPENDIX 1**

## Clinical responsibility and the prescription of drugs

### General Principles

7. When clinical, and therefore prescribing, responsibility for a patient is transferred from hospital to GP, it is of the utmost importance that the GP has full confidence to prescribe the necessary drugs. It is, therefore, essential that a transfer involving drug therapies with which GPs would not normally be familiar should not take place without *full* local agreement and the dissemination of sufficient information to individual GPs. When drawing up protocols or where there is a professional disagreement over who should prescribe, it may be necessary for local discussion to take place between DHAs, hospital managers and medical staff, FHSAs and the relevant LMC as a prelude to establishing agreement with individual GPs. A GP of course is only obliged to provide treatment consistent with the terms of service for GPs set out in the NHS (GMPS) Regulations.

8. Legal responsibility for prescribing lies with the doctor who signs the prescription.

9. When a GP takes responsibility for prescribing or dispensing drugs which have not normally been dispensed in the community, there should be liaison between the transferring hospital and the community pharmacist to ensure a continuity of supply of the drug.

### In-patients

10. Hospital consultants have full clinical responsibility for in-patients under their care, as well as responsibility for all drugs prescribed to them.

11. When a patient is discharged from hospital, sufficient drugs and dressings should normally be prescribed by the hospital and dispensed by the hospital pharmacy, where possible, for a minimum of 7 days after discharge unless the drugs are not required for so long a period. The GP, to whose care the patient is being transferred, should receive notification *in adequate time* of the patient's diagnosis and drug therapy so that any ongoing treatment can be maintained. In the event that information about the patient cannot

be transferred from hospital to GP within the timescale, drugs should be prescribed by the hospital for as long a period as necessary.

**Patients attending Accident and Emergency**

12. Patients attending an Accident and Emergency unit should also receive a supply of drugs from the hospital for 7 days, or less if drugs are not required for that length of time. Any appropriate prescribing after that period will then rest with the GP responsible for the patient's continuing care.

**Out-patients**

13. Consultants have full responsibility for prescribing drugs and dressings for specific treatments administered in hospital out-patient clinics.

14. Subject to paragraph 15, where a consultant feels that he or she should initiate immediate treatment to an out-patient, drugs should normally be prescribed for the patient by the hospital and dispensed, where possible, by the hospital pharmacy for not less than 14 days. In other instances the consultant may request that the GP consider initiating or continuing treatment. The consultant should give the GP notification *in adequate time* of the patient's diagnosis and drug therapy so that any on-going treatment can be maintained. In the event that information about the patient cannot be transferred from hospital to GP within the timescale, drugs should be prescribed by the consultant for as long a period as necessary.

**Shared care**

15. When a consultant considers a patient's condition is stable, he may seek the agreement of the GP concerned to share care. In proposing a shared care arrangement, a consultant may advise the general practitioner which medicine to prescribe. Where a new, or rarely prescribed, medicine is being recommended, its dosage and administration must be specified by the consultant so that the GP is properly informed and can monitor treatment and adjust the dose if necessary. In addition, when a treatment is not licensed for a particular indication, then full justification for the use of the drug should be given by the consultant to the GP. Provision of a protocol for treatment should normally be provided. Where a hospital drug formulary is in operation and a recommended treatment is not included, the GP must be informed that this is the case and given the option of prescribing alternatives.

## APPENDIX 1

**Where responsibility for prescribing should remain with consultants**

16. Occasions will arise when responsibility for prescribing for a patient, who is otherwise under the care of his or her GP, will more appropriately rest with a consultant, for example where

- drugs are undergoing or included in a hospital based clinical trial;
- the consultant considers that only he is able to monitor the patient's response to medication because, for example, of the need for specialised investigations;
- drugs or appliances are only available through hospitals or where there are supply problems.

**Role of Regional Health Authorities (RHAs)**

17. RHAs are well placed to encourage and facilitate developments which better integrate the care provided and ensure a smooth transition of patients from hospital to GP and vice versa. Their responsibility is to ensure that local prescribing
policies are compatible with this guidance and that patient care is "seamless".

18. In particular, RHAs should further stimulate the representation of joint primary and secondary care interests through debate in Drug and Therapeutics Committees, and facilitate development of treatment protocols in which GPs, consultants and other appropriate health care professionals can locally agree how certain treatments should be handled.

19. FHSAs, via their Medical Advisers, in co-operation with hospital consultants, should ensure that GPs are sufficiently informed on new and/or unfamiliar drugs and the related local prescribing policies. Regional Pharmaceutical Officers (RPhOs), through their drug information services, are able to provide support. Telephone numbers are given in the British National Formulary (BNF).

# APPENDIX 1

**Contracting and the reforms**

20. With the inception of the NHS reforms from 1 April, the Department of Health will be encouraging RHAs, through the contracting system, to identify the extent of local hospital drug provision and to ensure that it is consistent, or made consistent, with these guidelines. Specifying local hospitals' drug provision responsibilities in contracts should lead to a more effective and efficient targeting of the necessary resources towards the provision of hospital drugs. RHAs should ensure that this objective is pursued as vigorously as possible, in the interests of patient care.

**APPENDIX 2**

# DORSET AND SOMERSET PRESCRIBING FORUMS

# "TRAFFIC LIGHT" SYSTEM

## Summary

## 1. BACKGROUND

### Aim

1.1 The "traffic light" system defines where responsibility for prescribing between primary and secondary care should lie through categorising individual drugs as **red, amber** or **green**. The system is intended to encourage appropriate shifts in prescribing between hospital clinicians and general practitioners (GPs) consistent with clinical responsibility and supported by shared care arrangements.

1.2 Following review of clinical data on efficacy, safety and cost-effectiveness by the Dorset or Somerset Prescribing Forums, drug treatments will either be:

- **recommended,** following which they will receive a "traffic light" category as follows:
  - red - for hospital prescribing;
  - amber - appropriate for shared care;
  - green – appropriate for prescribing in primary and secondary care;
- **not recommended,** that is where prescribing is **not** generally recommended in primary or secondary care.

1.3 Drugs not categorised as red, amber, green, or not recommended will **not** have been referred to the Prescribing Forums. Prescribing of these will be at the discretion of individual NHS Trusts and GPs.

1.4 Where drug treatments have been appraised by the National Institute for Health and Clinical Excellence (NICE), their categorisation will be consistent with the recommendations that have been made.

1.5 For unlicensed medicines the prescriber, patient and GP should be aware of unlicensed nature of the drug and reference to the protocol on the use of unlicensed drugs should be made.

## 2. CATEGORIES

### Red

2.1 These are drugs for which it is considered that responsibility for prescribing should be retained within secondary care. These will generally be specialist treatments requiring special monitoring or where rigorous supervision is required due to their side-effect profile. Other criteria for categorising a drug as red are set out in the full guidance.

**Amber**

2.2 These are drugs for which transfer of responsibility for prescribing, from secondary to primary care, is considered appropriate when:

- the GP has agreed to accept clinical responsibility for an individual patient, this should be in the form of a signed proforma. It is the responsibility of the consultant to approach the GP with the drug and patient information, any relevant shared care guideline and the proforma of acceptance;

- The shared care agreement in place between the clinician and GP. should clarify to the doctor accepting responsibility what monitoring is required and at what point further advice should be sought;

- where appropriate, a shared care guideline should be developed and accepted by the Prescribing Forum to support the transfer of clinical responsibility.

**It should be noted that an amber categorisation is made on the basis that:**

- the hospital clinician is usually responsible for initiating and stabilising treatment;

- where possible, the GP is contacted to agree future shared care **prior** to initiating treatment in secondary care;

- monitoring requirements and responsibility for monitoring treatment have been clearly defined;

- the drug is being used for the indication and in accordance with the shared care guidance that has been agreed;

- a GP may choose **not** to accept clinical responsibility on the basis of lack of familiarity or experience with a drug or if it is being used outside of the guidance that has been agreed.

**Green**

2.3 Drugs categorised as green are not complex specialist drugs and their introduction is regarded as appropriate in both primary and secondary care.

2.4 Categorisation of a drug as green is on the basis that it is considered to offer significant benefit over existing treatment and that its use as a first, second or third-line drug has been defined.

