Department of Health
An Roinn Sláinte
Männystrie O Poustie
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RESPONSIBILITY FOR PRESCRIBING BETWEEN PRIMARY AND SECONDARY /TERTIARY CARE SERVICES FOR THE SUPPLY OF MEDICINES AND OTHER PHARMACEUTICAL PRODUCTS



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Introduction

1. Good organisation of care across the interface between primary and secondary/tertiary care is crucial in ensuring that patients receive high quality care – and in making the best use of clinical time and health service resources in all care settings. Good professional practice requires care for patients to be seamless; patients should be facilitated to obtain the medicines they need, when they need them.

2. Lack of, or unclear communication between primary and secondary/tertiary care and misunderstandings around the responsibilities of the professionals involved are often cited as reasons for patients not being able to get their medicines in a timely manner, despite effective collaborative working and communication being an important part of patient-centred professionalism.

3. Many people are living with long-term conditions, some with multi-morbidities requiring multiple medicines as part of their treatment plan. This challenge to the sustainability of our health and social care system was recognised in "Health and Wellbeing 2026: Delivering Together", which clearly outlined the case for a new patient-focused model of care that delivers care and support in the most appropriate setting, ideally in people's homes and communities.

4. The requirements for those professionals responsible for prescribing medicines therefore need to consider the whole needs of the patient, and care should be provided where it can be most appropriately monitored and reviewed in the best interest of the patient.

5. The response to the COVID-19 emergency across primary, community and secondary care services has resulted in innovative new practices that could potentially be mainstreamed as part of HSC rebuilding in the wake of the pandemic. The way we design and deliver services will be focused on providing continuity of care in an organised way and to do so we will increasingly work across traditional organisational boundaries, to develop an environment characterised by trust, partnership and collaboration.

6. In order to facilitate this fundamental transformation of how services are delivered in Northern Ireland, this best practice guidance aims to provide clarity on the responsibilities of all those involved in commissioning or provision of medicines related services and prescribing across primary, secondary and tertiary care (and includes community and specialised services, and care for those patients in secure residential and supported living settings) and to provide support in developing shared care agreements and in the transfer of care.

Scope

7. The guidance covers:

- In-patients and day cases;
- Outpatient clinics or urgent and emergency care centres;
- Intermediate care e.g. step-down beds and intermediate care units, acute care at home;
- Hospital diversion services People at risk of self-harm;
- Patients who reside in mental health facilities, respite care facilities or care homes;
- Hospice patients;
- Patients receiving care in their own homes; and
- Patients attending primary care interface clinics.

This list may be added to, as part of the annual review of this guidance as services are transformed as part of the rebuild agenda.

8. The previous guidance document HSS(OP1) 2/92 was issued in 1992 and highlighted a number of issues, including:

- Patients being caught in the middle where there is lack of agreement over prescribing responsibilities and the risk that they might be left without the medication they need;
- Cost saving incentives to shift responsibility for medicines between secondary care and primary care;
- GPs concerns over taking responsibility for unfamiliar treatment;
- Lack of consultation and agreement between professionals over the transfer of prescribing responsibility;
- Hospitals providing insufficient quantities of drugs on discharge or following an out-patient, minor injury unit or Emergency Department visit; and
- Patients having the additional inconvenience of obtaining prescriptions via their general practitioner, rather than directly from hospital, immediately after a hospital visit or admission.

9. While some of these issues have been addressed during intervening years through a range of local and regional initiatives and guidelines, there is still a need to ensure that healthcare professionals are clear about their clinical responsibilities with regard to prescribing, are supported to carry out these responsibilities, and that patients are facilitated to access the medication they need in a timely way. Many of the current arrangements have evolved without discussion between primary and secondary care healthcare professionals.

10. This guidance is not intended to undermine existing prescribing arrangements that appear to be working well across health communities by primary and secondary care, but it does aim to help reduce the level of variation and to improve the quality of patient care.

11. The range of healthcare professionals now legally authorised to prescribe medicines has broadened and continues to expand. This guidance therefore relates to all those professionals with responsibility for prescribing currently and as additional groups of healthcare professionals become eligible to prescribe, or via novel models of prescribing in the future.

Medicines Optimisation

12. Since the previous guidance was written, the role of Medicines Optimisation has become better understood in helping patients make the most of medicines and improve their health outcomes. Medicines Optimisation has been defined by the National Institute for Health and Care Excellence (NICE) as "a person centred approach to safe and effective medicines use to ensure that people obtain the best possible outcomes from their medicines".

