

April 2013

GPC

General Practitioners
Committee

Prescribing in General Practice

BMA 

INTRODUCTION

This guidance was put together by the Clinical and Prescribing subcommittee to meet the increasing demand from individuals and organisations for information relating to prescribing in general practice. Doctors have specific clinical rights and responsibilities in relation to prescribing, and as most general practitioners work within the NHS, they are also bound by the NHS regulatory system.

The first section sets out the BMA policy on some common issues. The rest of the guidance is set out in a series of questions and answers for ease of use. The earlier sections of the FAQs are likely to be of most interest to doctors, PCOs (and in the future CCGs) and other NHS organisations, whereas the later part deals with general issues around prescribing that may be of particular interest when dealing with queries from patients.

GPC POLICY

Drug switching

The GPC is aware that in some areas practices are being encouraged by their PCO to switch patients from one drug to a less expensive drug. The prescriber must assess each patient individually when taking the decision to change a patient's medication. Any changes must be made in the patient's best interests and must be fully explained to the patient.

Where a bulk switch is made at the request of the primary care organisation (PCO) or CCG they should provide adequate resources to facilitate the switch including the input of the pharmacy advisor and resources to inform patients of the change. Where it is reasonable to switch a patient then practices may agree to do so. However, GPs must always use their clinical judgement and, where they can make a clinical case for not switching a patient, they have every right to continue to prescribe as they feel is clinically appropriate. GPs continue to carry responsibility for their prescribing decisions.

Repeated switching on the basis on cost savings alone can irritate patients and can erode trust and compliance. These detrimental effects need to be borne in mind.

A related issue is the confusion patients can experience when the colour and shape of their tablets are changed as a result of pharmacists changing supplier. With some pharmacists this can happen frequently. Continuity in prescribing for individual patients is safer and will improve compliance.

Exemptions from prescription charges

People with certain medical conditions can get free NHS prescriptions, and in April 2009 cancer was added to the list of conditions that give exemption from prescription charges. Patients receive an application form which needs to be countersigned by their GP or hospital doctor (or, at their GP's discretion, a member of the practice who can access their medical records). The full list of exempted conditions is available on the [NHS Business Services Authority website](#), including [further guidance](#).

The BMA has long called for a review of the prescription charge system and believes that prescriptions should be free of charge for all patients in England as they already are in the rest of the UK.

Excessive prescribing

The GPC is aware that some PCOs have in the past attempted to misuse Annex 8 of the 2006/07 GMS contract (*'Excessive and inappropriate prescribing: guidance for health professional on prescribing NHS medicines'*) to control prescribing (e.g. for antibiotics) or threaten termination of GMS contracts. The GPC has produced further guidance *'Focus on excessive prescribing'* which is available at the following [link](#).

Please contact your [LMC](#) or [a BMA advisor](#) if you are experiencing a threat to your contract.

Medicines shortages

The GPC continues to be involved in discussions with the Department of Health (DH), Pharmaceutical Representatives and MHRA via a Medicines Supply Chain group. Via this group, the BMA was involved in producing joint guidance ([Best practice for ensuring the efficient supply and distribution of medicines to patients](#)) that sets out the key legal and ethical obligations on manufacturers, wholesalers, NHS Trusts, registered pharmacies and dispensing doctors in relation to the supply and trading of medicines.

However, there is a growing concern about this issue and the reason for the shortages are often given as 'manufacturing problems', but we believe this may also be due to the bulk buying of stocks of drugs in the UK and reselling of them in Europe at a profit. The GPC is concerned about the lack of action taken by the DH and has raised this issue with them again.

Non-GP prescribing

When a non-GP prescriber initiates a new drug they accept responsibility for that prescription, but they usually have no method of reissuing repeats and that responsibility invariably falls on GPs. When faced with a request from the patient for a repeat prescription, GPs should review the patient and set up a repeat prescription if appropriate or refer the patient back to initial prescriber.

Good working practice would advise that anything prescribed for long term prescription should be notified to those likely to continue the medication (i.e. the GP). The responsibility for checking interactions remains with the prescriber who should take a full drug history if they do not have access to the main clinical record. [See also FAQs on supplementary and independent prescribers]

Prescribing numbers for GPs

Following pressure from the GPC, from 2007, salaried GPs have been entitled to have their own prescribing number. Primary Care Organisations (PCOs) can apply to the NHS Information Centre (GMS Team) for an individual unique number for each of the salaried GPs on their Performers' List. We therefore advise salaried GPs to contact their PCO for a prescribing number. We continue to make representations for all GPs to have a unique identifier for their prescribing, which will be particularly important with the introduction of revalidation.

