Can prescribing responsibilities be transferred to primary care?

Check GMMMG RAG List

Medicines are classified into a RAG (**RED/AMBER/GREEN/DNP/GREY**) status:

Red	**Specialist only medicines**. It is recommended these medicines should only be initiated and prescribed by specialist teams. Supply of these medicines should occur via the hospital or specialist service (this may include via a home care company).	**NOT SUITABLE FOR TRANSFER OF PRESCRIBING**
Amber	**Suitable for shared care arrangements.** Prescribing and monitoring responsibilities may be transferred from specialist teams to primary care prescribers in line with a shared care protocol Shared care arrangements will usually be supported by a GMMMG shared care protocol (SCP).	**SEE PAGE 2 FOR FURTHER INFORMATION.**
Green following specialist initiation	**Suitable for continuation in primary care following initiation by specialist service.** Little or no monitoring required.	**SEE PAGE 2 FOR FURTHER INFORMATION.**
Green following specialist advice	**Suitable for initiation by primary care, following written or verbal advice from a specialist service to primary care prescriber.** Little or no monitoring required.	
Green	**Suitable for initiation and continued prescribing within primary care.**	
DNP	**Not recommended for prescribing in any setting. "Do Not Prescribe" status may relate to a specific medicine, or to prescribing for a particular indication.**	**DO NOT PRESCRIBE**
Grey	**Not suitable for routine prescribing but suitable for exceptional use in a defined patient population.** Prescribers should ensure that more suitable alternatives have been considered and ruled out as not being appropriate before recommending or prescribing a medicine with a GREY list status. In these cases a RAG of RED, AMBER or GREEN will also be assigned to clarify in which care setting prescribing responsibility lies.	

What if the medicine is not on the GMMMG Joint Formulary or RAG list?

The GMMMG Joint Formulary and RAG list are based on medicines that may be used for the majority (approx. 80%) of the general population. Local specialist services may therefore need to approve some medicines that are not included on the GMMMG formulary or RAG list.

Check Local Trust Formulary:

The Local Trust Formulary should indicate whether prescribing should remain in hospital or might be suitable for transfer to primary care. Where there is no GMMMG recommendation available it is good practice for the specialist clinician to share as much information as possible with primary care prescribers before initiating the medicine based on Local Formulary recommendation.

- **Non-formulary-** medicines not listed in the Local Trust Formulary or the GMMMG Joint Formulary/ RAG will not be suitable for transfer of care.
- **Unlicensed or off-label medicines** will be unsuitable for transfer unless there is a national body of evidence to support their safety and efficacy and there are little or no monitoring requirements. Insufficient information detailing the rationale for the choice of an unlicensed/off-label medicine(s) may result in a delay in prescribing from primary care. It is the responsibility of the requesting specialist to provide this. If unsure about the suitability of transferring the prescribing of a medicine to primary care, specialists should contact their Trust's Medicines Management Team while primary care prescribers can contact their CCG Medicines Optimisation Team for advice.

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The medicine is classed GREEN or GREEN (specialist initiation/ advice)

Inpatient/ day case /A&E setting

Provide the patient with an appropriate supply of medicine from the hospital. This should be a **minimum of 7 days,** unless a shorter period is indicated. For some medicines the appropriate duration might be until their next scheduled review.

Supply full courses of treatment when appropriate; e.g. antibiotics and steroid therapy for acute treatment.

Take into account holiday periods; allow sufficient time for the patient to contact the GP practice.

New medications should be highlighted on the Discharge Summary and sufficient clinical information should be included to allow primary care prescribers to continue prescribing safely.

**Local policy may vary- some services may require a longer minimum duration of supply.*

Outpatient setting

Immediate clinical need?
Provide a sufficient supply of medicines from the hospital up to when the clinic letter should reach the GP practice and the primary care prescriber can prescribe accordingly.*

Full courses should be supplied where possible e.g. acute antibiotics, steroid treatment, analgesics.

**Note: The NHS Standard Contract requires that the Clinic Letter must be sent within 7 days of the outpatient appointment. This allows GP practices adequate time to process prescriptions and helps to avoid interruption in supply.*

Non-urgent?
Request can be sent to primary care prescriber if a delay in prescribing will not affect clinical outcomes to the patient.*

The request should include sufficient clinical information to allow the primary care prescriber to prescribe safely.

