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Responsibility for prescribing between hospitals and GPs

Introduction

1. On 25 February 1987 Sir Leonard Peach, the then acting Chairman of the NHS Management Board, issued guidance on prescribing policy. The guidance indicated that it was for the doctor who had clinical responsibility for a patient to undertake the necessary prescribing. The guidance in the letter ceased to be operational on 1 March 1991 and is superseded by this guidance which, however, preserves its basic principles.

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 1991, 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 taken on this prescribing, either wholly or on a shared-care basis

- **GPs' concerns over taking 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 there was not budgetary cover

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

- patients who are caught in the middle of a professional dispute were worried about the **continuity of their treatment** and the threat that they may 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,** rather than directly from hospital, immediately after a hospital visit.

4. The deliberations of the Working Group were enhanced by a study[1] conducted by a research team from St.George's Hospital Medical School.

5. The NHS Management Executive, having considered the helpful views and advice provided by the Working Group, has produced the following guidance to address the above concerns. The guidance re-affirms 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.

[1] *Prescribing at the Hospital/General Practice Interface; Current Hospital Dispensing Policies in England and their impact on Hospital Chief Pharmacists, General Practitioners and Community Pharmacists* – Anderson, Freeling, Rafferty, Sibbaid, Wilkie. April 1991.

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.

Clinical Responsibility and the prescription of drugs

General Principles

7. 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 necessary 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 DHAs, hospital managers and medical staff, FHSAs and the relevant LMC 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) Regulations.

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

9. When a GP takes responsibility for prescribing or dispensing 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 drug.

In-patients

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

11. When a patient is discharged from hospital, sufficient drugs and dressings should normally be prescribed by the hospital and dispensed by the hospital pharmacy, where possible, for a minimum of 7 days after discharge unless the drugs are not required for so long a period. 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

12. 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

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

14. Subject to paragraph 15, where a consultant feels that he or she should initiate immediate treatment to an out-patient, drugs should normally be prescribed for the patient by the hospital and dispensed, where possible, by the hospital pharmacy for not less than 14 days. In other instances the consultant may request that the GP consider initiating or continuing treatment. 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 should be prescribed by the consultant for as long a period as necessary.

Shared care

15. 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, if 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.

Provision of a protocol for treatment should normally be provided. 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.

Where responsibility for prescribing should remain with consultants

16. 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;

    - the consultant considers that only he is able to monitor the patient's response to medication because, for example, of the need of specialised investigations;

    - drugs or appliances are only available through hospitals or where there are supply problems.

Role of Regional Health Authorities (RHAs)

17. RHAs 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 and that patient care is "seamless".

18. In particular, RHAs should further stimulate the representation of joint primary and secondary care interests through debate in Drug and Therapeutics Committees, and facilitate development of treatment protocols in which GPs, consultants and other appropriate health care professionals can locally agree how certain treatments should be handled.

19. FHSAs, 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. Regional Pharmaceutical Officer (RphOs), through their drug information services, are able to provide support. Telephone numbers are given in the British National Formulary (BNF).

Contracting and the reforms

20. With the inception of the NHS reforms from 1 April, the Department of Health will be encouraging RHAs, through the contracting system, to identify the extent of local hospital 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. RHAs should ensure that this objective is pursued as vigorously as possible, in the interests of patient care.