MEDICINES IN PRACTICE

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Transfer of prescribing from private provider to NHS GP

Question: What do NHS prescribers need to be aware of when they are asked by a private healthcare provider, and/or patient, to take on the regular prescribing of a medication for a patient, including medicines supplied under formal shared care agreements?

This document is intended as guidance and is based on suggested best practice.

NHS prescribers should ensure that a patient has gone through the same criteria to access the medicine as a non-private patient (i.e., they haven't skipped other treatment options/steps in disease pathways that NHS patients may have been trialled on prior to the medicine now being requested).

Patients should be informed at the point of seeking private healthcare of the possible restrictions and limitations that may arise with requests for ongoing prescriptions from an NHS GP. This should be communicated to the patient by the private healthcare provider. GPs may wish to consider making this clear to patients on their practice website.

Principles:

There are existing principles which underpin the transfer of patients from private to NHS provision:

- A patient seeking private care should be neither advantaged nor disadvantaged compared to someone receiving NHS care.[1]
- Patients wishing to be treated privately are entitled to the same NHS services as any other patient with the same clinical need. However, it should always remain clear whether the patient is receiving private or NHS care.[2]
- There is no obligation on behalf of the GP to prescribe the recommended treatment if it is contrary to his/her normal clinical practice.[3]
- If the medicine is a specialist one and is not something GPs would generally prescribe, it is for the GP to decide whether to accept clinical responsibility for the prescribing decision recommended by another doctor.
- If a GP prescribes based on the recommendation of another doctor, nurse or other healthcare professional, they must be satisfied that the prescription is needed, appropriate for the patient and within the limits of their competence.[3,4,5]
- BMA Medical Ethics Department Guidance 2009 states that "although some doctors feel unhappy about their patients switching between the NHS and private sector, this is not unethical as long as the patient, when re-joining the NHS, is treated in the same way as those receiving all of their care within the NHS."[6]
- Private, fully registered GPs are free to refer their patients to the NHS in the same way as NHS GPs can refer their patients to the private sector.[2] Similarly, all fully registered GPs may refer patients to NHS hospitals irrespective of whether they are treating them under the NHS or privately.[2]
- Prescribers are responsible for the prescriptions they sign.
    - When prescribing based on the recommendation of another doctor, nurse or other healthcare professional, the prescriber should assure themselves that the person providing the recommendation:
        - has the necessary qualifications, experience, UK registration, knowledge and skills to be making the recommendation and
        - are working for a CQC-regulated service. This may be confirmed by searching the full list of services CQC regulate at: https://www.cqc.org.uk
    - Should a request for continued prescribing of a medicine come from unregulated sources or unregulated providers, the GP should not assume responsibility for prescribing recommendations, nor will they enter into shared cared arrangements in these circumstances.[11]
    - If a GP is unsure or unable to establish whether a specialist working outside the NHS is suitably qualified, the GP is not obliged to follow their recommendations. However, the GMC states that it would "not be acceptable to simply refuse to treat the patient." They advise the prescriber to discuss their concerns with the patient, carefully assess their needs, seek to understand their concerns and preferences, consult more experienced colleagues, and provide care in line with the guidance in good medical practice.[3,4,5,6]
- The 'General Guidelines For The Use Of Hormone Treatment In Gender Dysphoria' produced by the Northern Region Gender Dysphoria Service has a useful section on prescribing on the recommendation of a private practitioner – including information on harm minimisation.[7] These principles could also be applied to the prescribing of medicines in other therapeutic areas, e.g., ADHD.

Shared Care specific considerations:

The NHS England guidance 'Responsibility for prescribing between primary and secondary/tertiary care' defines shared care and the principles for a national system of shared care for medicines.[8] 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 GP, or other primary care prescriber, is supported by a shared care agreement.

When a specialist considers a patient's condition to be stable or predictable, they may seek the agreement of the GP concerned (and the patient) to share their care.[8]

A medicine is deemed suitable for shared care if it requires ongoing monitoring which can be undertaken in the primary care setting but is such that overarching specialist involvement is retained.[9]

Considerations:

- There are no definitive national guidelines or position statements available on the handling of requests from a private provider to NHS GPs to prescribe a medicine under shared care arrangements. GMC guidance states that shared care requires the agreement of all parties, and it is essential that all parties communicate effectively, work together and explain what is happening to manage a patient's expectations. The principles laid out in the RMOC 'Shared Care for Medicines Guidance' and standard template will facilitate this.[9]As with requests from NHS consultants, GPs should not take on prescribing for medicines if there is a need for specialist knowledge or monitoring unless there are shared care arrangements in place.
- It should be explained to the patient/ carer, ideally before seeking /initiating private care, the practicalities of the necessary monitoring and review until a successful initiation and stabilisation period is completed, for transfer of prescribing under a shared care agreement to be considered.
- Prescribing under shared care between an NHS GP and private healthcare clinician may be possible if, as a minimum, the medicine requested is:
    - managed under shared care locally already.
    - approved for use within the local formulary.
    - would have been used had the patient been seen via NHS services.