**Note: Allow up to a week following receipt of the Clinic Letter by the GP practice for the patient to receive the medicine.*

The medicine is classed AMBER

Is a GMMMG shared care protocol available?

YES

Prescribing from the specialist service must continue until the patient meets the criteria for shared care (as outlined in the shared care protocol).

NO

Continue to prescribe from hospital; this medicine is not currently approved for shared care arrangements.[Δ]

[Δ]A review of all AMBER RAG classification with no GMMMG SCP is underway

The specialist must write to the patient's primary care prescriber requesting shared care. The correspondence must include a fully completed copy of the GMMMG SCP. Alternatively, details required from the specialist service may be provided within a local letter template *providing* the letter includes the full information required as indicated in sections 1-7 of the SCP template, and sent along with a link to the SCP. Prescribing information, results of baseline investigations/ relevant monitoring information, local contact details and the procedure for seeking specialist advice should be provided within the SCP or letter. **Any incomplete information in either the SCP itself or within a letter template will result in the shared care protocol being invalid which can lead to refusal or delay of shared care**.

The initiating specialist must be available to answer any questions the primary care prescriber may have. The specialist should allow **approximately 28 days** from the date of request for the primary care prescriber to take on shared care. **If there is a delay in communication this process will take longer. Sufficient medicine should be supplied from the specialist service in the interim until shared care is accepted and the patient should be advised on how to obtain further supplies.**

The primary care prescriber should respond to the request for shared care within 14 days of receiving the request to confirm acceptance or refusal of shared care.

Shared care accepted

The GP practice will contact the patient once shared care is approved and a prescription is ready; a SNOMED code should be added to the patient's GP records to highlight the existence of shared care.

The **GP practice and initiating specialist** must comply with their ongoing responsibilities as outlined in the SCP.

Care should be available from the specialist service in a timely manner, without requiring a new referral. Patients formerly treated on the advice of the specialist service who are no longer being regularly seen in that setting still need a pathway to access the service, in the event that problems arise.

Shared care declined

A written response must be provided to the initiating specialist. This should be done within 14 days; reasons for declining shared care must be provided. A letter template is included within the SCP to facilitate this.

The initiating specialist may contact the GP practice to understand the reason and discuss possible solutions. If a solution is not found, prescribing and monitoring must continue from the specialist service.

The initiating specialist and primary care prescriber must document and copy all correspondence relating to shared care within the patient's records.

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Frequently asked Questions

1. What is GMMMG and how do I access the website?

Greater Manchester Medicines Management Group (GMMMG) provides prescribing support for primary and secondary/tertiary care in Greater Manchester. To date, they have published:

- a joint formulary for medicines and device- applicable to prescribing by primary and secondary care clinicians;
- clinical guidance and pathways;
- Shared Care Protocols (SCPs) and
- local commissioning decisions for high cost drugs.

Clinical and commissioning representatives from both care settings support the preparation of these resources to ensure seamless prescribing across the interface. Prescribing clinicians in Greater Manchester are expected to use GMMMG publications and recommendations to support them with their prescribing decisions. GMMMG's website can be accessed via: www.gmmmg.nhs.uk.

2. Do I refer to the local Trust formulary or GMMMG when transferring prescribing to primary care?

All local Trust formularies in Greater Manchester should be cross-referenced against GMMMG's formulary and include the RAG status for each medicine.

The GMMMG formulary is based on medicines that are used for the majority (approx. 80%) of the general population. Therefore, local specialist services may need to approve some medicines that are not relevant for inclusion on the GMMMG formulary or RAG list.

When medicines are approved at local Trust level, there should be consideration as to whether prescribing should remain in hospital or transferred to primary care. When a decision is made to transfer prescribing responsibilities to primary care, it is good practice to submit a formulary request to GMMMG and wait for their approval before a hospital clinician transfers prescribing to primary care. It will be at the discretion of the primary care prescriber to prescribe a medicine before GMMMG approves a formulary request. It is good practice for the specialist clinician to share as much information as possible with primary care prescribers before initiating the medicine.

Hospital clinicians should not prescribe, or request primary care prescribers to prescribe, medicines that are not included in the local Trust formulary. Please contact your local Trust's medicines management team for further information.

If unsure about the suitability of transferring the prescribing of a medicine to primary care, specialists should contact their Trust's Medicines Management Team while primary care prescribers can contact their CCG Medicines Optimisation Team for advice.