**Not Recommended**

2.5 For a drug treatment to be categorised as “not recommended” it will have been referred to, and been reviewed by, the Dorset or Somerset Prescribing Forums.

2.6 A drug treatment may also be categorised as “not recommended” as an interim measure pending review of the drug treatment. When this is the case, it should be clearly stated and a date for completion of the review agreed.

2.7 It should be noted that there may be occasions where the use of a drug treatment that has been categorised as “not recommended” is considered appropriate. This should be managed by NHS Trusts and Primary Care Trusts on an individual patient basis.

## 3. SUMMARY OF "TRAFFIC LIGHT DRUGS"

3.1 The table attached provides a summary of the drugs categorised as red, amber, green and not recommended listed in alphabetical order. **A line at the right hand side of the table indicates entries that have been added or amended since the previous edition.**

3.2 The Dorset Prescribing Guide should also be referred to for drugs categorised as green.

3.3 **Information on the "traffic light" system, guidelines included in the Dorset Prescribing Guide and shared care guidelines can be accessed on the Dorset and Somerset Health and Social Care Extranet (nww.dorsetsomerset.nhs.uk).** Further information can be obtained from Primary Care Trust Prescribing Leads and Pharmaceutical Advisers or NHS Trust Chief Pharmacists.

November 2005

# APPENDIX 2

## SUMMARY OF "TRAFFIC LIGHT DRUGS"

| Drug | Category | Notes |
|---|---|---|
| Acamprosate (Campral EC) | Amber | For maintenance of abstinence in alcohol dependent patients in accordance with locally agreed shared care guideline. |
| Adalimumab (Humira) | Red (Dorset) | For rheumatoid arthritis in accordance with locally agreed guidance and the recommendations made by NICE for Etanercept and Infliximab (Appraisal No. 36 March 2002).<br><br>To be endorsed by the Somerset Prescribing Forum. |
| Alglucerase (Ceredase) | Red | Trusts are responsible for making the necessary arrangements for patients to receive intravenous treatment. |
| Alprostadil (Caverject, Viridal, MUSE) | Green (erectile dysfunction) | When used in accordance with Health Service Circular 1999/148 * |
| Alprostadil (Prostin VR) | Red (Somerset) | For congenital heart defects in neonates prior to corrective surgery. |
| Amisulpride (Solian) | Amber | In accordance with the recommendations made by NICE for the use of atypical antipsychotic drugs for the treatment of schizophrenia (Appraisal No. 43 June 2002) and locally agreed shared care guideline.<br><br>Refer also to the guidance on drug treatment of newly diagnosed schizophrenia included in the Dorset Prescribing Guide. |
| Anastrozole (Arimidex) | Amber | For second-line endocrine treatment of postmenopausal patients with advanced oestrogen receptor-positive breast cancer, in accordance with locally agreed shared care guideline. |
| Anti-D | Red | For routine antenatal anti-D prophylaxis for RhD-negative women in accordance with the recommendations made by NICE (Appraisal No. 41 May 2002). |
| Anti-retrovirals for HIV | Red | |
| Apomorphine (Britaject) | Red | Treatment is managed by the Parkinson's disease speciality nurses. |
| Apomorphine (Uprima) | Green | When used in accordance with Health Service Circular 1999/148 * |

## APPENDIX 2

| Drug | Category | Notes |
|---|---|---|
| Aripiprazole (Abilify) | Amber | In accordance with the recommendations made by NICE for the use of atypical antipsychotic drugs for the treatment of schizophrenia (Appraisal No. 43. June 2002) and locally agreed shared care guideline.<br><br>Refer also to the guidance on drug treatment of newly diagnosed schizophrenia included in the Dorset Prescribing Guide. |
| Asasantin Retard | Green | Separate ingredients are the preferred option. Use to be in accordance with the recommendations made by NICE for the use of clopidogrel and dipyridamole in vascular disease (Appraisal No 90. May 2005). |
| Atomoxetine (Strattera) | Amber | Second-line use according to locally agreed shared care guideline |
| Azathioprine (Imuran) | Amber | In accordance with the guidance on the use of disease modifying anti-rheumatic drugs included in the Dorset Prescribing Guide. |
| Bicalutamide (Casodex) | Amber (provisional)<br><br>Red (Dorset) | Role in management of prostate cancer to be clarified and shared care guideline to be developed.<br>For locally advanced disease as an alternative to LHRH and also as neo-adjuvant/adjuvant treatment prior to and after radiotherapy. |
| Bupropion (Zyban) | Green | As an adjunct to smoking cessation in combination with motivational support in accordance with the recommendations made by NICE (Appraisal No. 39 March 2002). |
| Buserelin (Suprefact, Suprecur) | Amber | Shared care guideline to be developed for use in prostatic cancer and endometriosis. |
| Cancer drugs | Red<br><br>Red | Hospital Trusts are responsible for making the necessary arrangements for patients to receive intravenous treatment. Red category also includes oral cancer treatments<br><br>Drug treatments reviewed and recommended by NICE. |
| CAPD (Continuous Ambulatory Peritoneal Dialysis fluids) | Red | Special purchasing arrangements in place through secondary care. |
| Celecoxib (Celebrex) | Green | In accordance with the recommendations made by NICE (Appraisal No. 27 July 2001).<br><br>Refer also to locally agreed guidance (not |

| Drug | Category | Notes |
|---|---|---|
| | | included within Poole and Bournemouth formularies) and national safety guidance from CSM. |
| Cerazette (under Desogestrel) | | |
| Chorionic gonadotrophin (Choragon, Pregnyl, Profasi) | Red | Special purchasing arrangements in place through secondary care. |
| Ciclosporin (Neoral, Sandimmun) | Amber (Dorset)<br><br>Red (Somerset) | Treatment initiated in Plymouth for renal transplant. Shared care guideline to be reviewed.<br><br>For transplant patients. |
| Ciclosporin (Neoral, Sandimmun) | Amber | In accordance with the guidance on the use of disease modifying anti-rheumatic drugs included in the Dorset Prescribing Guide. |
| Cidofovir (Vistide) | Red | Hospital Trusts are responsible for making the necessary arrangements for patients to receive intravenous treatment. |
| Clinical trial drugs | Red | |
| Clopidogrel (Plavix) | Green<br><br>Amber | For patients hypersensitive to aspirin or patients not tolerating low-dose aspirin or a combination of low-dose aspirin + gastroprotective agent.<br><br>In accordance with the recommendations made by NICE for the use of clopidogrel and dipyridamole in vascular disease (Appraisal No 90. May 2005).<br><br>In accordance with the recommendations made by NICE for the use of clopidogrel in the treatment of non-ST-segment-elevation acute coronary syndrome (appraisal No.80 July 2004) clopidogrel should be used for up to 12 months.<br><br>Post stent insertion (unless follows acute coronary syndrome, see above):<br>• Clopidogrel should be used for one month following insertion of a non-drug eluting stent.<br>• Clopidogrel should be used for six months following insertion of a drug-eluting stent |

## APPENDIX 2

| Drug | Category | Notes |
|---|---|---|
| Clozapine (Clozaril) | Red<br><br>(Amber in original pilot sites) | In accordance with the recommendations made by NICE for the use of atypical antipsychotic drugs for the treatment of schizophrenia (Appraisal No. 43 June 2002).<br><br>Refer also to the guidance on drug treatment of newly diagnosed schizophrenia included in the Dorset Prescribing Guide. |
| Colistin | Red | Inhaled use as an adjunct to standard antibacterial therapy in patients with cystic fibrosis. |
| Continuous subcutaneous insulin infusion (under Insulin) | | |
| Cyproterone (Cyprostat) | Amber | Shared care guideline to be developed. |
| Deflazacort (Calcort) | Not recommended | Insufficient evidence of significant additional clinical benefit over Prednisolone. |
| Desferrioxamine (Desferal) | Red | Specialist use only. |
| Desogestrel (Cerazette) | Green | In accordance with local guideline agreed with Dr A Vaughan. |
| Dipyridamole m/r capsules (Persantin Retard) | Green | In accordance with the recommendations made by NICE for the use of clopidogrel and dipyridamole in vascular disease (Appraisal No 90 May 2005). |
| Disodium pamidronate (Aredia) | Red | For use in the management of multiple myeloma. |
| Donepezil (Aricept) | Amber | In accordance with the recommendations made by NICE (Appraisal No. 19 January 2001).<br><br>Refer also to the guidance on drug treatment of Alzheimer's disease included in the Dorset Prescribing Guide and locally agreed shared care guideline. |
| Dornase alfa (Pulmozyme) | Amber (Dorset)<br><br>Red (Somerset) | Local guidance and category to be reviewed. |

