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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.

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 This is a valuable document for LMCs to keep on file and it has not so far been superseded.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 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 discussed this issue with the hospital. 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 pharmacies are there to meet the needs of patients passing through hospitals – 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.

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) 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 choose 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?
- 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.