NORTH CENTRAL LONDON
MEDICINES OPTIMISATION NETWORK

PRESCRIBING GUIDANCE

This operational guidance has been developed by the NCL Medicines Optimisation Network (NCL MON) to facilitate continuity of prescribing and governance across primary, secondary and tertiary care interfaces.

This document is based on a London Framework Pharmacy & Prescribing Guidance and has been ratified by the North Central London Joint Formulary on behalf of the following organisations:

Barnet and Chase Farm Hospitals NHS Trust
Barnet, Enfield and Haringey Mental Health NHS Trust
Camden and Islington NHS Foundation Trust
Central and North West London NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
North Middlesex University Hospital NHS Trust
Royal Free London NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
University College London Hospitals NHS Foundation Trust
Whittington Health

Reviewed by NCL Medicines Optimisation Network
Ratified by NCL Joint Formulary Committee
Review date
Version 9

December 2013
January 2014
September 2015
1. Introduction
This guidance has been developed by the North Central London Medicines Optimisation Network and has been ratified by North Central London Joint Formulary on behalf of all acute, community and mental health NHS provider trusts and Clinical Commissioning Groups (CCGs) in North Central London.

The aim of this document is to facilitate consistent prescribing practice across North Central London and is included in the generic NHS provider contract. The appendices may be subject to amendment.

It is recommended that all provider trusts and Clinical Commissioning Groups seek the advice of their Chief Pharmacist/Pharmaceutical Adviser during the commissioning process to ensure that implications for medicines and prescribing are taken into account.

Most medicines are included in the National Tariff, except for nationally defined PBR excluded medicines, where commissioners and providers should agree local prices and arrangements for commissioning and monitoring. This is described in the CCG Commissioning of High Cost Drug Policy.

The ‘red list’ and shared care document is reviewed and updated on quarterly basis. The current version can be found at http://ncl-jfc.org.uk/ or contact your local Chief Pharmacist.

2. General Principles
The following general principles apply to all provider trusts and Clinical Commissioning Groups,

2.1 All provider trusts should ensure they have a Drug and Therapeutics Committee (or equivalent) in place to co-ordinate medicine use. Each hospital Drug and Therapeutics Committee should regularly liaise with the Joint Formulary Committee (JFC) regarding the most appropriate forum to assess a medicine. It has been agreed that all decisions will need to be first ratified by the JFC. Until a joint trust formulary is established, each Trust should maintain an up to date formulary with the involvement of CCG prescribing advisers and CCG prescribing lead, GP or nominated deputy. Hospital prescribing should be from the Hospital Trust formulary and prescribers should not seek to avoid restrictions by asking GPs to prescribe non-formulary medicines.

2.2 All provider trusts will contribute to the local arrangements for the managed entry of new medicines. This should consider the clinical and cost-effectiveness, and safety of new medicines and the impact on primary as well as secondary care.

2.3 Prescribers and pharmacists should recommend, dispense and label by generic name except where this is clinically inappropriate.

2.4 All provider trusts should usually dispense medicines in patient packs, in order to comply with European Community directive 92/27/EEC on pharmaceutical labelling, and the provision of information to patients.

2.5 All provider trusts should have policies approved by their Drug and Therapeutics Committee for:
- the use and disposal of patients own medicines in hospital.
- self-administration of medicines by patients
- use of unlicensed medicines and medicines used for unlicensed indications.
- dealing with the pharmaceutical industry.

2.6 All provider trusts should comply with principles contained in local, national and professional guidance including National Service Frameworks, NICE Technology Appraisal Guidance and
relevant Health Service Circulars & Guidance, Executive Letters and Audit Commission reports.

2.7 The NCL prescribing guidance should be applied within GMC guidance ‘Good practice in prescribing and medicines management and devices’. The GMC guidance can be found at http://www.gmc-uk.org/Prescribing_Guidance__2013__50955425.pdf

3. Admission arrangements
3.1 CCGs and all local provider trusts should ensure that written guidance is in place covering information flow on admission or referral as recommended by the Care Quality Commission (CQC).