## APPENDIX 2

| Drug | Category | Notes |
|---|---|---|
| Dressings not prescribable available in primary care | Red | |
| Drotrecogin alfa (Xigris) | Red | In accordance with locally agreed interim guidance. Arrangements to be reviewed in the light of the recommendations made by NICE. |
| Eflornithine (Vaniqa) | Red (Dorset)<br><br>Not recommended (Somerset) | Use should be discussed at local drug and therapeutics committees where required. Alternative treatments available locally. |
| Entacapone (Comtess) | Amber | Used as an adjunct to levodopa therapy in patients who cannot be stabilised, particularly those with "end-of-dose" fluctuations. Refer to locally agreed guidance on drug treatment of Parkinson's disease and shared care guideline. |
| Eplerenone (Inspra) | Amber | Used, in addition to standard therapy, to reduce the risk of cardiovascular mortality and morbidity after recent myocardial infarction in stable patients with left ventricular dysfunction and clinical evidence of heart failure, as an alternative to spironolactone, where sex hormone mediated adverse effects experienced. |
| Epoprostenol (Flolan) | Red | Hospital Trusts are responsible for making the necessary arrangements for patients to receive intravenous treatment. |
| Erythropoietin (Eprex, NeoRecormon) | Red<br><br>Red (Dorset) | For renal use.<br><br>For use in patients with ovarian cancer in accordance with locally agreed guideline. |
| Etanercept (Enbrel) | Red | For rheumatoid arthritis in accordance with the recommendations made by NICE (Appraisal No. 36 March 2002). |
| Etonogestrel (Implanon) | Green | For use by doctors with appropriate training and up-to-date documentary evidence of competency from the Faculty of Family Planning |
| Exemestane (Aromasin) | Amber | In accordance with locally agreed shared care guideline. |
| Ezetimibe (Ezetrol) | Green | To be reserved for patients not reaching target lipid levels on maximum tolerated doses of statins. |
| Flutamide (Drogenil) | Amber | Shared care guideline to be developed. |

## APPENDIX 2

| Drug | Category | Notes |
|---|---|---|
| Follitropin alfa and beta (Gonal-F, Puregon) | Red | Special purchasing arrangements in place through secondary care. |
| Formestane (Lentaron) | Amber | Shared care guideline to be developed. |
| Foscarnet (Foscavir) | Red | Hospital Trusts are responsible for making the necessary arrangements for patients to receive intravenous treatment. |
| Galantamine (Reminyl) | Amber | In accordance with the recommendations made by NICE (Appraisal No. 19 January 2001).<br><br>Refer also to the guidance on drug treatment of Alzheimer's disease included in the Dorset Prescribing Guide and locally agreed shared care guideline. |
| Ganciclovir (Cymevene) | Red | Hospital Trusts are responsible for making the necessary arrangements for patients to receive intravenous treatment. |
| Gold (Auranofin, Myocrisin) | Amber | In accordance with the guidance on the use of disease modifying anti-rheumatic drugs included in the Dorset Prescribing Guide. |
| Goserelin (Zoladex) | Amber | Shared care guideline to be developed for use in prostatic cancer and endometriosis. |
| Growth hormone (Genotropin, Humatrope, Norditropin, NutropinAq, Saizen, Zomacton) | Children - Red<br><br>Adults – Red | In accordance with the recommendations made by NICE (Appraisal No. 42 May 2002). Arrangements through Southampton (Dr Betts) and Poole (Dr McAuley).<br><br>In accordance with the recommendations made by NICE (Appraisal No. 64 Aug 2003) |
| Hyaluronic acid and derivatives (Arthrease, Durolane, Fermathron, Hyalgan, Orthovisc, Ostenil, Supartz, Suplasyn, Synvisc) | Red | On the basis of a locally agreed guideline. |
| Hydroxychloroquine (Plaquenil) | Amber | In accordance with the guidance on the use of disease modifying anti-rheumatic drugs included in the Dorset Prescribing Guide. |
| Implanon (under Etonogestrel) | | |
| Infliximab (Remicade) | Red | For rheumatoid arthritis in accordance with the recommendations made by NICE (Appraisal No. 36 March 2002). |

| Drug | Category | Notes |
|---|---|---|
| | Red | For Crohn's disease in accordance with the recommendations made by NICE (Appraisal No. 40 April 2002). |
| Insulin<br>(Continuous subcutaneous insulin infusion) | Red | In accordance with the recommendations made by NICE (Appraisal No. 57 February 2003).<br><br>Refer also to locally agreed guidance (Dorset). |
| Insulin glargine (Lantus) | Green | In accordance with the recommendations made by NICE (Appraisal No. 53 December 2002).<br><br>Refer also to locally agreed guidance. |
| Interferon alfa<br><br>Interferon alfa / Peginterferon alfa | Red<br><br>Red | For chronic myeloid leukaemia.<br><br>Chronic hepatitis C in accordance with the recommendations made by NICE (Appraisal Nos. 14 and 75, October 2000 and January 2004). |
| Interferon beta (Avonex, Rebif, Betaferon) | Red | In accordance with the recommendations made by NICE (Appraisal No. 32 January 2002) and Department of Health guidance contained in HSC 2002/004. |
| Intravenous antibiotics | Red | Hospital Trusts are responsible for making the necessary arrangements for patients to receive intravenous treatment. |
| Intravenous immunoglobulins | Red | Hospital Trusts are responsible for making the necessary arrangements for patients to receive intravenous treatment. |
| Isotretinoin (Roaccutane) | Red | Side-effects require specialist supervision. |
| Lanreotide (Somatuline LA) | Red | **Third-line** treatment for acromegaly (second-line if patient is unfit for surgery). |
| Leflunomide (Arava) | Amber (Dorset)<br><br>Red (Somerset) | For **third-line** use in patients with active rheumatoid arthritis when treatment with sulphasalazine and methotrexate is contra-indicated or has been found to be ineffective or not tolerated. Treatment is initiated by a consultant rheumatologist who will prescribe for the first month. Refer to locally agreed shared care guideline. |

| Drug | Category | Notes |
|---|---|---|
| Leuprorelin (Prostap SR) | Amber | Shared care guideline to be developed for use in prostatic cancer and endometriosis. |
| Levonorgestrel (Levonelle-2) | Green | Emergency post-coital contraception. |
| Memantine (Ebixa) | Red | In accordance with locally agreed guideline. |
| Menotrophin (Menogon, Menopur) | Red | Special purchasing arrangements in place through secondary care. |
| Methotrexate (Maxtrex) | Amber<br><br>Red - Injectable methotrexate (Somerset) | In accordance with the guidance on the use of disease modifying anti-rheumatic drugs included in the Dorset Prescribing Guide.<br><br>Appropriate safeguards and liability issues to be considered and shared care arrangements agreed. |
| Methylphenidate (Ritalin, Concerta XL) | Amber | In accordance with the recommendations made by NICE (Appraisal No. 13 October 2000).<br><br>Refer also to locally agreed shared care guideline.<br><br>The prolonged-release formulation Concerta XL should be reserved for patients experiencing problems with conventional tablets. Treatment should be initiated by the consultant, on an individual patient basis, following review and the patient's GP informed of the rationale for this decision. |
| Minocycline (Minocin) | Amber | In accordance with the guidance on the use of disease modifying anti-rheumatic drugs included in the Dorset Prescribing Guide. |
| Montelukast (Singulair) | Amber | For use in asthma in accordance with locally agreed guideline. |
| Mycophenolate mofetil (CellCept) | Red | |
| Nafarelin (Synarel) | Red | Use *in vitro* fertilisation. Special purchasing arrangements in place through secondary care. |
| Naltrexone (Nalorex) | Red<br><br>Amber | As an adjunct to prevent relapse in detoxified, formerly opioid-dependent patients.<br>Naltrexone may be used as an amber drug in accordance with locally agreed shared care guideline where supporting infrastructure is |