Prescribing incentive schemes

Prescribing incentive schemes are implemented in some areas to reward practices for cost effective prescribing. GPs should be aware of the costs involved and ensure ethical consideration when signing up to schemes. The GPC supports prescribing incentive schemes where they are evidence-based and introduced with the support of local GPs. For further advice see the GMC guidance [Good Medical Practice](#) about good clinical care and [Good practice in prescribing and managing medicines and devices](#).

Prescribing advice

Some practices and GPs may wish to use prescribing decision support software, for example ScriptSwitch and EMISweb. This provides GPs with national and locally authored patient safety information messages, drug switch recommendations and other prescribing information. Practices do not have to use this software if they choose not to and PCOs / CCGs should not place undue pressure on them to install this software. GPs must ensure that their prescribing decisions are in the patient's best interests and must be fully explained to the patient.

Requests to transcribe medication directions

Some community hospitals and care homes are refusing to accept verbal orders or faxed directions based on the Nursing and Midwifery Council guidance [Standards for medicines management](#) which advises that transcribing should only be done in 'exceptional' circumstances. We believe that having to organise for a registered prescriber to attend and transfer a record is a waste of resources and that a written record of confirmation (a written FP10 prescription and a record of that in the patient's record) should suffice. There is no obligation to write anything in the community hospital / care home records or charts.

Working with pharmacists

The GPC is represented on the Professional Relationships Working Group (PRWG), along with NHS Employers and the Pharmaceutical Services Negotiating Committee (PSNC), which focuses on improving professional relationships between GPs and community pharmacists for patient benefit. Further information about the PRWG is available on the [NHS Employers website](#).

Questions and Answers on prescribing issues

PRESCRIPTION INTERVALS

- **Is there a standard prescription interval?**

Doctors provide prescriptions for intervals that they feel are clinically appropriate, taking into account such factors as possible reactions, a possible need for a change in prescription and consequent waste of NHS resources, patient compliance, and any necessary monitoring. Sometimes a doctor may give six or even twelve months supply on one prescription (for example the contraceptive pill, or thyroxine with a regular review in surgery once the patient is safely stabilised). This is cost-effective and patients often prefer it. A recent report¹ on prescribing durations recognise that blanket instructions to only give 28 days supply are associated with significant increases in dispensing and other transaction costs, together with reductions in compliance in previously stable patients, and an increase in dissatisfaction amongst patients because of travel costs and time to obtain regular medicines. It can also place significant and unnecessary workload on the doctor and surgery staff.

Doctors are sometimes being put under pressure to prescribe at seven day intervals simply in order that the pharmacist can be reimbursed for 'Multi-compartment Compliance Aid (MCA) dispensing' [MCAs were previously referred to as Medidose or Dosette boxes] when there is no other payment currently available. Pharmacists and dispensing doctors may prefer 28-day intervals for reasons of reimbursement and financial viability of a dispensary, but many other factors should be considered by prescribers.

The Department of Health takes the view that prescribing intervals should be in line with the medically appropriate needs of the patient, taking into account the need to safeguard NHS resources, patient convenience, and the dangers of excess drugs in the home. Dispensing doctors should treat patients for whom they dispense, and any patients for whom they only prescribe, in the same way.

- **What should we do about seven day prescribing for MCA dispensing?**

The request for seven day repeat prescriptions to defray the pharmacist's costs for the filling of MCAs has become an increasing pressure for GPs. Our advice is to resist such demands unless there is a clinical reason for restricting supply to seven days. Length of prescriptions should be specific to the status and condition of the patient and their particular clinical needs. Consistency of size, shape and colour of the medication could be more effective than using MCAs, as it can be confusing for patients to receive medication that appears different every time that it is prescribed. There are also some storage problems involved in using MCAs, such as possible deterioration of drugs after being taken out of the packet.

There are also alternative ways to support patients taking medication, such as medicine advice charts, which allow the drugs to then be retained in their original packaging with advice sheets.

We have also been involved in discussions with the Department of Health in order to develop a means of assessing whether MCA dispensing is indicated for any particular patient, and where it is deemed appropriate, remunerating the pharmacist (or dispensing doctor) adequately for providing the service. We anticipate that in this particular situation it will be reasonable for doctors to agree to issue 28-day prescriptions in order to minimise waste.

The GPC supports the Pharmaceutical Services Negotiating Committee in that both pharmacists and dispensing doctors issuing MCAs should be properly reimbursed for the services they provide to patients.