3.2 The recommended minimum dataset for information provided on patient admission to hospital is listed in Appendix 1 and should be agreed locally between CCGs and Hospital Trusts.

3.3 CCGs should develop a standard template letter that GP practices can use to ensure all information required is readily available.

3.4 Information on prescribed medicines should be available to the hospital as soon as possible and ideally within 24 hours of admission where possible.

3.5 An agreement should be made between the hospital and CCG to enable audits to be undertaken to monitor the quality and timeliness of information provided on admission and ensure compliance with CQC recommendations.

3.6 Health economies should support and encourage patients to bring all their own medicines into hospital with them through a pre-admissions policy.

3.7 Medicines management arrangements on admission should include:
   • provision of information to patients before planned admissions about the arrangements in the hospital for e.g. bringing in own medicines, self-administration, use of patients own medicines, dispensing for discharge.
   • arrangements for medicines history taking and pharmacist review of medication.

4. In-patients
4.1 The provider trust should maximise the use of patients own drugs and is responsible for the supply of any new medicine started or continuation of existing medicine for in-patients. Patients at risk of experiencing problems managing their medicines should be identified and, if appropriate, a referral made for pharmaceutical support.

5. Discharge Arrangements
5.1 CCGs and all local provider trusts should ensure that written guidance is in place covering information flow on discharge from inpatient, outpatient, urgent or emergency care as recommended by the Care Quality Commission (CQC).

5.2 Patients should be discharged from hospital with a minimum of 14 days supply, unless the full course of treatment is less, a smaller supply is deemed appropriate on mental health grounds, or after assessment it is clear the patient already has appropriate supplies at home.

5.3 The recommended minimum dataset for information provided on patient discharge is listed in Appendix 2 and should be agreed locally between CCGs and provider trusts.
5.4 Discharge summaries should be sent to the GP at the time of discharge and ideally received within 24 hours of patient discharge. Consideration should be given to the most convenient form of communication to ensure appropriate information transfer across the interface (for example fax or email).

5.5 Hospitals should review templates for electronic discharge systems (where applicable) and adapt where necessary to ensure the fields comply with the required minimum dataset.

5.6 An agreement should be made between provider trusts and CCG to enable an audit to be undertaken to monitor the quality and timeliness of information provided on discharge and ensure compliance with CQC recommendations.

5.7 Patients should be provided with appropriate written information about the medication prescribed, duration of treatment and obtaining further supplies of medicine.

5.8 Monitored Dosage Systems and other Compliance Aids:
Hospital Trusts should develop discharge planning arrangements for vulnerable patients. Where these include supply of monitored dosage or other similar systems there must be a policy in place for their use, including assessment of need and making appropriate arrangements for continuity after discharge. This arrangement should reflect guidance on support to people with disabilities, compliance with the Disabilities Discrimination Act and include community pharmacies, where appropriate.

6. Out-patients/Day Case

6.1 If medicines are required immediately they should be provided from the provider trust.

6.2 If a medicine is required for non-urgent routine care it is appropriate to write to the GP and recommend a medicine, provided it is in the provider trust’s formulary and suitable for prescribing by GPs. In this case the patient should be told that the medicine is not urgent and that they should contact their surgery after at least 7 days when the full information in writing must have been received by the GP. The Outpatient form must be completed fully and legibly.

6.3 If the provider trust prescriber is recommending that the GP prescribes, the GP cannot make an informed decision before receiving the full outpatient information. If the patient requires any medicine before the hospital can guarantee that the practice will receive such a letter, it is the responsibility of the hospital to provide the prescription. It is the responsibility of the hospital to provide medicine if it is a hospital only medicine.

6.4 Information provided to the GP must include details of any medicines that have been stopped, the reason why the medicine has been prescribed and the intended duration of the new medicine. It is recommended that hospitals and CCGs agree an outpatient template letter to ensure this information is communicated effectively.