13. In Northern Ireland, the Medicines Optimisation Quality Framework, launched in March 2016, aims to drive the consistent delivery of high quality services related to the prescribing, dispensing and administration of medicines across Health and Social Care (HSC).

14. The responsibilities around prescribing and the decisions that are made by healthcare professionals and patients therefore need to reflect the principles of Medicines Optimisation, deliver patient focused care and the best possible outcomes for patients from the use of medicines. The patient and/or carer should be centrally involved in any decision making process which requires the provision of good quality information.

General Principles

15. Clinical responsibility for prescribing should sit with those professionals who are in the best position and appropriately skilled to deliver care which meets the needs of the patient. In many cases it will be the GP who is the most appropriate clinician to provide continuing care however this care may also increasingly be best delivered by other appropriately trained prescribing professionals. In terms of patient experience, those patients who are on long-term medication or are less well may prefer to avoid unnecessary hospital appointments by receiving their prescriptions closer to home.

16. A greater number of healthcare professionals are now qualified to prescribe and in some cases it will be more appropriate for those professionals to directly prescribe to patients. Greater collaboration between primary care prescribers, hospital consultants and other prescribers is essential to ensure the best outcome for the patient.

17. Healthcare organisations need to ensure that there are robust and effective arrangements in place that enable timely and effective communication and information sharing between healthcare professionals in all settings in the interests of seamless patient care.

18. **Legal responsibility for prescribing lies with the prescriber who signs the prescription** and it is the responsibility of the individual prescriber to prescribe within their own level of competence and scope of practice. Because patients' healthcare needs are constantly changing, prescribers will need to adapt their practice through continuing professional development ('CPD') so they can continue to best serve the needs of their patient population in a safe and effective manner (please see the General Medical Council's 'Good Medical Practice' for more information and Royal Pharmaceutical Society's guide 'A Competency Framework for All Prescribers').

19. In all cases, it is essential for good patient care that there is prompt and clear communication on the transfer of care between hospital and primary care in both directions, and also at key stages during the outpatient and urgent care pathways.

20. As part of good clinical governance, all prescribers must ensure that they make appropriate records, including electronic records where appropriate, of what they prescribe and that when patients transfer between care providers that accurate information about any changes to new or existing medication transfers to the continuing care provider to enable the new prescriber to continue existing treatment.

21. The use of cipher codes in primary care will ensure the individual prescriber is held accountable, but the use of live electronic systems are key to effective communication and timely sharing of prescribing/de-prescribing details and actions from specific moments in time and locations.

22. Professionals involved in the prescribing of medicines should be registered and regulated by the relevant professional and regulatory bodies, and should ensure that their activities are sufficiently covered by indemnity insurance. Staff who are not registered professionals must always work under the supervision of a registered professional to undertake activities within the scope of their competence, with the registered healthcare professional remaining fully accountable for their actions. There should be clear lines of accountability for handling complaints, errors or clinical incidents involving medicines.

23. Whatever the mechanism for prescribing, the treatment provided to patients must be safe, effective and clinically appropriate for the patient. This is not only important when a medicine is initiated; there should be appropriate mechanisms in place for regular review of treatment and monitoring so that treatments are adjusted, stopped or started as appropriate and that prescribing continues to be evidence-based and reflect local commissioning decisions and best practice.

Service Design

24. The emergency response to the COVID-19 pandemic across primary, community and secondary care services has helped to break down professional and administrative boundaries and has resulted in innovative new practices that could potentially be mainstreamed as normal services are resumed. Innovation has emerged across all services and embedding recent innovations, along with transformation activities already underway, into service delivery will be an important strand in achieving the rebuilding of HSC services following the acute pandemic response.

25. In primary and secondary care settings, the use of telephone triage and video consultations is now widely embedded. During the pandemic, multi-disciplinary teams including; nursing, pharmacy, physiotherapy, mental health practitioners and social workers have emerged as an essential part of the primary care response, delivering essential support to vulnerable people at a time of extreme need in the community. The value of skill mix and staff working at the top of their professional licence in advanced and extended roles has enabled services to respond to the increasing complexity of care for patients and demand for consultations.

26. Arrangements to facilitate the prescribing, dispensing and monitoring of medicines arising in service re-design should be considered carefully and at the early stages of planning. **Service design should always ensure that practice is safe, complies with all relevant legislation, provides clarity around responsibilities for clinical and prescribing decisions and meets the accountable organisation's clinical governance requirements.** The accountable organisation for managing prescribing activity and associated costs must also be clearly defined and agreed.