TRAVEL VACCINATIONS

Guidance on travel vaccinations can be found in our [Focus on travel immunisations](#).

¹ Individualisation or standardisation: trends in National Health Service prescription durations in England 1998-2009, <http://www.ncbi.nlm.nih.gov/pubmed/23031628>

SUPPLEMENTARY AND INDEPENDENT PRESCRIBING

- **What is a supplementary prescriber?**

Supplementary prescribing involves a voluntary partnership between an independent prescriber and a supplementary prescriber (a trained nurse, midwife, pharmacist, physiotherapist, diagnostic and therapeutic radiographer, or optometrist who has completed the relevant training programme) to implement an agreed patient-specific Clinical Management Plan with the patient's agreement. However, this arrangement is becoming less common, with the broadening of the group of professionals that can be independent prescribers (see below).

- **What is an independent prescriber?**

Currently independent prescribers include nurses, pharmacists and optometrists, although as from April 2013, chiropodists, physiotherapists and podiatrists will also be able to be classed as independent prescribers.

Nurse independent prescribers include district nurses and health visitors who can prescribe in their own right. Independent nurse prescribers can prescribe any medicine for any medical condition within their competence, including some controlled drugs for specified medical conditions².

Qualified and registered pharmacist independent prescribers can prescribe any medicine for any medical condition within their competence, with the exception of controlled drugs³.

Optometrist independent prescribers are able to prescribe any licensed medicine for ocular conditions affecting the eye and surrounding tissue, but cannot prescribe any controlled drug independently⁴.

- **Does this mean that doctors bear no responsibility for the actions of independent prescribers?**

Independent prescribers are professionally responsible for their own actions. However, where a nurse is appropriately trained and qualified as an independent prescriber and prescribes as part of his or her nursing duties with the consent of their employer, the employer may also be held vicariously responsible for the nurse's actions. All independent prescribers should ensure they have professional indemnity and the employing GP should be satisfied that any employee has the relevant skills and training.

- **Have prescribing by podiatrists, chiropodists and physiotherapists now been introduced?**

In 2011, the Department of Health published consultations about the introduction to prescribing by podiatrists, chiropodists and physiotherapists, to which the BMA responded. We believe that appropriately trained physiotherapists, chiropodists and podiatrists should be permitted to prescribe independently from a list of specified medicines for a specified list of conditions, as is the case for dentists, unless under supervision of a named consultant. To enable these changes, amendments to the Medicines Act legislation were laid before Parliament in autumn 2012 and changes to NHS Regulations will be laid in April 2013.

²

<http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Prescriptions/The-Non-MedicalPrescribingProgramme/Nurseprescribing/index.htm>

³

<http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Prescriptions/The-Non-MedicalPrescribingProgramme/Independentpharmacistprescribing/index.htm>

⁴

<http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Prescriptions/The-Non-MedicalPrescribingProgramme/Optometristindependentprescribing/index.htm>

THE USE OF LICENSED DRUGS FOR UNLICENSED PURPOSES

- **Can I give my patients Botox injections for cosmetic reasons?**

Botulinum toxin is sold under a number of names as a licensed product for specific indications. Cosmetic surgery is not one of them. When considering doing work in this area we would stress the importance of remembering that as the prescribing doctor you will be held responsible for your prescribing decisions. You need to consider carefully the consequences of using this licensed product for unlicensed indications if something goes wrong or the patient lodges a complaint. We would strongly advise against it. You should also check the position with your medical defence union.

PRIVATE PRESCRIPTIONS

- **If a patient has been seen privately in secondary care and is given a private prescription, is it acceptable for them to come to their GP and ask for it to be converted to an FP10?**

If they are being seen as an NHS patient in a private facility (e.g. through Choose & Book), they should be provided with NHS prescriptions by the clinician responsible for their care.

If a GP receives a letter from a private consultation advising/suggesting a course of action then it may be appropriate for a script to be issued on an FP10 if the GP agrees with the advice. The prescriber takes clinical responsibility for monitoring so the GP must ensure that they are able to accept this responsibility

- **Can I prescribe drugs which are cheaper than the prescription charge, e.g. amoxicillin, on a private script to save the patient money?**

Yes, but you have to offer both a private and an NHS prescription (FP10) to comply with the rules, and cannot charge for either. It would then be the patient's choice which one to use (which may be one of cost). There is a view that the patient should not be given two prescriptions, as both may be obtained, but this might cause difficulties at the Pharmacy should the costs have changed.