6.5 If medicine is required, patient packs should be dispensed unless the full course of treatment is less or a smaller supply is deemed appropriate on clinical health grounds.

6.6 GPs should not be asked to prescribe medicines and dressings which are intended to be used / administered in hospital out-patient clinics or day-care surgery. (e.g.: intrauterine levonorgestrol implants).
(Note: this does not apply to those medicines which have been prescribed by the GP for patient's use at home and which the patient has brought into hospital as a "patients own medicine" for an in-patient stay: see section 3)

7. Dressings and Appliances
7.1 Suitable local arrangements should be in place for the supply of dressings and appliances. Sufficient information about a patient’s dressing and appliance treatment should be supplied to ensure continuity of care in the community.
7.2 Provider trusts should not make arrangements with appliance contractors for ongoing supplies of dressings or appliances in the community without involving patients in the decision about where their prescriptions are dispensed. Patients should be informed of the other providers available, e.g. community pharmacists.

8. Patients attending Accident and Emergency
8.1 If a medicine is necessary, an original pack/ pre-pack should be supplied, unless the full course of treatment is less in line with paragraph 2.4 and Medicines Act.

9. Unlicensed Medicines
9.1 The safe prescribing of unlicensed medicines will be assessed when new drugs are reviewed by the NCL JFC, including the appropriateness of transferring prescribing to primary care using a shared care arrangement. Unlicensed medications must be initiated by the clinician in the Acute Trust,

9.2 Prescribing by a GP of an unlicensed medicine must be in line with GMC prescribing guidance [http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp]

9.3 Informed consent for the use of unlicensed medicines should be obtained from patients before the prescription is written.

9.4 GPs should not be asked to prescribe unlicensed “specials” when a suitable alternative, more cost effective dosage form/licensed product is available.

9.5 If the medicine is prescribed for a child in line with information in the Childrens BNF and is not on the red list then a GP will be supported to continue prescribing.

10. Drugs Used Outside of Their Licensed Indications (often referred to as ‘off-label’)
10.1 Ideally, informed consent for the use of use of licensed medicines outside their licensed indications should be obtained from patients before the prescription is written.

10.2 Where there is a substantial body of evidence to support the use of a licensed medicine outside of its licence (e.g. in paediatrics), the GP may be asked to prescribe. However, the licensed state of the medicine should be brought to the attention of the GP or other prescriber. The full agreement of the GP concerned must be obtained before prescribing is transferred.

11. ‘Red List' When Responsibility for Prescribing Remains with Hospital Trust Consultants (see Appendix 3)
11.1 The provider trust is expected to retain prescribing responsibility where:
   • Medicine has been commenced in the provider trust and specialist ongoing intervention and monitoring is needed.
   • Medicines are only available through Hospital Trusts.
   • Medicines are part of a provider trust initiated clinical trial.
   • Medicines are not stated in the Drug tariff and therefore not available on FP10.
   • Medicines have not been approved by the Drugs & Therapeutics Committee (or equivalent).

11.2 If there is disagreement about where prescribing of a patient’s treatment should best take place the case should be referred to the CCG, via the Chief Pharmacist who will seek resolution.
12. Transfer of Prescribing Medicines Requiring Specialist Monitoring (see Appendix 4)

12.1 Increasingly, patients with continuing specialist clinical needs can be cared for at home or in the community. There are medicines which could be prescribed by GPs if sufficient support, review and information is shared between the GP and consultant.

12.2 It is the responsibility of the consultant to ensure that the GP is willing to prescribe before mentioning the possibility of shared care to the patient. In no circumstance should the patient be used as the vehicle for informing the GP that prescribing could be transferred to the GP.

12.3 A GP should not decline to prescribe a medicine solely on the basis of cost. Likewise, if the patient is to receive the majority of their ongoing care through the hospital then prescribing must remain with the hospital and must not be transferred solely on the basis of cost.