27. The vast majority of practice within the HSC currently involves either medicines prescribed in primary care or primary care interface services and dispensed by a community pharmacy, or those medicines prescribed in secondary care and dispensed by a hospital pharmacy. Any alternative prescribing and supply arrangements should be locally agreed to meet the accountable organisation's clinical governance requirements.

28. The DOH Strategic Planning and Performance Group (SPPG) is establishing the governance arrangements that are required for **prescribers working across the interfaces between primary and secondary care settings to enable more timely access to medicines and appliances. This may be facilitated through prescribing directly to patients using an HS21 prescription form which is dispensed in a community pharmacy.**

29. This will only be possible where it has been agreed by the employing organisation and robust governance arrangements exist including a cipher number for the accountable organisation. The system must include a process to enable community pharmacies to contact the secondary care prescriber to resolve queries in a timely manner and to allow them to verify the legal authority of prescribers to prescribe as part of the dispensing process.

30. These governance arrangements will underpin and enable new models of care delivery with services operating across the traditional interface between care sectors. Models where secondary care prescribers issue prescriptions for dispensing by a community pharmacy may help to facilitate timely care in circumstances where, for example:

- Medication should be commenced urgently i.e. within 72 hours e.g. acute infection;
- A specialist medicine or appliance is required that primary care prescribers would generally be unfamiliar with e.g. compression garment for lymphoedema, trans-anal irrigation system; or
- Complex regimen that requires titration, tapering, or frequent review and assessment.

Information Technology

31. Advances in technology such as the Electronic Care Record (ECR) and the rollout of the ENCOMPASS programme, which will introduce a digital integrated care record to Northern Ireland, will help to transform health and social care in order to improve health outcomes and create better experiences for those receiving, using and delivering services. The potential of existing systems such as the ECR to support safer prescribing across the interface between primary and secondary care should be maximised, including extending ECR access to community pharmacies.

32. The ongoing HSC ICT development programme will facilitate better and timelier sharing of information between healthcare professionals and enable advances such as electronic prescribing. The DOH SPPG's 'New Models of Prescribing' project has been established to define and establish the governance requirements for safe prescribing across the interface of primary and secondary care, and has identified that there needs to be 'one source of truth' regarding documentation of patient's medications which can be accessed by the patient and healthcare professionals in all settings.

33. Patients' views also need to be taken into consideration when decisions are being made regarding the level of clinical data being shared, in line with the principles set out in NICE guidance NG197 on 'Shared Decision Making'.

34. It is vital that these advances enable prescribers in all settings to have seamless and real time access to all aspects of the patients' medical records that are required in order to ensure that prescribing and de-prescribing decisions can be made safely. When linking of IT systems is in place, **changes to medication will be communicated in real time to ensure that prescribers in all sectors are sighted on any changes in order to provide safe and effective care.**

Supply of medicines

Inpatient, intermediate care and day case patients

35. When a patient is discharged from the care of a secondary care provider in an inpatient, intermediate care or day case setting, they should receive an appropriate supply of their prescribed medicines which may be a combination of inpatient and discharge medicines dispensed as a single supply labelled for discharge.

36. Most HSC Trust Pharmacy Departments have extended their opening hours to beyond 5pm Monday to Friday (opening times range from 6pm to 10pm depending on need) and at weekends and this, along with one stop dispensing on admission in preparation for discharge, ensures that the majority of patients who need medicines on discharge will receive a minimum of 14 days' supply, or up to 28 days' supply, dispensed by pharmacy staff. This is reflected in the common approach to dispensing medicines on discharge that has been agreed by the DOH Strategic Planning and Performance Group (SPPG, formerly HSC Board) and the five HSC Trust pharmacy departments.

37. It is recognised that there may be some variation in practice depending on individual patient needs. Exceptions may include, but are not limited to, the use of a compliance aid to support medicines adherence; discharge from an inpatient psychiatric ward where risk of self-harm or overdose has been identified for an individual patient; supply of short courses of antibiotics or analgesia, or where the patient has an adequate supply (at least 14 days) of Patient Own Drugs or One Stop Dispensing medicines remaining.

38. HSC Trusts should ensure that relevant policies are aligned with DOH SPPG guidance on Trust dispensing on discharge from hospital and take steps to minimise as far as possible the number of patients provided with only 3 day's supply of medicines, e.g. out-of-hours or unplanned discharges. The minimum period of time covered by the prescription should take into account bank holidays and weekends, to allow patients sufficient time to contact staff at their general practice. Primary care prescribers should not be asked to prescribe medicines for patients during inpatient stays.