| Drug | Category | Notes |
|---|---|---|
| | | available to primary care. |
| Octreotide (Sandostatin) | Red | **Third-line** treatment for acromegaly (second-line if patient is unfit for surgery). |
| Octreotide (Sandostatin) | Red | For carcinoid syndrome and use in palliative care. |
| Olanzapine (Zyprexa) | Amber | In accordance with the recommendations made by NICE for the use of atypical antipsychotic drugs for the treatment of schizophrenia (Appraisal No. 43 June 2002) and locally agreed shared care guideline.<br><br>Refer also to the guidance on drug treatment of newly diagnosed schizophrenia and guidance on drug treatment of psychotic conditions other than schizophrenia included in the Dorset Prescribing Guide. |
| Orlistat (Xenical) | Green | In accordance with the recommendations made by NICE (Appraisal No. 22 March 2001). |
| Oseltamivir (Tamiflu) | Green | In accordance with the recommendations made by NICE (Appraisal No. 58 February 2003 and Appraisal No. 67 September 2003).<br><br>Vaccination, particularly targeting “high risk” patients, remains the mainstay of influenza management. |
| Peginterferon alfa (under Interferon alfa) | | |
| Penicillamine (Distamine) | Amber | In accordance with the guidance on the use of disease modifying anti-rheumatic drugs included in the Dorset Prescribing Guide. |
| Pimecrolimus (Elidel) | Amber | In accordance with the recommendations made by NICE for the use of tacrolimus and pimecrolimus for atopic eczema (Appraisal No.82 August 2004) and locally agreed shared care guideline. |
| Pioglitazone (Actos) | Green | In accordance with the recommendations made by NICE (Appraisal No. 63 August 2003). |
| Pramipexole (Mirapexin) | Green | In accordance with locally agreed guidance on drug treatment of Parkinson’s disease. |
| Pregabalin (Lyrica) | Not recommended | Categorisation to be reviewed in the light of peer-reviewed evidence. Patients currently receiving drug should be maintained on therapy if they are deriving benefit from it. |

## APPENDIX 2

| Drug | Category | Notes |
|---|---|---|
| Quetiapine (Seroquel) | Amber | In accordance with the recommendations made by NICE for the use of atypical antipsychotic drugs for the treatment of schizophrenia (Appraisal No. 43 June 2002) and locally agreed shared care guideline.<br><br>Refer also to the guidance on drug treatment of newly diagnosed schizophrenia and guidance on drug treatment of psychotic conditions other than schizophrenia included in the Dorset Prescribing Guide. |
| Raloxifene (Evista) | Green | In accordance with the recommendations made by NICE (Appraisal No.87 January 2005). |
| Ribavirin (Rebetol) | Red | For use in combination with interferon alfa in the management of hepatitis C in accordance with the recommendations made by NICE (Appraisal Nos. 14 and 75, October 2000 and January 2004). |
| Riluzole (Rilutek) | Amber | In accordance with the recommendations made by NICE (Appraisal No. 20 January 2001).<br><br>Refer also to locally agreed shared care guideline. |
| Risperidone (Risperdal)<br><br>Risperidone injection (Risperdal Consta) | Amber<br><br>Red | In accordance with the recommendations made by NICE for the use of atypical antipsychotic drugs for the treatment of schizophrenia (Appraisal No. 43 June 2002) and locally agreed shared care guidance.<br><br>Refer also to the guidance on drug treatment of newly diagnosed schizophrenia and guidance on drug treatment of psychotic conditions other than schizophrenia included in the Dorset Prescribing Guide. |
| Rivastigmine (Exelon) | Amber | In accordance with the recommendations made by NICE (Appraisal No. 19 January 2001).<br><br>Refer also to the guidance on drug treatment of Alzheimer's disease included in the Dorset Prescribing Guide and locally agreed shared care guideline. |
| Rosiglitazone (Avandia) | Green | In accordance with recommendations made by NICE (Appraisal No. 63 August 2003). |

## APPENDIX 2

| Drug | Category | Notes |
|---|---|---|
| Sevelamer (Renagel) | Amber | In accordance with the guidance agreed with Dorset Renal Unit. Refer to shared care guideline. |
| Sibutramine (Reductil) | Green | In accordance with the recommendations made by NICE (Appraisal No. 31 October 2001). |
| Sildenafil (Viagra) | Green | When used in accordance with Health Service Circular 1999/148 * |
| Sodium clodronate (Bonefos, Loron) | Red (Dorset)<br><br>Amber (Somerset) | For use in the management of multiple myeloma. |
| Stalevo (Co-careldopa with Entacapone) | Amber | Refer to the locally agreed guidance on drug treatment of Parkinson's disease and shared care guideline. |
| Tacrolimus (Prograf) | Red | Prescribed by West Dorset Renal Unit. |
| Tacrolimus (Protopic) | Amber | In accordance with the recommendations made by NICE for the use of tacrolimus and pimecrolimus for atopic eczema (Appraisal No.82. August 2004) and locally agreed shared care guideline. |
| Teriparatide (Forsteo) | Red | In accordance with locally agreed interim guidance. Arrangements to be reviewed in the light of the recommendations made by NICE. |
| Tiotropium (Spiriva) | Green | In accordance with locally agreed guidance. |
| Tizanidine (Zanaflex) | Red | In accordance with local guideline agreed with Dr J Burn. |
| Tolterodine (Detrusitol) | Green | For **second-line** use in patients who are unable to tolerate or who do not respond to oxybutynin. |
| Total parenteral nutrition (TPN) | Red | Hospital Trusts are responsible for making the necessary arrangements for TPN. |
| Triptorelin (De-capeptyl sr) | Amber | Shared care guideline to be developed for use in prostatic cancer and endometriosis. |
| Urofollitropin (Metrodin) | Red | Special purchasing arrangements in place through secondary care. |
| Yasmin | Not recommended | Insufficient evidence of benefit over existing preparations and absence of long-term safety data. |
| Zafirlukast (Accolate) | Amber | For use in asthma in accordance with locally agreed guideline. |

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| Drug | Category | Notes |
|---|---|---|
| Zanamivir (Relenza) | Green | In accordance with the recommendations made by NICE (Appraisal No. 58 February 2003).<br><br>Vaccination, particularly targeting “high risk” patients, remains the mainstay of influenza management. |

# APPENDIX 2

## *TREATMENT OF IMPOTENCE

**Summary of Health Service Circular 1999/148**

General practitioners may issue National Health Service prescriptions (endorsed SLS) to those men whom, in their clinical judgement, are suffering from erectile dysfunction and have any of the following medical conditions:

- diabetes;
- multiple sclerosis;
- Parkinson's disease;
- poliomyelitis;
- prostate cancer;
- prostatectomy (including TURP);
- radical pelvic surgery;
- renal failure treated by dialysis or transplant;
- severe pelvic injury;
- single gene neurological disease;
- spinal cord injury;
- spina bifida.

In addition, men who were receiving a course of drug treatment for impotence on the National Health Service on 14 September 1998 can continue to receive a drug treatment for impotence from their general practitioner on the National Health Service. For example, a man who was prescribed a course of Caverject on the National Health Service on 10 September 1998 may continue to receive prescriptions for Caverject or may be changed to a different drug for impotence if necessary.

Men who do not fall into either of the above categories but who are suffering from severe distress on account of their impotence may be able to obtain treatment from specialist services. Guidelines for use of these services locally have been prepared.

# Local Enhanced Service for Shared Prescribing

# Service Outline for April 2006-March 2007

# Local Enhanced Service for Shared Prescribing

## Service Outline for April 2006 – March 2007

### 1 Shared Prescribing

The treatment of several diseases within the fields of medicine, particularly in rheumatology, is increasingly reliant on drugs that, while clinically effective, need regular blood monitoring. This is due to the potentially serious side-effects that these drugs can occasionally cause. It has been shown that the incidence of side-effects can be reduced significantly if this monitoring is carried out in a well-organised way, close to the patient's home. The nGMS contract therefore contains a provision for an enhanced service entitled 'near-patient testing' (NPT).