12.4 The following conditions should be met before the shared care takes place:
- the patient's condition is stable;
- the agreement of the patient's GP is sought prior to the transfer of prescribing and the GP is sufficiently informed and able to monitor treatment, identify medicine interactions and adjust the dose of any medicines as necessary.
- Resources are available to ensure (where required) the safe administration of any specialist medication in the community e.g. IV therapy. This would usually be agreed with the community nursing services.

12.5 All prescribers should be aware of their responsibilities to develop their expertise and the expertise of others in the managed introduction of new medicines.

12.6 A framework for the production and use of shared care guidelines for medicines in North Central London is detailed in Appendix 4.

12.7 A list of shared care guidelines and the organisations which approve their use is detailed in part B of Appendix 5.

12.8 It is essential that a copy of the NCL MON approved shared care guideline / prescribing monitoring document including the baseline monitoring information is provided to the GP in order to facilitate the shared care transfer.

13. Tertiary Care Referrals and Prescribing Medicines Requiring Specialist Monitoring

13.1 Where it is clinically appropriate for the patient to be cared for at home, under the supervision of the tertiary centre, the centre should make appropriate arrangements for prescribing and supply of specialist medicines (e.g. High tech home health care schemes EL(95)5 or using FP10 (HP)s).

13.2 In some circumstances it may be appropriate to transfer prescribing to a more local Hospital Trust or more rarely to a GP. In all situations there should be robust processes in place between the tertiary centre, Hospital Trust and GP to ensure timely and accurate transfer of a patient’s medication details to appropriate professionals responsible for his/her care.

13.3 The principles outlined in Section 12 should be applied.

14. Clinical Trials & Ethics Committees

14.1 All clinical trials must have been subject to Ethical Committee approval and research governance approval, where the arrangements for consulting and informing should be considered. In order to respond appropriately to any suspected adverse events that occur outside hospital, the GP should be adequately informed if a patient is participating in a clinical trial.
14.2 Prescribing and supply of clinical trial medicine is the responsibility of the provider trust. Standard out-patient or in-patient treatment costs will be met for patients on a trial as required by HSG (97)32; this will not include the cost of the trial medicines either during or after the trial.

14.3 Patients participating in a clinical trial must be made aware that there is no guarantee that the medicine will be continued at the end of the trial, irrespective of the results and this should be clearly stated in the information for patients. The trial documentation must include a clear exit strategy for any trial medication detailing any post trial funding implications that must be agreed by the CCG prior to entry to the trial.
Appendix 1
Standard dataset for information on medicines required on admission to hospital

Introduction

In October 2009 the Care Quality Commission (CQC) published a report on a national study which raised concerns about the quality and timeliness of information on patients’ medicines transferred between acute trusts and general practitioners and vice versa when patients are admitted to and discharged from hospitals. This paper lists the minimum dataset for information which should be provided on admission to hospital, adapted from the CQC self-assessment tool. The CQC recommends that written guidance be in place covering information flow at admission.

Minimum dataset for information provided on admission

☐ Complete patient details (full name, date of birth, NHS number, GP, date of admission)
☐ Presenting condition plus co-morbidities
☐ A list of all medicines currently prescribed for patient (furthermore, it is good practice for this to additionally include those bought over the counter)
☐ Dose, frequency, formulation and route of all medicines listed
☐ An indication of medicines not intended to be continued
☐ Known allergies
☐ Major side effects / sensitivities / adverse reactions to previously taken medicines (if relevant)

Other recommendations

☐ This information should be available to hospital when a patient is admitted for planned admissions and as soon as possible (ideally within 24 hours of admission) for unplanned admissions.
☐ Guidance may set out schemes / systems for ensuring that a patient’s medicine is brought with them into hospital – this could apply to either elective or emergency admissions (or both). An example of this would be the ‘Green Bag’ scheme. This will assist the reconciliation process. This recommendation is considered good practice and not an expectation.