39. The secondary care provider should ensure that accurate and up-to-date information about medicines is shared with the primary care prescriber to whose care the patient is being transferred, and with the patient or carer as appropriate for individual circumstances e.g. care home residents. Information should be communicated in the most effective and secure way, such as electronically, ideally within 24 hours of discharge.

40. Secondary care providers should ensure that systems are in place for the timely verification of medicines information by senior discharging clinicians to facilitate the safe transition of care to the primary care clinician. Primary care providers should also have robust systems in place to ensure that timely and appropriate action is taken in response to electronic transfer of medicines information on discharge.

41. The Department of Health's Medicines Optimisation Quality Framework and the NICE guidance on Medicines Optimisation both recommend that the patient's nominated community pharmacist should also receive information on the patient's current medication and any change to medication to support safe transfer and continuity of care, especially for those receiving medicines via compliance aids or in Nursing or Residential care homes. This information should be communicated in the most effective and secure way possible and should seek to utilise advances in technology that will facilitate the secure transfer of discharge information to community pharmacies.

Patients attending Outpatient Clinics or Emergency Departments

42. Where a patient has an immediate clinical need for medication as a result of attending an outpatient clinic or Emergency Department, typically where treatment must commence within 72 hours of consultation, the secondary care provider (whether HSC or independent sector provider) must supply medication sufficient to last at least until the point at which the clinic's letter can reasonably be expected to have reached the patient's GP, and when the GP or other primary care prescriber can therefore accept responsibility for subsequent prescribing. **Consideration should be given to providing a minimum of 7 days' supply where appropriate to allow patients sufficient time to contact staff at their general practice** (or shorter if medicines are not required for that length of time).

43. Alternative prescribing and supply arrangements should be locally agreed to meet the accountable organisation's clinical governance requirement, such as consideration of prescribing and supply through community pharmacy to meet the needs of patients attending community or mental health clinics that are on a different geographical site from the hospital pharmacy.

44. Patients and primary care prescribers need to be informed about the degree of urgency required for implementation of any change of therapy in primary care. Routine practice applies when the change in therapy recommended by the specialist clinician is non-urgent. In such circumstances patients should be advised to await a review of the prescribing recommendation by the GP or other appropriate primary care prescriber. The goal should be to reassure patients and avoid unnecessary pressure on GP appointment schedules.

45. In all cases where information about medication supplied or changed by the secondary care provider is transferred electronically to the GP or other primary care clinician, the secondary care provider should ensure that robust systems are in place for the safe and secure direct transfer of information to primary care. This should include measures to ensure the timely verification of electronic information by the secondary care prescriber that facilitates the safe transition of care back to the primary care provider. Primary care providers should also have systems in place to alert the primary care clinician to any such changes fed through from secondary care, either electronically or otherwise.

People at risk of harm

46. When, following a clinical decision by the prescriber based on individual risk assessment, arrangements are being made for the prescribing and dispensing of medicines for someone who may be at risk of self-harm, who has the potential to misuse the medication, or who requires adherence solutions to facilitate administration of medicines such as instalment dispensing, the arrangements should fit within the overall care plan for the individual service user. The prescriber is responsible for liaising with the dispensing pharmacy to notify the pharmacy of these requirements and for working with the pharmacy to ensure that suitable arrangements are put in place.

Shared Care

47. The General Medical Council (GMC) describes shared care as "where decisions about who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on the patient's best interests, rather than on convenience or the cost of the medicine and associated monitoring or follow-up. Shared care requires the agreement of all parties, including the patient. It's essential that all parties communicate effectively and work together.".

48. As set out under 'General Principles', **all prescribers are responsible for any prescriptions they sign and so must be prepared to explain and justify their decisions and actions.**

49. In many cases patient experience will be best served by a transfer of clinical and prescribing responsibility to primary care settings in order to facilitate timely access to medication. When decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the primary care prescriber feels clinically competent to prescribe the necessary medicines. It is essential that a transfer of prescribing responsibility involving medicines with which primary care prescribers may not initially be familiar should not take place without full agreement between the specialist clinician and the relevant primary care prescriber, and the dissemination of sufficient, up to date information to individual primary care clinicians.

50. If the primary care clinician considers him or herself unable to take on this responsibility, then this should be discussed between the relevant prescribers so that additional information or support can be made available, or alternative arrangements for ongoing prescription and supply made. Shared care arrangements may be necessary as a prelude to establishing agreement with individual primary care prescribers. GPs are obliged to provide treatment consistent with current contract requirements.

