Dear Colleague

RESPONSIBILITY FOR PRESCRIBING BETWEEN HOSPITALS AND GPs

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

2. The guidance, which has been drawn up taking into account recommendations which have been made in England and Wales and the views of NHS managers and representatives of the medical profession in Scotland:-

   - reinforces the basic principle that prescribing for a patient should be undertaken by the doctor who has clinical responsibility;

   - emphasises the need for shared care arrangements to include proper hand-over procedures to ensure GPs are fully equipped for their role and responsibilities;

   - specifies the minimum amounts of medication to be provided to patients on discharge and to certain categories of out-patients.

3. The guidance should be brought to the attention of all general practitioners and hospital doctors. Bulk supplies of this circular are being sent to Health Boards under separate cover for appropriate distribution.

4. Any enquiries about this Circular should be addressed to Mr J Ballantyne, (Ext 2532) at the above address.

Yours sincerely

DON CRUICKSHANK
ANNEX TO NHS CIRCULAR NO 1992(GEN)11

RESPONSIBILITY FOR PRESCRIBING BETWEEN HOSPITALS AND GPs

INTRODUCTION

1. On 18 November 1986 the Scottish Home and Health Department issued guidance on prescribing policy in my letter to Health Board General Managers (reference SHHD/DGM(1986)44). The essential message was that it was for the doctor who had clinical responsibility for a patient to undertake the necessary prescribing. The matter was subsequently addressed in chapter 11 of the SOHHD publication "Improving Prescribing in Scotland", published in January 1991. This repeated the basic principles set out in the earlier guidance. The guidance which follows adheres to the same principles but deals with the various aspects of the matter in greater detail.

BACKGROUND

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

3. With this in mind, and the introduction of indicative prescribing amounts from 1 April 1992, it was important to reconsider the issue of interface prescribing with the aim of providing updated guidance to the NHS. In June 1990, the Department of Health set up a working group of NHS professionals and managers operating prescribing policy day-to-day and charged it with examining current prescribing practices in relation to Government health policy. The main issues that needed to be addressed were:

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

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

- consultants' concerns about prescribing drugs for which no budgetary provision had been made thereby causing unanticipated demands on the resources of their departments;

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

- patients who were caught in the middle of a professional dispute were worried about the continuity of their treatment and the threat that they might be denied treatment, particularly where expensive drugs were involved;
- hospitals providing insufficient quantities of drugs on discharge, or following an out-patient/casualty visit, to allow patients time to obtain follow-on treatment from GPs;

- patients having the additional inconvenience of obtaining prescriptions via their general practitioner, immediately after a hospital visit, rather than directly from hospital (as is current practice in England).

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

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

THE INDICATIVE PRESCRIBING SCHEME

6. The guidance given below sets out the basis on which prescribing responsibility should be determined and, where appropriate, transferred. General practitioners should note that the operation of the indicative prescribing scheme does not in any way inhibit them financially from accepting prescribing responsibility under these guidelines. If a GP is concerned about the effect on the practice's indicative amount of prescribing an expensive treatment the Board's Medical Prescribing Adviser should be consulted.

CLINICAL RESPONSIBILITY AND THE PRESCRIPTION OF DRUGS

GENERAL PRINCIPLES

7. As has been explained in "Improving Prescribing in Scotland" it is a long established tradition in Scotland that a referral of a patient to a hospital out-patient clinic by a GP is treated as a consultation following which a recommendation on treatment may be made to the referring GP who continues to have clinical responsibility for the patient's treatment and prescribes accordingly. This ensures that the GP is fully aware of the treatment from its inception and provides smooth continuity. No change is therefore proposed to the current procedures. It will however remain open to the hospital consultant to prescribe for out-patients where it is felt that treatment should be initiated without delay.

8. The principle whereby prescribing responsibility attaches to clinical responsibility holds also where in-patients are discharged from hospital but remain on treatment. If the treatment is of a type about which the GP has sufficient knowledge and for which he or she is prepared to take

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

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

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

IN-PATIENTS

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

12. When a patient is discharged from hospital, sufficient drugs and dressings and appliances should normally be provided by the hospital for a minimum of 7 days after discharge unless the drugs, etc are not required for so long a period. Where a single limited course of treatment is required, eg of antibiotics, it may be appropriate to provide sufficient drugs for the complete course (eg 5 days in the case of some antibiotics). The GP, to whose care the patient is being transferred, should receive notification in adequate time of the patient's diagnosis and drug therapy so that any on-going treatment can be maintained. In the event that information about the patient cannot be transferred from hospital to GP within the timescale, drugs should be prescribed by the hospital for as long a period as necessary.