References


Acknowledgement with thanks: Imperial College Healthcare NHS Trust
Author: Patrick O’Sullivan
Lead Pharmacist
April 2010
Appendix 2
Standard dataset for information on medicines required on discharge from hospital

Introduction
In October 2009 the Care Quality Commission (CQC) published a report on a national study which raised concerns about the quality and timeliness of information on patients’ medicines transferred between acute trusts and general practitioners and vice versa when patients are admitted to and discharged from hospitals. This paper lists the minimum dataset for information on medicines which should be provided on discharge from hospital, adapted from the CQC self-assessment tool¹ and National Prescribing Centre recommendations.

Minimum dataset for information on medicines provided on discharge
This information is also included in the NHS standard contract.²

☐ complete patient details (full name, date of birth, NHS and hospital number, GP, date of discharge)
☐ key diagnosis made during the patient’s admission, plus co-morbidities, and any procedures carried out
☐ medication prescribed at the time of discharge, including any medication not dispensed
☐ dose, route, frequency, formulation (where relevant) and length of course for all medications, with details of any variable prescriptions
☐ the reasons for any medications started or stopped
☐ any adverse reactions or allergies to medications or treatments observed in the patient during admission, and any previous reactions
☐ the name of the responsible Consultant at the time of the patient’s discharge
☐ any immediate post-discharge requirement from the primary healthcare team
☐ any planned follow-up arrangements
☐ whether the patient has any relevant infection, for example MRSA
☐ who should be contacted in the event of a query (e.g. responsible doctor and their contact details)

Other recommendations
☐ Discharge summaries must be received by the GP within 24 hours²
☐ The patient should be given a copy of the discharge letter
☐ The CCG should have considered how community pharmacists can be included in the flow of discharge information.

References

Acknowledgment with thanks: Imperial College Healthcare NHS Trust
Author: Patrick O’Sullivan
Lead Pharmacist June 2010
Appendix 3
Management of the North Central London ‘Red List’ of Medicines that hospital/NHS Trust doctors should not ask GPs to prescribe

North Central London Joint Formulary Committee (NCL JFC) or NHS Trust Drug and Therapeutics Committees (D&TC) consider published evidence on the effectiveness of a new medicine and its cost-effectiveness and safety before deciding whether to add it to the hospital’s formulary. All such committees in NCL have representation from local CCGs. When a medicine is added to a provider formulary, the committee must also consider whether it is reasonable for a GP to prescribe the medicine, or whether it should be added to the red list (see Appendix 4 for criteria for shared care, and Appendix 5 for the red list).

When NCL JFC or D&TC decide a new medicine should be added to the red list or that a fact sheet or shared care agreement be developed, the NCL Medicines Optimisation Network (MON) will be informed. A fact sheet will be developed when additional information needs to be provided to the GP to support safe and effective prescribing but no specific additional monitoring is required.

Any North Central London CCG or NHS Trust can request that a medicine is added to or removed from the red list. The trigger for consideration for the red list is normally following the review of a new medicine at NCL JFC or NHS Trust D&TC. The Trust’s Chief Pharmacist (or equivalent) should make the case for the change at a NCL MON meeting. The NCL MON will normally take a view on red list decisions at the first meeting to which the decision is presented.

The red list will include recommendations for medicines commissioned by NHS England.

The following criteria are used by D&TCs and the NCL MON in deciding whether a change to the red list should be made:

The Hospital Trust is expected to retain prescribing responsibility where:

- Medicine has been commenced in the hospital and specialist ongoing intervention and monitoring is needed.
- Medicines are only available through Hospital Trusts.
- Medicines are part of a Hospital Trust initiated clinical trial.
- Medicines are not stated in the Drug tariff and therefore not available on FP10.
- Medicines have not been approved by the Drugs & Therapeutics Committee (or equivalent).

If there is disagreement about where prescribing of a patient’s treatment should best take place the case should be referred to the CCG, via the Chief Pharmacist who will seek resolution.