51. When a specialist clinician considers a patient's condition to be stable or predictable, they may seek the agreement of the primary care prescriber concerned (and the patient) to share their care. Shared care is a particular form of the transfer of clinical responsibility from a hospital or specialist service to general practice in which prescribing by the primary care prescriber is supported by a shared care agreement. In proposing shared care agreements, a specialist should advise which medicines to prescribe, what monitoring will need to take place in primary care, how often medicines should be reviewed, and what actions should be taken in the event of difficulties including single point of contact details.

52. In "Good practice in prescribing and managing medicines and devices" guidance, the GMC outlines key principles in support of effective shared care arrangements that prescribers should observe, including:

- To act in the best interests of the patient.
- Acknowledgement of the medico-legal responsibilities of the prescriber.
- The requirement for the agreement of all parties and that effective communication is essential.
- That the prescriber should have sufficient knowledge, experience and information.
- That the specialist should provide the GP or other primary care prescriber and the patient with sufficient information to permit the safe management of the condition.
- That if the GP or other primary care prescriber is not satisfied to take prescribing responsibility this should be explained to the specialist and patient and alternative arrangements provided.

53. Several factors need to be taken into account to ensure that a satisfactory shared care arrangement is in place. This can be achieved by effective communication between all parties, for example via clinic letters, on a patient specific basis. However it is recognised that some degree of standardisation of shared care is helpful for all parties and helps minimise risk.

54. In Northern Ireland this standardisation is led by the Regional Group for Specialist Medicines (RGSM), which focuses on the safety aspects of prescribing, supply and administration of specialist medicines relative to their management in secondary care, primary care or jointly. The RGSM exists to ensure safer systems, with the responsibility for prescribing specialised medicines lying with the most appropriate practitioner; and better communication between prescribers leading to better working relationships and enhanced patient care.

55. The RGSM produces professional guidance for clinicians on where prescribing responsibility should lie for a defined list of specialist medicines, known as the Red Amber List. This ensures that clinicians can make an informed choice with regard to the prescribing of these medicines, and thereby facilitate access to these medicines by patients throughout Northern Ireland.

56. The Red Amber List is advisory, and appearance of a medicine on the list does not imply endorsement of use, but is rather a recommendation on prescribing responsibilities and whether or not the supply of a medicine should be organised through the hospital pharmacy network.

57. In Northern Ireland a specialist medicine within the context of the Red Amber List has been defined as *'a medicine, which has significant pharmacological complexity and/or rarity of use to make the prescribing of the medicine relatively uncommon in the community. Patients for whom complex medicines are prescribed, may have particular complex monitoring requirements, which require specialist knowledge for the appropriate interpretation of results.'*

58. Red List medicines are those medicines which it is recommended that responsibility for prescribing should remain with the consultant or specialist clinician, and supply should be organised through the hospital pharmacy. Amber List medicines are those medicines where it is recommended that responsibility for prescribing may be safely transferred from secondary to primary care when agreed shared care arrangements for the patient have been established between specialist and primary care prescriber. All prescribers should be aware of those medicines included in the Red Amber List and their status, in order to ensure that prescribing decisions can be made most effectively and in the best interests of the patient.

59. To support a consistent approach the RGSM also commission regional shared care guidelines for a large number of defined Amber List medicines in Northern Ireland. These regional shared care guidelines follow a standard format and contain information on indications, dose, route of administration, adverse effects, monitoring requirements and responsibilities, and clinically relevant drug interactions. Prescribers should use these resources to support patient specific shared care arrangements and the principles contained within the GMC guidance.

60. It is recognised that there may be circumstances where shared care may not be the most appropriate mechanism, and where specialists would therefore normally retain responsibility for prescribing. This determination is made regionally by the RGSM and Red / Amber List arrangements in Northern Ireland. These situations may include, but are not limited to:

- Patient undergoing or included in a hospital-based clinical trial;
- Patient requiring specialist monitoring and ongoing specialist intervention;
- Medicines that are unlicensed; or are used off-label without an associated evidence base and Medicines that are only available through hospitals.

61. The developing role for multi-disciplinary teams in general practice, including operating in advanced roles as independent prescribers, also provides an opportunity to build stronger links between hospitals and general practice. Clinical pharmacists in general practice are experts in optimal medicines use, monitoring, and review; and so can provide valuable support to all general practice staff.

Review of this Guidance

62. Due to the significant changes being undertaken as a result of rebuilding the HSC in Northern Ireland, this Guidance will be reviewed annually during the continued period of transformation to support redesign of services and to future-proof the Guidance.