CHARGING PATIENTS

- **May GPs charge their own patients?**

The GMS contract prevents contractors from charging their patients for most services. There are however instances where charges may be made. Schedule 5 of GMS Regulations 2004 lists the strictly limited circumstances in which GPs may charge fees for providing treatment to their NHS patients. Similar arrangements apply to the other contractual options.

- **May GPs charge for issuing a private prescription?**

GPs may write private prescriptions for patients which they may wish to do particularly in relation to drugs not available through the Drug Tariff. However, GPs may not normally charge their registered patients for providing such a prescription, although a dispensing doctor may charge for dispensing the prescription. The only occasions when a doctor may charge for a private prescription are:

1. For drugs which are being issued solely in anticipation of the onset of an ailment whilst outside the UK, but for which the patient does not require treatment when the medicine is prescribed.
2. For drugs issued for the prevention of malaria.

- **May GPs charge for dispensing a private prescription for 'black/grey listed' drugs?**

Prescribing doctors may not charge. Dispensing doctors can supply 'black/grey' listed drugs and make a charge for the supply of the drug as set out in schedule 5, section 24 of the GMS Regulations 2004.

PATIENTS AND PRESCRIBING: RIGHTS AND RESPONSIBILITIES

- **Am I right, that as an NHS patient my GP must prescribe for me whatever I want?**

Under the NHS regulations your GP must prescribe for you any drugs that he or she feels are needed for your medical care. A patient is entitled to drugs that the GP believes are necessary, not those which the patient feels should be prescribed. GPs are responsible for all prescribing decisions they make and for any consequent monitoring that is needed as a result of the prescription given.

The Department of Health lists all drugs that the NHS is prepared to pay for in a list called the Drug Tariff. It is likely that most, if not all, the drugs you need are available through the NHS, however the Drug Tariff does have exceptions. Some drugs, like phosphodiesterase inhibitors (e.g. Viagra) listed in Schedule 11 will only be offered on the NHS to patients suffering from specified conditions. Similarly some products other than drugs, such as high energy or gluten free foods, are listed as 'Borderline Substances' and may only be prescribed at NHS expense in defined circumstances. Other drugs or substances, listed in Schedule 10, cannot be prescribed at all on the NHS, such as Evening Primrose Oil, many vitamins, bath preparations, cough syrups and expensive brand names of some drugs.

- **If a drug is not available on the NHS, can my GP write me a private prescription for it?**

Any doctor can write a private prescription for a patient if they feel it is clinically appropriate and they are happy to take responsibility for that prescribing decision. Under the NHS regulations, a GP or his deputy can write a private prescription for a patient but cannot charge the patient for writing a private prescription if the patient is registered for NHS care with that GP or any other GP in the same practice.

The only exceptions to this rule are when an NHS GP writes either a private prescription for:

1. Drugs which are being issued solely in anticipation of the onset of an ailment whilst outside the UK, but for which the patient does not require treatment when the medicine is prescribed.
2. Drugs issued for the prevention of malaria.

- **Can my GP supply me with drugs directly rather than going to a pharmacist?**

The supply of drugs in the NHS is highly regulated. NHS prescriptions must be dispensed at pharmacies except where a doctor has been granted permission to be a dispensing doctor. This is most likely to happen when there are few, if any, pharmacies in a rural or semi-rural area. The area is then known as a 'Controlled Area' and a dispensing doctor is allowed to supply drugs to named patients who live more than one mile as the crow flies from a pharmacy. Many dispensing doctors can only dispense to some of their patients depending on the position of a pharmacy. All patients have the right to take their prescription to a pharmacy of their choice if they wish to do so.

Out of hours (OOH) doctors may supply a patient with immediately necessary emergency drugs when the pharmacy or dispensary is likely to be closed (following the 'Carson Report'⁵, instead of limited supply or a 'starter pack' plus a prescription, an OOH doctor can now supply a complete course of any necessary emergency medicine to the patient, and charge a prescription charge where the patient is not exempt).

Malaria chemoprophylaxis - There is no NHS Regulation that prevents a GP prescribing drugs for the prevention of malaria at NHS expense. However, the Department of Health has issued guidance that medication for malaria prophylaxis may not be reimbursed under the NHS and instead advise that this should be prescribed privately.

A GP, even a dispensing GP, is not allowed to sell any 'over the counter' medicines.

⁵ *Raising Standards for Patients New Partnerships in Out-of-Hours Care*: <http://www.out-of-hours.info/downloads/oohreview.pdf>

- **Why can't my GP give my child single vaccines for measles, mumps and rubella?**

The Department of Health believes that on the basis of currently available evidence the MMR vaccine is the most effective and safe means of ensuring protection against measles, mumps and rubella, and therefore this is the only treatment it will provide for on the NHS. The three vaccines combined in MMR boost the effects of one another, whilst there are doubts about the efficacy of single vaccines.