Criteria for adding a medicine to the red list:

- Safe or effective use of the medicine, throughout its use, requires expertise or facilities that a GP will not normally have.
- Medicines added to the red list will normally be ‘specialist medicines’ that a GP will see infrequently, medicines used in the treatment of rare conditions, or medicines only available from a hospital or requiring a special ‘package of care’
- Relevant changes to a medicine’s licensing or to national policy (e.g. Summary of Product Characteristics, NICE guidance, BNF monographs, MHRA alerts, Patient Safety alerts).

Criteria for removing a medicine from the red list:

- Relevant changes to a medicine’s licensing or to national policy (e.g. from NICE or other sources as above) now states that it is reasonable for GPs to prescribe the medicine, perhaps in the context of a shared care agreement.
- New trial evidence or a change in licence has made the medicine easier to use than at the time it was added to the red list (e.g. by demonstrating that less monitoring is needed than previously or appropriate support or packages of care are now provided in primary care).
A medicine will not be added to the red list:

- If, although the medicine should only be initiated by a hospital specialist, it is reasonable for a GP to continue to prescribe it once the patient and treatment are stable (e.g. monitoring, dose changes and stopping treatment require no specialist expertise or facilities).
- On grounds of cost.

There should be a quarterly review of the red list and regular review of shared care agreements to incorporate any change in national policy or if a significant incident occurs in clinical practice.

If a NDP or D&TC decision appears inconsistent with these criteria, the NCL MON will review the decision against the above criteria and may recommend referral to the JFC for final decision.

The NCL Medicines Management team will be responsible for updating the red list and circulating to NCL MON members.
Appendix 4
Framework for the Production and Use of Shared Care Agreement for Medicines in North Central London

1. Background
Safe shared care and transfers of prescribing should be undertaken with regard to the General Medical Council’s [GMC’s] Good Practice in Prescribing Guidance (http://www.gmc-uk.org/guidance/ethical_guidance/14321.asp). Shared care is where one clinician shares responsibility for a patient’s care with a colleague. In proposing a shared care arrangement, specialists may advise the patient’s general practitioner which medicine to prescribe. If a treatment requires specialist initiation, is rarely prescribed in primary care or is a medicine or clinical condition that requires monitoring by a specialist, this will require a formal shared care agreement. Shared care requires the agreement of all parties, including the patient, defining respective roles and responsibilities. Effective communication and continuing liaison between all parties to a shared care agreement are essential.

Treatments can be assigned the following features:

- Prescribing should remain in secondary / tertiary care due to the specialist nature of the treatment or condition. These treatments, with their respective indication, are documented in the Red List, and are usually accessed directly at the hospital or via Homecare arrangements.
- Where shared responsibility is required between the specialist and primary care due to the treatment or the condition, a shared care agreement would be required.
- Prescribing is initiated and stabilized by the specialist, who can then request a primary care clinician to continue prescribing and monitoring of the patient. The primary care clinician will need to be supported with additional prescribing and monitoring guidance and the roles and responsibilities of all parties should be well defined and clearly documented.
- Have previously been considered specialist and now deemed appropriate to be initiated by a primary care clinician. This would be supported by a more simplified treatment fact sheet.

2. Essential features of effective shared care agreements

- **Best interests of the patient**
  Any shared care arrangement should be focused on providing the best standard of care for the patient.

- **Individual, patient by patient arrangements**
  Shared care documents should be accompanied by information about the patient in question, outlining all relevant aspects of that patient’s care. The hospital doctor and GP must agree which elements of the patient’s care each will undertake. If the GP agrees to undertake a specific element of care subject to receiving appropriate support the onus is on the hospital to provide this support.

- **The GP should never be asked to initiate prescribing for shared care medicines**

- **Reasonably predictable clinical situation**
  Sharing care with primary care should only be considered where a patient’s clinical condition is stable or predictable.

- **Willing and informed consent of all parties, including patients and carers**
  All parties must have sufficient accurate and up-to-date information in a form they can understand. Consent must be given voluntarily.