  However, many other factors also need to be considered.
- The prescribing of medicine under shared care arrangements between an NHS GP and an ongoing private healthcare episode of treatment could be considered conflicting with DHSC policy if it is seen as subsidising the patient's private care, and there could be difficulties in continuity of care, e.g., if financial difficulties arose or the clinical condition of the patient changes.[6] Instead, the GP should usually seek to refer the patient to a locally commissioned NHS service and engage in shared care via that route. This could be done in advance of the patient being discharged from the private provider so as to try and ensure a seamless transfer of care.[1,6]
- If a GP wishes to support a request from a private provider for a medicine, which is locally (and/or nationally) considered to be most safely prescribed under a shared care protocol (SCP), the private provider should use a locally (or nationally) approved SCP, though a local one may be most appropriate. Ideally, a referral to an NHS specialist should take place, and shared care with a private service considered as an interim solution if needed.
- It is essential that the private provider who has initiated the treatment and is requesting shared care:
    - Sends a formal request to the GP, and with the patient's permission shares all relevant patient information with that GP.
    - Is able to demonstrate the same level of service that would be expected from the local NHS service under local shared care protocols, where available.
    - Is able to meet the specialist responsibilities of the locally agreed shared care protocol in terms of monitoring provided and reviews.
    - Documents and confirms with the NHS provider that a discussion with the patient has taken place, explaining that should they fail to continue to meet the review schedule outlined, it is unlikely the NHS prescriber will continue prescribing.
- Should the private provider be unable to meet the responsibilities of the SCP then,
    - The NHS GP should inform the patient and private provider that they are no longer able to continue care for that patient without referral back to NHS specialist services.
    - The patient and private provider should be informed as soon as practically possible.
    - The reasons should be carefully explained to the patient, who should remain under the care of the private provider until their care can be transferred to the NHS and the episode of care with the private provider is ended.
- Transfer of clinical responsibility from a private specialist to primary care should only be considered where the individual's clinical condition is stable or predictable, and the private specialist will assume and retain responsibility both for providing prescriptions and monitoring, until the GP has agreed to a transfer of responsibilities through a documented shared care agreement for the individual.[10] From then on, the individual will obtain prescriptions from the GP, who will be supported by that specialist as appropriate to the individual's needs.

- If the private specialist is unable to continue supporting the shared care protocol, then an alternative specialist needs to be identified who will support the GP under a shared care protocol to provide continuity of care for the patient.

Ethical considerations:

BMA medical ethics department guidance 2009 addresses the issue of patients switching between the NHS and the private sector and concluded that "this is not unethical as long as the patient – when re-joining the NHS – is treated in the same way as those receiving all of their care within the NHS."[6]

There are ethical considerations associated with prescribing shared care medicines under a shared care protocol between a private provider and an NHS GP, including:

1. This could be seen as the NHS subsidising private care, i.e., patient paying to be seen by private specialist, and obtaining part of the treatment privately at a cost but the NHS subsidising medicines costs and associated ongoing monitoring.
2. This could also be seen as allowing people to 'skip the queue' and bypass NHS waiting lists based on ability to pay, thereby adding to health care inequalities.
3. If a patient has been started on a medicine and discharged from private healthcare without an agreed transfer to the NHS, there is a risk of treatment being interrupted. If the patient were to run into financial difficulties, or the private provider ceases to operate, this could result in the private care being discontinued. The GP would then be in a difficult position as they would either need to prescribe a shared care medicine without specialist oversight, discontinue the medicine, or try and refer to an NHS specialist on an urgent basis, potentially adversely affecting referral times for other patients.
4. Mixing private and NHS care. If the situation where the clinical picture of the patient was uncertain, or a discussion is needed regarding future treatment, this might require the NHS GP to spend time meeting with the private provider to discuss one patient and one condition. DHSC guidance states that "the patient should bear the full costs of any private services. NHS resources should never be used to subsidise the use of private care."[1] To avoid this risk, there should be as clear a separation as possible between private and NHS care.[1]
5. There is no definitive answer on how to safely manage care for patients who have already seen a private provider and present with a "shared care request" but have effectively been discharged from the private provider. It may not be an option to refuse treatment as that may not be in the patient's best interests, even though the GP would not normally prescribe the treatment except under a shared care agreement. GPs must remain sympathetic to the needs of the patient to retain that relationship but must also follow the rules of NHS treatment. Each case will need to be assessed on an individual basis, considering the risk/benefits of discontinuing the medicine and risks associated with the GP agreeing to prescribe the medicine.

General information:

- Single episode of care: If a patient is seen privately by a specialist or GP for a single episode of care, the private clinician remains clinically responsible and will determine the ongoing treatment for the particular condition. Until the specialist discharges the patient, this remains an episode of care and any short-term medication required should be paid for by the patient as part of that package of care.[3]
- Longer-term: If a private consultation identifies a long-term condition, or a need for medication which is available as routine NHS treatment, this should be provided by the patient's usual GP. However, the consultant's advice on choice of treatment is advisory and the NHS doctor may choose to prescribe an alternative product in line with national and local guidelines/formulary to ensure equity with NHS patients. [3,4,5,7,8] By prescribing, a clinician assumes clinical responsibility for the treatment.
- GPs may not issue private prescriptions alongside or as an alternative to FP10s.[12] However, GPs may write private prescriptions for patients for medicines blacklisted in the Drug Tariff if they feel it is clinically appropriate and they are happy to take responsibility for that prescribing decision.[12,13] Under the NHS regulations, GPs may not normally charge their registered patients for providing such a prescription [12] The only occasions when a doctor may charge for a private prescription are:
    1. For medicines which are being issued solely in anticipation of the onset of an ailment while outside the UK, but for which the patient does not require treatment when the medicine is prescribed (e.g., antibiotics for travellers' diarrhoea or acetazolamide for prevention of altitude sickness).
    2. For medicines issued for the prevention of malaria.
    3. The product is a travel vaccine not included in current public health policy, e.g., tuberculosis, Japanese encephalitis vaccine, rabies vaccine, yellow fever vaccine (if at a yellow fever vaccination centre).
- Where the GP cannot issue an FP10 for an item following a request to prescribe from a private provider, they cannot provide the item as a private prescription. This would be the responsibility of the private provider used by the patient.

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