Such drugs represent a small proportion of those where treatment is initiated by experts in secondary care, but where for various reasons, ongoing monitoring and treatment is provided in primary care. Such reasons include patient convenience, willingness of GP to accept clinical responsibility for ongoing care, reduction of workload in secondary care and transfer of costs (both prescribing costs and associated costs), as well as better risk management.

A number of shared prescribing guidelines have already been developed for such drugs. Several more shared care guidelines are in development for other clinical areas. For 2004-2006, it was agreed by the PCT Primary Care Commissioning Group (formerly the Enhanced Services Steering Group) that in order to facilitate the introduction of shared care guidelines practices would be encouraged to participate in a shared prescribing local enhanced service (LES).

The aim of the LES is to prevent patients, for whom shared prescribing arrangements are requested by secondary care for a pre-arranged range of drugs, being referred back to secondary care for financial reasons (rather than risk management or clinical responsibility reasons). It is proposed that practices will be reimbursed a fixed amount according to practice list size, for shared prescribing arrangements for up to 20 drugs, some of which have already been identified (see Para 3).

This Service Level Agreement (SLA) replaces the SLA for April 2004 – March 2006.

### 2 Service Outline

The service will operate in accordance with the Principles of Shared Care (see Appendix 1). Up to 20 drugs may be included in the service (see Para 3 for those already identified). Less than 20 will be included in 2006/07. This will be treated as a windfall to practices. If more than 20 are included in 2006/07 (see Para 10 for an explanation of future development of the service) then the funding will be re-evaluated.

The principles of shared care are:

#### 2.1 Best interest of the Patient

The best interests of the patient should be at the centre of any shared care agreement. Arrangements should never be detrimental or inconvenient for the patient.

#### 2.2 Individual, patient by patient arrangements

Shared care prescribing guidelines should be accompanied by individual patient information, outlining all relevant aspects of that patient's care.

#### 2.3 Reasonably predictable clinical situation

Transfer of clinical responsibility to primary care should only be considered where a patient's clinical condition is stable or predictable.

#### 2.4 Willing & informed consent of all parties, including patients and carers

All parties must have sufficient, accurate, timely information in an understandable form. Consent must be given voluntarily.

### 2.5 Clear definition of responsibility

The areas of care for which each partner has responsibility should be clearly defined and should be patient specific. The guideline should include details of any specialist resources that may be available.

### 2.6 Communication network & emergency support

A telephone contact point, fax number and email address (if appropriate) should be detailed so that the GP can access advice and information if problems arise. This should include out-of-hours contact numbers e.g. how to access the on-call Duty Doctor.

### 2.7 Clinical information

This should include a brief overview of the disease and more detailed information on the treatment(s) being transferred including (as a minimum):

Summary of NICE or other guidance, where applicable (and a web link to access the full guidance)

Licensed indications & therapeutic class

Dose, route of administration and duration of treatment

Adverse effects (incidence, identification, importance and management)

Monitoring requirements and responsibilities

Clinically important drug interactions and their management

Peer reviewed references for product usage

### 2.8 Contacts for more detailed information

The guideline should state how often the patient will be reviewed; and provide a 'route of return' should the patient's condition become less predictable (return of symptoms, development of adverse effects). Progress reports should be produced to an agreed timescale.

## 3 Register of Shared Prescribing Guidelines (SPG) for 2006-07

Shared prescribing guidelines have already been developed and circulated for the following drugs:

3.1 Methylphenidate in ADHD
3.2 Acetylcholinesterase inhibitors (donepezil, rivastigmine & galantamine) for Alzheimers Disease
3.3 Disodium clodronate for management of bone metastases
3.4 Erythropoietin & darbepoietin for renal patients with anaemia
3.5 Calcium acetate for correction of hyperphosphataemia associated with chronic renal failure
3.6 Methotrexate (update due in 2006/07)
3.7 Growth hormone in children with growth failure
3.8 Triptorelin for precocious puberty

Shared prescribing guidelines in development:

3.9 Tacrolimus / sirolimus for prophylaxis of organ rejection in kidney allograft patients
3.10 Mycophenolate for prophylaxis of acute rejection in renal transplant patients
3.11 Bicalutamide for prostate cancer
3.12 Leflunomide
3.13 Letrozole

For those shared prescribing guidelines not yet developed the PCT expects practices to adhere to the service outline as agreed in the NES for near-patient testing for the following drugs (already been circulated to practices):

3.14 Penicillamine
3.15 Auranofin
3.16 Sulphasalazine
3.17 Sodium Aurothiomalate

## 4 Referrals

Each shared prescribing guideline is (or will be) specific concerning responsibilities and reasons for route of return-consult for details e.g. instability, non-compliance.
For shared prescribing guidelines not yet developed (see 3) agreement will be sought by the PCT from consultants in secondary care concerning their responsibilities and reasons for route of return. Specifically this relates to access to results e.g. blood, pathology, X-rays, scans. The PCT will provide secondary care consultants with a list of GPs who have agreed to participate in the LES so that all results can be copied to GPs. Practices should report non-compliance with this requirement to the relevant Associate Director for Commissioning at the PCT. Persistent non-compliance by secondary care clinicians may necessitate re-referral of patients for prescribing purposes i.e. this represents a route of return from GP to secondary care. Should this become necessary, practices should ensure this is documented in the quarterly reports to the PCT Chief Pharmacist (see 11).
There should be a reciprocal arrangement where tests are requested by the practice (to enable hospital clinicians to access results).
It is always the responsibility of secondary care to make decisions on dosage changes.

## 5 Accreditation, Competency & Training

Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.
The specialist department seeking the shared care arrangement (i.e. secondary care consultant) should provide any specific training, which may be needed by the GPs e.g. managing the disease, administration of the drug etc. Information on how to access this should be provided in the shared care prescribing guideline. GPs who do not have the confidence or knowledge to prescribe will be expected to attend such training.
It is not expected that GPs will decline to prescribe on the basis of inadequate knowledge, in view of the above.

## 6 Patient records

**6.1 A register**. Practices should be able to produce and maintain an up-to-date register of all shared care drug monitoring service patients, indicating patient name, date of birth and the indication and duration of treatment and last hospital appointment.
Shared drug monitoring should be indicated-* by the use of the following standard READ codes, which have been agreed by the NHSIA. Use of these codes should be restricted to the drugs outlined in this LES, to facilitate searching and reporting to the PCT.

| | |
|---|---|
| Shared prescribing declined | 8BM6 |
| Shared prescribing referred back to secondary care | 8BM7 |

**6.2 Call and recall**. To ensure that systematic call and recall of patients on this register is taking place either in a hospital or general practice setting
**6.3 Education and newly diagnosed patients**. To ensure that all newly diagnosed / treated patients (and / or their carers when appropriate) receive appropriate education and advice on management of and prevention of secondary complications of their condition. This should include written information where appropriate
**6.4 Continuing information for patients**. To ensure that all patients (and/or their carers and support staff when appropriate) are informed of how to access appropriate and relevant information
**6.5 Individual management plan**. To ensure that the patient has an individual management plan, which gives the reason for treatment, the planned duration, the monitoring timetable, the therapeutic range to be obtained, if appropriate and the names of the designated responsible clinicians. For those drugs for which SWL shared prescribing documentation exists, the box on the front page should be completed and scanned into the

patient record (or alternative retrievable electronic records may be kept).

**6.6 Professional links**. To work together with other professionals when appropriate. Any health professionals involved in the care of patients in the programme should be appropriately trained

**6.7 Referral policies**. Where appropriate to refer patients promptly to other necessary services and to the relevant support agencies using locally agreed guidelines where these exist

**6.8 Record keeping**. To maintain adequate records of the service provided, incorporating all known information relating to any significant events e.g. hospital admissions, death of which the practice has been notified, route of return & reasons

**6.9 Training**. Each practice must ensure that all staff involved in providing any aspect of care under this scheme have the necessary training and skills to do so

**6.10 Annual review**. All practices involved in the scheme should perform an annual review which must include brief details as to arrangements for each of the aspects highlighted in the LES i.e. points 6.1 to 6.9 above to include the following information where appropriate:

(a) details as to any computer-assisted decision-making equipment used and arrangements for internal and external quality assurance

(b) details as to any near-patient testing equipment used and arrangements for internal and external quality assurance

(c) details of training and education relevant to the drug monitoring service

(d) details of the standards used for the control of the relevant condition

(e) assurance that any staff member responsible for prescribing must have developed the necessary skills to prescribe safely.