Consultants and GPs are encouraged to communicate directly when questions arise around shared care for a particular patient. If issues about prescribing remain after these discussions, a Pharmacist at the CCG or Hospital Trust should be contacted for advice.

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

- **Communication network and emergency support**
  A telephone contact number, fax number and/or email address must be provided so that the GP can access advice and information if problems arise. Out-of-hours contact numbers must be provided so that the GP can contact an appropriate healthcare professional out-of-hours.

The documentation should state how often the patient will be reviewed and must detail a ‘route of return’ should the patient’s condition become less predictable (e.g. return of symptoms, development of adverse effects). Progress reports should be produced to an agreed timescale.

- **Clinical information**
  Shared care documentation should not duplicate information that is available in the British National Formulary (BNF) or Summary of Product Characteristics (SPCs); it should direct the reader to the BNF/SPC when appropriate. It may however be appropriate to include the following:
  - A brief overview of the disease
  - A note of relevant NICE or other guidance and weblink to the full guidance
  - Intended duration of treatment
  - Common and important adverse effects (incidence, identification, importance and management)
  - Clear information regarding monitoring requirements (e.g. liver or renal function), who is responsible for obtaining and interpreting samples, frequency of testing and what to do when adverse test results occur.

It is envisaged that all prescribers will want to keep reasonably up-to-date with important developments in therapeutics. Practitioners have a duty to keep themselves informed of the medicines that are recommended for their patients.

- **Review**
  Shared care documentation must be reviewed by the authors, every 3 years or sooner if indicated (e.g. when NICE guidance is reviewed or updated).

3. **Circumstances in which prescribing and monitoring responsibility is retained by the specialist**

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

- When the GP does not feel competent to take over responsibility for prescribing.
- Where patients receive the majority of care, including monitoring, in hospital and the only benefit achieved by sharing care would be a reduction in hospital expenditure.
- Where the medicine is unlicensed, only available through hospital or being used as part of a hospital-initiated clinical trial.
- Where the medicine is included on the NCL Red List of medicines that hospital doctors should not ask GPs to prescribe (see Appendix 5).

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

GPs should only agree to prescribe if, after reading the shared care document, 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 document?
- Have you been provided with, or have access to, relevant clinical details including monitoring data to manage the patient?
- Are you confident in accepting clinical and legal responsibility for prescribing?
If the answer is NO to any of these questions the GP should write to the consultant, within 14 days, outlining their concerns. Refusal to prescribe must ONLY be on the grounds of clinical responsibility. The cost of the medicine should not be a barrier to sharing care nor should a hospital seek to transfer prescribing on the grounds of cost alone, unless the commissioning arrangements stipulate that the hospital must make all supplies and retain all responsibility.

5. Involving the patient
The consultant should only obtain the consent of the patient (and his or her carers if appropriate) after the GP has agreed in principle to share 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 development and approval of shared care arrangements
6.1 The need to have a pan-NCL shared care agreement, prescribing and monitoring document or a fact sheet will be considered at the time when a treatment is considered by the Joint Formulary Committee (JFC) or local Drug and Therapeutics Committee (DTC).

6.3 NCL MON will identify a lead Trust who will draft a shared care arrangement using the relevant standard template, gain agreement with other NCL Trusts, and share the final draft with CCG colleagues.

6.4 CCGs will obtain comments from their local clinicians through their Medicines Management Committee structures.

6.5 The final draft will be approved by NCL MON, endorsed at NCL JFC and made available on the JFC website.

6.6 Each shared care document should be reviewed every 3 years or sooner if indicated (e.g. if new NICE guidance or MHRA/NPSA medicine safety alerts are issued).

Adapted by the North Central London Medicines Management Pharmacy Network from NWL Prescribing policy, that was adapted from ‘Effective Shared Care Arrangements’ issued by the Midlands Therapeutic Review & Advisory Committee.