Any prescribing outside of the GMMMG RAG framework should be a patient specific request, as part of direct discussion/ correspondence between the relevant prescribers. Any such agreement should be adequately documented in the patient's clinical record held by both the GP practice and the specialist team.

3. What does 'immediate clinical need' and 'non-urgent' mean?

Immediate clinical need

A hospital clinician must provide medication after an outpatient clinic if a patient requires treatment immediately. The quantity of medication should be tailored towards the length of time it takes for a clinic letter to be processed internally, to be then sent to the GP practice and processed by the GP or other primary care prescriber. Courses of medicines for acute indications should be prescribed in full whenever possible including, antibiotics, steroids and analgesia.

Non-urgent

A hospital clinician can request a primary care prescriber to initiate treatment after an outpatient clinic as long as the delay in prescribing will not affect clinical outcomes to the patient.

A hospital clinician cannot ask a patient to verbally communicate a prescription request to their GP practice. On the rare occasion, when the hospital clinician has concerns that a request won't get to the GP practice in a reasonable timeframe, the hospital clinician can give the patient or their carer a locally approved prescription request form which can then be taken to their GP practice. The patient should be advised to drop their request off to the GP practice as soon as possible as they will not be able to pick up a

prescription from the GP practice on the same day. Responsibility to provide the GP practice with this request will lie with the patient and requesting specialist clinician.

4. Can I send a request to a primary care clinician to prescribe treatment from a positive diagnostic test result I performed?

The results of a diagnostic test initiated and performed by hospital colleagues should be communicated to the patient directly. All clinicians, whether in primary or secondary care, retain clinical and medico- legal responsibility for the results of these investigations; sending a result on to another clinician does not absolve the original requester of that responsibility. Hospital colleagues should consider whether the medicine is non-urgent or there is an immediate clinical need. If there is an immediate clinical need, hospital colleagues should supply the medicine to the patient.

5. I have developed a local shared care protocol; can I use it for my patients?

Shared care protocols used within Greater Manchester must be approved by GMMMG. A primary care prescriber will not accept shared care unless it has gone through appropriate GMMMG approval pathways. The process for submitting a local shared care protocol for GMMMG consideration can be found here. If a shared care protocol is approved at one local CCG, this does not mean it is approved for all CCGs. All current GMMMG protocols are currently being revised to indicate which CCGs/ providers are signed up to them.

6. Can any grade of healthcare professional initiate and accept shared care?

The clinician who has overall responsibility for the patient's condition in secondary care and primary care should be the one to initiate and accept shared care. This is often a consultant and a GP but it could be a specialist registrar and a specialist non-medical prescriber.

7. What if a GP has been prescribing an AMBER medicine historically without a shared care agreement on file?

GP practices should ask the specialist clinician for a shared care agreement with up to date guidance, contact and monitoring details.

8. What do I do if a patient is discharged from the specialist service but is still on a shared care medicine?

Primary care prescribers should not be in a position to be solely responsible for the management of a shared care medicine.

It is recommended that all patients on a shared care medicine are not discharged from secondary care services and there should be a clear pathway for access to the specialist service when required. If there is a plan to discontinue the medicine and discharge the patient from shared care, this should still be done in collaboration with the specialist team who must provide the primary care prescriber with appropriate instructions and be available for support during the process.

9. What do I do when my patient's primary care prescriber declines the transfer of prescribing responsibilities?

The legal responsibility lies with the doctor or healthcare professional who signs the prescription and it is the responsibility of the prescriber to prescribe within their own level of competence. Therefore, it is important for specialist clinicians to provide the relevant training, advice and guidance to the primary care prescriber when requesting shared care.

Consider the reasons why the primary care prescriber does not want to take over prescribing responsibilities. If more clarity is needed, contact them to discuss these reasons further. If the primary care prescriber does not agree after additional discussions, prescribing must continue from the specialist service. Please consider incident reporting the decision through local reporting systems and ensure your patient has a supply of medicines whilst prescribing responsibilities are decided. If there are any queries regarding shared care across the interface, contact the CCG's medicines optimisation team in which the relevant GP practice is located.

10. What happens to the shared care agreement if a patient moves between specialist teams or practices?
Where patient care is transferred from one specialist team or GP practice to another, a new shared care agreement must be completed.

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