## 7 Review

Shared care prescribing guidelines will be reviewed by acute Trust and host PCT (varies) every 3 years or sooner if indicated. Revised guidelines will be disseminated to practices.

## 8 Feedback

The PCT will develop a questionnaire to ask patients about satisfaction with the service they have received (compared with the previous service). This will be used to inform future development of the service.

## 9 Funding

| | |
|---|---|
| Total budget 2006/07 | £50,000 |
| Payment per practice | According to list size-see Appendix 2 |
| Practice payment 2006/07 | Quarterly in arrears on submission of data (see para 11) |

## 10 Future development of the service

At the end of each year of operation of the service, it will be reviewed by the PCT Enhanced Services Steering (Primary Care Commissioning) Group in the light of

- secondary to primary care shift in activity
- any changes in legislation
- ICRS changes
- Patient feedback
- Practice feedback

## 11 Monitoring & Evaluation

Each practice must run three-monthly searches on READ codes (see 6.1) and drug searches to identify patients as follows:

- Numbers of patients for whom the practice is prescribing under shared care arrangements
- Number of patients for whom shared prescribing has been declined
- Number of patients referred back (see 2.8 Route of Return)
- Numbers of patients on each drug for whom the practice is prescribing under shared care arrangements
- Number of patients on each drug for whom shared prescribing has been declined
- Number of patients on each drug referred back (see 2.8 Route of Return)

and provide this information to the PCT Prescribing Support Officer by dates listed below using the Shared Care Monitoring Proforma (Draft copies of these are included in this SLA. Final copies of these will be sent out in year).

| ***Form and Data required by PCT*** | ***Deadline date*** |
|---|---|
| Share Prescribing Monitoring Pro forma 2006/07 Q1 | 30th June 2006 |
| Share Prescribing Monitoring Pro forma 2006/07 Q2 | 29th September 2006 |
| Share Prescribing Monitoring Pro forma 2006/07 Q3 | 29th December 2006 |
| Share Prescribing Monitoring Pro forma 2006/07 Q4 | 16th March 2007 |

Practices will also need to provide evidence and narrative on reasons for declining to prescribe (e.g. IPI forms for KHT & WMUH patients or anonymised copy letters for other patients).

Additional monitoring:

- Decrease in outpatient activity possibly leading to disinvestment from secondary care (to be monitored by PCT)

## 12 Risk Management

### 12.1 Untoward events

It is a condition of participation that practitioners will give notification, in addition to their statutory obligations, within 72 hours of the information becoming known to him/her, to the PCT clinical governance lead of all emergency admissions or deaths of any patient covered under this service, where such admission or death is or may be due to usage of the drug(s) in question or attributable to the relevant underlying medical condition.

To be addressed by monitoring arrangements:

- Refusal by GPs/practices to participate-GP freedom to prescribe, clinical responsibility issues as outlined in EL 91(127) which will be monitored by use of the relevant READ code (see 6.1)
- Adherence to shared prescribing guideline, which will be monitored by use of the relevant READ code (see 6.1)
- Route of return for patients & management of this, which will be monitored by use of the relevant READ code (see 6.1)
- Lead-in time for paperwork development (often dependent on other PCTs)
- £ (primary care prescribing budget)-allowable appeal against LPIS if overspend incurred (evidence from LES data monitoring will be used to test any appeals)
- £ (secondary care-additional activity)

## 13 Length of contract

Practices undertaking this LES will be required to sign the attached SLA which states that if the practice fails to meet the above service outline then 3 months notice will be given by the Commissioner (PCT). The same period of notice 3 months will be required to be given by the practice if they no longer wish to provide this service to the Commissioner. The contract will run from April 2006-Mar 2007.

*Brenda So*
*On behalf of the PCT Primary Care Commissioning group, April 2006*

# SERVICE LEVEL AGREEMENT

This service level agreement is between:

**Commissioner:** Richmond and Twickenham Primary Care Trust

**Provider:** (name of practice)

Both parties agree to the content of this service level agreement and are bound by its terms for the specified period:

**Provider:**

**1st April 2006 to 31st March 2007**

**Practice Name:**

**Authorised Signatory (Senior Partner):**

**Signature:**

**Date:**……

**Commissioner:**

**Richmond and Twickenham Primary Care Trust**

**Authorised Signatory (Name):**

**Signature:**

**Date**……..

**Please sign and return to Caroline Allanson by 7th April 2006**
**Fax 020 8973 3134**

# Shared Prescribing Monitoring Pro forma (draft)
# 2006/07 Q1

Please answer the following questions for each drug in the table below:

1. How many patients do you provide Shared Care Prescribing service to Quarter 1 2006/2007? Total No of Pts on Register: ……..
2. How many patients do you have for each drug for whom the practice is prescribing under shared care arrangements (Search on each "drug ") for Quarter 1 2006/07.
3. How many patients do you have for each drug for whom shared prescribing has been declined (READ Code: 8BM6 and "drug ") for Quarter 1 2006/07.
4. How many patients do you have for each drug who have been referred back, having previously undertaken shared prescribing (see 2.8 Route of Return) for Quarter 1 2006/07 (READ code 8BM7and "drug")
5. How many patients do you have for each drug who have stopped treatment during Quarter 1 2006/07 (READ code: 9kDØ and "drug")

| Quarter 1 (Apr-Jun) 2006/07 | | | | |
|---|---|---|---|---|
| | **Prescribing- see 2 above** | **prescribing declined- see 3 above** | **prescribing referred back- see 4 above** | **prescribing stopped- see 5 above** |
| **Drug** | **READ Code for "drug "** | **READ Code 8BM6 and for "drug"** | **READ Code 8BM7 and for "drug"** | **READ Code 9kDØ and for "drug"** |
| Methylphenidate | | | | |
| Acetylcholinesterase inhibitors (donepezil, rivastigmine & galantamine) | | | | |
| Disodium clodronate | | | | |
| Growth hormone in children **(not** adults) | | | | |
| Tacrolimus | | | | |
| Sirolimus | | | | |
| Erythropoietin & darbepoietin | | | | |
| Mycophenolate | | | | |
| Bicalutamide | | | | |
| Calcium acetate | | | | |
| Methotrexate | | | | |
| Penicillamine | | | | |
| Auranofin | | | | |
| Sulphasalazine | | | | |
| Sodium Aurothiomalate. | | | | |
| Triptorelin | | | | |
| Leflunomide | | | | |
| Letrozole | | | | |
| **Total** | | | | |

**Name:……Signature:……..**
**Senior Partner**

**Name:……Signature:……..**
**Practice Manager**

**Date: ……**
***see over**

Please return by **30th June 2006** to:

Caroline Allanson, Prescribing Support Officer Tel: 020 8973 3141
E mail: caroline.allanson@rtpct.nhs.uk Fax: 020 8973 3134

## Prescribing declined

Please describe reasons for declining to prescribe and number of patients declined for this reason (please also attach anonymised copy letters or other evidence e.g. IPI form):

| Quarter 1 (Apr-Jun 2006/07) | | |
|---|---|---|
| **Drug** | **Number of patients declined** | **Reason (please state)** |
| | | |
| | | |
| | | |
| | | |

# Shared Prescribing Monitoring Pro forma (draft)
# 2006/07 Q2

Please answer the following questions for each drug in the table below:

1. How many patients do you provide Shared Care Prescribing service to Quarter 2 2006/2007? Total No of Pts on Register: ……..
2. How many patients do you have for each drug for whom the practice is prescribing under shared care arrangements (Search on each "drug") for Quarter 2 2006/07.
3. How many patients do you have for each drug for whom shared prescribing has been declined (READ Code: 8BM6 and "drug ") for Quarter 2 2006/07.
4. How many patients do you have for each drug who have been referred back, having previously undertaken shared prescribing (see 2.8 Route of Return) for Quarter 2 2006/07 (READ code 8BM7and "drug")
5. How many patients do you have for each drug who have stopped treatment during Quarter 2 2006/07 (READ code: 9kDØ and "drug")

| Quarter 2 (Jul - Sep) 2006/07 | | | | |
|---|---|---|---|---|
| | **Prescribing- see 2 above** | **prescribing declined- see 3 above** | **prescribing referred back- see 4 above** | **prescribing stopped- see 5 above** |
| **Drug** | **READ Code for "drug"** | **READ Code 8BM6 and for "drug"** | **READ Code 8BM7 and for "drug"** | **READ Code 9kDØ and for "drug"** |
| Methylphenidate | | | | |
| Acetylcholinesterase inhibitors (donepezil, rivastigmine & galantamine) | | | | |
| Disodium clodronate | | | | |
| Growth hormone in children **(not** adults) | | | | |
| Tacrolimus | | | | |
| Sirolimus | | | | |
| Erythropoietin & darbepoietin | | | | |
| Mycophenolate | | | | |
| Bicalutamide | | | | |
| Calcium acetate | | | | |
| Methotrexate | | | | |
| Penicillamine | | | | |
| Auranofin | | | | |
| Sulphasalazine | | | | |
| Sodium Aurothiomalate. | | | | |
| Triptorelin | | | | |
| Leflunomide | | | | |
| Letrozole | | | | |
| **Total** | | | | |

**Name:……Signature:……..**
**Senior Partner**

**Name:……Signature:……..**
**Practice Manager**

**Date: ……**
***see over**

Please return by **29th September 2006** to:

Caroline Allanson, Prescribing Support Officer Tel: 020 8973 3141
E mail: caroline.allanson@rtpct.nhs.uk Fax: 020 8973 3134

## Prescribing declined

Please describe reasons for declining to prescribe and number of patients declined for this reason (please also attach anonymised copy letters or other evidence e.g. IPI form):

| Quarter 2 (Jul – Sep 2006/07) | | |
|---|---|---|
| **Drug** | **Number of patients declined** | **Reason (please state)** |
| | | |
| | | |
| | | |
| | | |

# Shared Prescribing Monitoring Pro forma (draft)
# 2006/07 Q3

Please answer the following questions for each drug in the table below:

1. How many patients do you provide Shared Care Prescribing service to Quarter 3 2006/2007? Total No of Pts on Register: ……..
2. How many patients do you have for each drug for whom the practice is prescribing under shared care arrangements (Search on each "drug") for Quarter 3 2006/07.
3. How many patients do you have for each drug for whom shared prescribing has been declined (READ Code: 8BM6 and "drug ") for Quarter 3 2006/07.
4. How many patients do you have for each drug who have been referred back, having previously undertaken shared prescribing (see 2.8 Route of Return) for Quarter 3 2006/07 (READ code 8BM7and "drug")
5. How many patients do you have for each drug who have stopped treatment during Quarter 3 2006/07 (READ code: 9kDØ and "drug")

| Quarter 3 (Oct - Dec) 2006/07 | | | | |
|---|---|---|---|---|
| | **Prescribing- see 2 above** | **prescribing declined- see 3 above** | **prescribing referred back- see 4 above** | **prescribing stopped- see 5 above** |
| **Drug** | **READ Code for "drug"** | **READ Code 8BM6 and for "drug"** | **READ Code 8BM7 and for "drug"** | **READ Code 9kDØ and for "drug"** |
| Methylphenidate | | | | |
| Acetylcholinesterase inhibitors (donepezil, rivastigmine & galantamine) | | | | |
| Disodium clodronate | | | | |
| Growth hormone in children **(not** adults) | | | | |
| Tacrolimus | | | | |
| Sirolimus | | | | |
| Erythropoietin & darbepoietin | | | | |
| Mycophenolate | | | | |
| Bicalutamide | | | | |
| Calcium acetate | | | | |
| Methotrexate | | | | |
| Penicillamine | | | | |
| Auranofin | | | | |
| Sulphasalazine | | | | |
| Sodium Aurothiomalate. | | | | |
| Triptorelin | | | | |
| Leflunomide | | | | |
| Letrozole | | | | |
| **Total** | | | | |

**Name:……Signature:……..**
**Senior Partner**

**Name:……Signature:……..**
**Practice Manager**

**Date: ……**
***see over**

Please return by **29th December 2006** to:

Caroline Allanson, Prescribing Support Officer Tel: 020 8973 3141
E mail: caroline.allanson@rtpct.nhs.uk Fax: 020 8973 3134

## Prescribing declined

Please describe reasons for declining to prescribe and number of patients declined for this reason (please also attach anonymised copy letters or other evidence e.g. IPI form):

| Quarter 3 (Oct - Dec 2006/07) | | |
|---|---|---|
| **Drug** | **Number of patients declined** | **Reason (please state)** |
| | | |
| | | |
| | | |
| | | |

# Shared Prescribing Monitoring Pro forma (draft)
# 2006/07 Q4

Please answer the following questions for each drug in the table below:

1. How many patients do you provide Shared Care Prescribing service to Quarter 4 006/2007? Total No of Pts on Register: ……..
2. How many patients do you have for each drug for whom the practice is prescribing under shared care arrangements (Search on each "drug ") for Quarter 4 2006/07.
3. How many patients do you have for each drug for whom shared prescribing has been declined (READ Code: 8BM6 and "drug ") for Quarter 4 2006/07.
4. How many patients do you have for each drug who have been referred back, having previously undertaken shared prescribing (see 2.8 Route of Return) for Quarter 4 2006/07 (READ code 8BM7and "drug")
5. How many patients do you have for each drug who have stopped treatment during Quarter 4 2006/07 (READ code: 9kDØ and "drug")

| Quarter 4 (Jan - Mar) 2006/07 | | | | |
|---|---|---|---|---|
| | **Prescribing- see 2 above** | **prescribing declined- see 3 above** | **prescribing referred back- see 4 above** | **prescribing stopped- see 5 above** |
| **Drug** | **READ Code for "drug"** | **READ Code 8BM6 and for "drug"** | **READ Code 8BM7 and for "drug"** | **READ Code 9kDØ and for "drug"** |
| Methylphenidate | | | | |
| Acetylcholinesterase inhibitors (donepezil, rivastigmine & galantamine) | | | | |
| Disodium clodronate | | | | |
| Growth hormone in children **(not** adults) | | | | |
| Tacrolimus | | | | |
| Sirolimus | | | | |
| Erythropoietin & darbepoietin | | | | |
| Mycophenolate | | | | |
| Bicalutamide | | | | |
| Calcium acetate | | | | |
| Methotrexate | | | | |
| Penicillamine | | | | |
| Auranofin | | | | |
| Sulphasalazine | | | | |
| Sodium Aurothiomalate. | | | | |
| Triptorelin | | | | |
| Leflunomide | | | | |
| Letrozole | | | | |
| **Total** | | | | |

**Name:……Signature:……..**
**Senior Partner**

**Name:……Signature:……..**
**Practice Manager**

**Date: ……**
***see over**

Please return by **16th March 2007** to:

Caroline Allanson, Prescribing Support Officer Tel: 020 8973 3141
E mail: caroline.allanson@rtpct.nhs.uk Fax: 020 8973 3134

## Prescribing declined

Please describe reasons for declining to prescribe and number of patients declined for this reason (please also attach anonymised copy letters or other evidence e.g. IPI form):

| Quarter 4 ( Jan - Mar 2006/07) | | |
|---|---|---|
| **Drug** | **Number of patients declined** | **Reason (please state)** |
| | | |
| | | |
| | | |
| | | |

## Appendix 1

# Principles of Shared Care

### 1. Introduction

The purpose of these guidelines is to provide a framework for the seamless transfer of care from the hospital to general practice, where this is appropriate and in the best interests of the patient.

Where possible, shared care will be 'disease specific' rather than 'drug specific' and will link into and complement local integrated care pathways.

Application of the following principles will facilitate effective shared care. However, it should be remembered that the provision of shared care prescribing guidelines does not necessarily mean the GP has to agree to and accept clinical and legal responsibility for prescribing; he or she should only do so if they feel confident in managing that condition.