PATIENTS ATTENDING ACCIDENT AND EMERGENCY

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

OUT-PATIENTS

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

15. Subject to paragraph 16, where a consultant feels exceptionally that he or she should initiate immediate treatment to an out-patient, drugs,
etc should normally be prescribed for the patient by the hospital and dispensed, where possible, by the hospital pharmacy for not less than 14 days or for sufficient time as a complete treatment demands where this is appropriate. The consultant should give the GP notification in adequate time of the patient's diagnosis and drug therapy so that any on-going treatment can be maintained. In the event that information about the patient cannot be transferred from hospital to GP within the timescale, drugs etc should be prescribed by the consultant for as long a period as necessary.

SHARED CARE

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

WHERE RESPONSIBILITY FOR PRESCRIBING SHOULD REMAIN WITH CONSULTANTS

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

- drugs are undergoing or included in a hospital based clinical trial;
- where it is considered that because of the need for specialised knowledge and/or investigations the consultant should monitor the patient's response to medication;
- drugs or appliances are only available through hospital or where there are supply problems.

It should be noted that the range of products which GPs can supply is limited to those generally recognised as necessary for normal GP treatment and which the patient can use without professional or technical assistance. Such products are listed as available for GP prescribing in the Drug Tariff. Hospitals are required, therefore, to continue to supply those products not available under general medical and pharmaceutical services.

ROLE OF HEALTH BOARDS

18. Health Boards are well placed to encourage and facilitate developments which better integrate the care provided and ensure a smooth transition of patients from hospital to GP and vice versa. Their responsibility is to ensure that local prescribing policies are compatible with this guidance. The aim is to ensure as far as possible that patient care is "seamless".
19. In particular, **Health Boards** should further stimulate the representation of the primary care interests in hospitals' Drug and Therapeutics Committees, and facilitate development of treatment protocols in which GPs and consultants can locally agree how certain treatments should be handled. It should be recognised however that in individual cases the transfer of responsibility must depend on agreement between the consultant and GP concerned. The agreed arrangements should include contingency provisions for continuing patient treatment in the event of a failure to reach agreement; **PATIENTS MUST NOT BE ADVERSELY AFFECTED**.

20. **Health Boards**, via their medical advisers, in co-operation with hospital consultants, should ensure that GPs are sufficiently informed on new and/or unfamiliar drugs and the related local prescribing policies. **Chief Administrative Pharmaceutical Officers (CAPOs)**, through their drug information services, are able to provide the necessary support, free of charge. These services are available locally through district arrangements; if required, details of local services can be obtained from the principal centres whose telephone numbers are given in the British National Formulary (BNF).

21. Where **Health Boards**, as part of the development of their local provision, propose to introduce new arrangements or treatments which will incur significant expenditure on the primary care drugs bill the Management Executive must be consulted before any commitment of resources is made. Subsequent local consultation will still be required where GPs are being asked to prescribe treatments which are not considered to be within normal general practice responsibilities.

**CONTRACTING AND THE REFORMS**

22. With the inception of the NHS reforms the Management Executive will be encouraging Health Boards through the contracting system, to identify the extent of local hospital (including NHS Trust hospitals) drug provision and to ensure that it is consistent, or made consistent, with these guidelines. Specifying local hospitals' drug provision responsibilities in contracts should lead to a more effective and efficient targeting of the necessary resources towards the provision of hospital drugs. It will be particularly necessary to ensure that the Board's requirements are specified to the receiving hospital where cross-boundary referrals are involved. Health Boards should ensure that this objective is pursued as vigorously as possible, in the interests of patient care.

23. Health Boards through their pharmaceutical advisers and Area Pharmaceutical Committees should ensure that primary care contractor pharmacies are made aware of the hospital/GP interface prescribing policies. This will ensure that pharmacies are able to rationalise their stock holding in the most efficient manner.