- **Can my GP refuse to give me a prescription that my consultant asked them to provide?**

The person who signs the prescription is legally liable for the prescribing and the consequent effects of that drug. Some drugs which may be very familiar to consultants in a specialised area of medicine can be potent drugs of which a GP will have little experience (for example many cancer drugs or specialised treatment for diseases such as rheumatoid arthritis – the group called 'biologicals').

If a consultant feels a drug is appropriate there is no reason why they cannot prescribe it themselves; they can also post a prescription to you.

There may be circumstances where in spite of a specialist opinion a GP is still unhappy to prescribe a drug, there may be some disagreement on the necessity of the drug or your GP may feel that there are other aspects of your medical condition that have not been considered and would make that prescription inappropriate.

- **A friend's GP wrote them a similar prescription on a consultant's advice, why won't mine? I think this is discriminatory.**

Each GP will make prescribing decisions based on what they are or are not prepared to take clinical responsibility for.

Some doctors might have special training or knowledge of a particular area of medicine which makes them comfortable to prescribe and monitor a drug where many GPs would not. Clearly, a GP should be aware of their limitations as well as their skills and will want to ensure that they are not prescribing beyond their knowledge or their ability to ensure patient safety.

The fact that highly specialist drugs are often the most expensive can give the wrong message. Expense should not limit a patient's access to good quality treatment from their GP, safety and lack of knowledge of specialised drugs which could affect that safety should.

- **What is a shared care agreement?**

Sometimes GPs will come to an arrangement with a consultant regarding a patient's care where in essence the clinical responsibility is shared between the two doctors. There will usually be a formalised written agreement/protocol setting out the position of each, to which both parties have willingly agreed, which is known as an 'effective shared care agreement'. This could also be an enhanced service that the GP provides. There are some drugs (e.g. certain growth hormones, Erythropoietin, Methotrexate, Ritalin and Memantine) which it would not be appropriate for a GP to take sole responsibility for without sharing the care with a consultant. A GP can refuse a shared care agreement if he or she is not happy with the burden of responsibility it puts on the GP, and then the consultant must take full responsibility for prescribing and any necessary monitoring. Pressure on a GP to prescribe, where a GP does not agree, is not acceptable.

- **I live abroad for six months of the year and my GP has refused to give me a prescription.**

The NHS accepts responsibility for supplying ongoing medication for temporary periods abroad of up to three months. If a person is going to be abroad for more than three months then all that the patient is entitled to at NHS expense is a sufficient supply of his/her regular medication to get to the destination and find an alternative supply of that medication.

USEFUL RESOURCES:

BMA guidance on drugs and prescribing

<http://bma.org.uk/practical-support-at-work/doctors-as-managers/prescribing>

General Medical Council (GMC) - Good practice in prescribing and managing medicines and devices

http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

NHS Prescription Services

For the monitoring, processing and information feedback related to NHS prescribing.

<http://www.nhsbsa.nhs.uk/prescriptions>

The Medicines and Healthcare products Regulatory Authority

For all issues relating to drug licensing, yellow card reporting, drug and device safety and varied medicine consultations.

www.mhra.gov.uk

The Royal Pharmaceutical Society of Great Britain

For guidance on controlled drugs and the misuse of drugs act, and guidance on medicines use and storage.

<http://www.rpharms.com/home/home.asp>

The Dispensing Doctors Association

For guidance, advice and support for all issues related to doctor dispensing – they also have particularly good guidance on the legal requirements for the storage and use of controlled drugs.

www.dispensingdoctor.org

National Health Service (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations 2004

<http://www.opsi.gov.uk/si/si2004/20040629.htm>

Medicines Matters – July 2006

This document describes the mechanisms available for the prescribing, supply and administration of medicines to support the development of new roles or service redesign. It also outlines the aims of the continuing work of the non-medical prescribing programme.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_064326.pdf

British National Formulary

The BNF provides UK healthcare professionals practical information on the selection and clinical use of medicines.

<http://bnf.org/bnf/index.htm>

Medicines Act (1968)

http://www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1968/cukpga_19680067_en_1

Electronic Prescription Service (EPS)

<http://www.connectingforhealth.nhs.uk/systemsandservices/eps>

NICE Medicine and prescribing support

Formerly the National Prescribing Centre, NICE now provides comprehensive advice and support for delivering quality, safety, and efficiency in the use of medicines.

<http://www.nice.org.uk/mpc>