### 2. Principles of Shared Care

- **Best interest of the Patient**
  *The best interests of the patient should be at the centre of any shared care agreement. Arrangements should never be detrimental or inconvenient for the patient.*

- **Individual, patient by patient arrangements**
  *Shared care prescribing guidelines should be accompanied by individual patient information, outlining all relevant aspects of that patient's care.*

- **Reasonably predictable clinical situation**
  *Transfer of clinical responsibility to primary care should only be considered where a patient's clinical condition is stable or predictable.*

- **Willing & informed consent of all parties, including patients and carers**
  *All parties must have sufficient, accurate, timely information in an understandable form. Consent must be given voluntarily.*

  *Consultants and general practitioners are encouraged to communicate directly where questions arise around shared care for a particular patient. If issues remain, after these discussions, the Chief / Senior Pharmacist at the PCT or Hospital Trust should be contacted for advice.*

- **Clear definition of responsibility**
  *The areas of care for which each partner has responsibility should be clearly defined and should be patient specific. The guideline should include details of any specialist resources that may be available.*

- **Communication network & emergency support**
  *lephone contact point, fax number and email address (if appropriate) should be detailed so the GP can access advice and information if problems arise. This should include out-of-hours tact numbers e.g. how to access the on-call Duty Doctor.*

  *The guideline should state how often the patient will be reviewed; and provide a 'route of return' should the patient's condition become less predictable (return of symptoms, development of adverse effects). Progress reports should be produced to an agreed timescale.*

- **Clinical information**
  *This should include a brief overview of the disease and more detailed information on the treatment(s) being transferred including (as a minimum):*
  - *Summary of NICE or other guidance, where applicable (and a web link to access the full guidance)*
  - *Licensed indications & therapeutic class*
  - *Dose, route of administration and duration of treatment*
  - *Adverse effects (incidence, identification, importance and management)*
  - *Monitoring requirements and responsibilities*
  - *Clinically important drug interactions and their management*
  - *Peer reviewed references for product usage*
  - *Contacts for more detailed information*

- **Training**
  *The specialist department seeking the shared care arrangement should provide any specific training, which may be needed by the GPs e.g. managing the disease, administration of the drug etc. Information on how to access this should be provided in the shared care prescribing guideline.*

- **Review**
  *Shared care prescribing guidelines will be reviewed every 3 years or sooner if indicated.*

**3. Circumstances where shared care is not appropriate**

Hospitals would normally retain responsibility for prescribing in the following instances:

- Where patients receive the majority of on-going care, including monitoring, in hospital and the only benefit to transferring care would be to hospital costs
- Where the drug is only available through hospitals
- The drug is included on the Commissioner's list of products not suitable for shared care
- Where a drug requires specialist intervention, stabilisation and monitoring; however, following stabilisation it may be possible to transfer care
- Drugs are unlicensed, or are being used for an unlicensed indication or at an unlicensed dose and the GP does not feel confident to take on clinical responsibility
- Where drugs are being used as part of a hospital-initiated clinical trial
- The GP feels that he/she does not have sufficient knowledge to accept clinical responsibility
- The indication for prescribing is contrary to NICE guidance and the use of the drug has not been approved on an 'exceptional basis'
- New drugs, until they have been approved for addition to the formulary and agreed as suitable for shared care by the Drug and Therapeutics Committee (see also under 6)

**4. Checklist for GPs when considering sharing care**

GPs should only agree to prescribe if, after reading the shared care prescribing guideline, they can answer **YES** to the following questions:

- Is the patient's condition predictable or stable?
- Do you have the relevant knowledge, skills and access to equipment to allow you to monitor treatment as indicated in this shared care prescribing guideline?
- Have you been provided with relevant clinical details including monitoring data?

If the answer is NO to any of these questions, the GP should not accept prescribing responsibility and should write to the consultant within 14 days, outlining the reasons for NOT prescribing. If the GP does not have the confidence to prescribe, this should be discussed with the local Trust/specialist service, who will be willing to provide training and support. If the GP still lacks the confidence to accept clinical responsibility, they still have the right to decline. PCT pharmacists will assist GPs in making decisions about shared care.

**5. Involving the Patient**

The consultant should only obtain the consent of the patient (and his/her carers if appropriate) after the GP has agreed in principle to sharing care.

Patients should never be used as a conduit for informing the GP that prescribing is to be transferred. Nor should they ever be placed in a position where they are unable to obtain the medicines they need because of lack of communication between primary and secondary/ tertiary care.

**6. Process for approval of shared care arrangements**

When an Acute / Mental Health Trust* or other specialist centre seeks to establish shared care arrangements with primary care, the suitability of a shared care prescribing arrangement should be assessed at the local Acute / Primary Care Trust Drug and Therapeutics Committee, Mental Health Prescribing Interface Forum (MHPIF) or equivalent committee. In case of doubt, the local host (or lead) Primary Care Trust may consult neighbouring PCTs or discuss the suggestion for shared care arrangements at the South West London (SWL) Prescribing Committee.

Once it has been agreed that shared care would be appropriate, the Acute / Mental Health* Trust or other specialist centre is responsible for producing the shared care prescribing guideline using the attached template while consulting with their pharmacy department, colleague clinicians that are affected by the guideline and the Primary Care Trust Chief / Senior Pharmacist and nominated healthcare professional (usually a GP).

Once all above parties are in agreement the host (or lead) PCT will subsequently circulate the shared care prescribing guideline to the administrator of the SWL Prescribing Committee for onward distribution to PCTs in South West London or the Mental Health Prescribing Interface forum for comments (deadline 1 month). In case of disagreement or controversy resolution should be sought at the SWL Prescribing Committee meeting.

The shared care prescribing guideline should subsequently be approved and signed by the local Acute / Primary Care Trust Drug and Therapeutics Committee, Mental Health Prescribing Interface Forum (MHPIF) or equivalent committee and the final version should be sent to the administrator of SWL Prescribing Committee for onward distribution to all relevant PCTs.

Any Trust seeking shared care arrangements for the same intervention can adapt the agreed shared care prescribing guideline for local use and agree this with the host (or lead) PCT. Each shared care prescribing guideline should be reviewed every 3 years or sooner if indicated.

* Please note that shared care prescribing guidelines produced by South West London and St. Georges (SWLSG) Mental Health Trust through the Mental Health Prescribing Interface Forum will only apply to Richmond and Twickenham, Kingston, Wandsworth and Sutton & Merton PCTs. Richmond and Twickenham PCT is the lead commissioner PCT for the SWLSG Mental Health Trust.

**7. Agreement of shared care between consultant and GP**

Prescribing responsibility will only be transferred when the consultant and the GP are in agreement that the patient's condition is stable or predictable. The patient will only be referred to the GP once the GP has agreed in each individual case and the hospital will continue to provide prescriptions until successful transfer of responsibilities as outlined below.

The signature section on the front cover of each shared care prescribing guideline, can be used to confirm that shared care has been agreed between both parties. It is suggested that the consultant will send a signed agreement to the GP. If agreeable, the GP should confirm the acceptance of the shared care prescribing arrangement by signing and returning a copy of the front cover to the consultant. The patient should subsequently be informed to obtain further supplies from the GP.

**APPENDIX 2**

| *Practice Code* | *Jan 06 Astro PU* | *Annual Payment* |
|---|---|---|
| H84002 | 50005 | £3,212 |
| H84005 | 25658 | £1,648 |
| H84006 | 33358 | £2,143 |
| H84007 | 29833 | £1,916 |
| H84012 | 43426 | £2,789 |
| H84014 | 15188 | £976 |
| H84017 | 55035 | £3,535 |
| H84018 | 21587 | £1,387 |
| H84023 | 30910 | £1,985 |
| H84031 | 19064 | £1,225 |
| H84032 | 31347 | £2,014 |
| 84036 | 15467 | £993 |
| H84039 | 40246 | £2,585 |
| H84040 | 56777 | £3,647 |
| H84041 | 17287 | £1,110 |
| H84043 | 20764 | £1,334 |
| H84044 | 27378 | £1,759 |
| H84048 | 22455 | £1,442 |
| H84055 | 36322 | £2,333 |
| H84057 | 6577 | £422 |
| H84059 | 14369 | £923 |
| H84060 | 20509 | £1,317 |
| H84608 | 9297 | £597 |
| H84615 | 13195 | £848 |
| H84623 | 24069 | £1,546 |
| H84625 | 18880 | £1,213 |
| H84630 | 8166 | £524 |
| H84632 | 16800 | £1,079 |
| H84633 | 10849 | £697 |
| H84639 | 5590 | £359 |
| Y01206 | 38013 | £2,442 |