The De Parys Group

Policy for not entering into Shared Care with Private Providers

Created by: Caroline Prentice, Project Lead Access & Governance
Created on: 14th May '24
Review period: 12 monthly

Introduction

This policy needs formalising to ensure that all practitioners within the practice are fully aware of the rationale for this policy and that this can be openly shared with patients.

This decision was not reached lightly, as the implication for patients is clearly understood and sympathised with. However, the risks of providing this for medications initiated by private providers remains significant, and so the practice will not enter into shared care agreements with private providers.

This includes, but is not limited to, ADHD medication, Gender medication, DMARD medication. These are the three most common areas where private shared care agreements are requested and declined. Others may occur, but have yet to do so.

What is Shared Care

Shared Care Agreements are an agreement between the patient, the GP and the hospital consultant. It enables the care and treatment that the patient receives for a specific health condition to be shared between the hospital and the GP. This will only occur with agreement with the patient, and when the condition is stable or predictable.

Rationale for not entering into these agreements with private providers

There are a range of risks / reasons / principles that are relevant when this decision was made, and all are articulated here to provide the full picture, as this is a complex area.

- Risk of patient or insurance company stop paying for the private services meaning care is no longer shared and the practice are left prescribing or stopping the much wanted/needed drug.
    - The practice would not continue to prescribe the medication if there was not access to the appropriate specialist, and so the patient would immediately be forced to obtain this privately or risk withdrawal risk

    - In addition, there are monitoring tests that need to be completed, and these would need to be completed by the private provider, e.g. blood tests or ECGs, or other monitoring. These cannot be passed to the GP team to complete as the interpretation of this information in the context of the prescribing is outside of the remit of the GP, and must remain with the specialist
- Challenges, in some circumstances, of ensuring that the private specialist is appropriately regulated and qualified
    - Not all diagnosis are made by specialists that would ordinarily be recognised as being qualified to make this diagnosis, and the patient is therefore at risk at being misdiagnosed and over-medicated
- Risk of NHS guidance not being followed by private sector
    - Anecdotally some private providers have initiated 3rd line medication, or medication not accessible on the NHS, when 1st or 2nd line medications have not been tried, or are being prescribed at levels that would not be accepted within NHS prescribing parameters
- Its voluntary- we are not obliged to do this
    - Shared Care Agreements are with consent, and cannot be forced
- Conceptually, the idea of if you go private- you stay private
    - The practice has a policy that medication that would ordinarily be prescribed on the NHS that has been prescribed privately, the first script is obtained privately before this is converted to NHS – e.g. if a patient has been see privately for depression, first prescription for Sertraline will be private, and provided a follow up is completed with the GP that this is safe to continue this will be added to repeat 'on the NHS'
- We will offer referral to NHS services, and those services do have a shared care agreement that we are happy to enter into.
    - But until the prescribing is accepted by the NHS secondary care team, and that team transfer the care under the shared care agreement the practice does not take over prescribing responsibilities
- The practice is providing NHS services, not private service support
    - There is no funding to support private services and with the complexity of this area, we have to consider if this something that we can sustainably provide
    - Other shared care agreements, e.g. DMARDS, has funding in place due to the level of additional monitoring in place that is needed
- Blanket no to all private shared care so it is equitable and non-discriminatory
    - We must apply this policy to all private shared care requests for medication that is not normally initiated by a GP, in order that we are not discriminatory
- Risk of being outside NHS indemnity as potentially acting outside of NHS guidance
    - This is a grey area, as it is not clear whether a GP would be covered by the national indemnity scheme to prescribe medication that was initiated privately and was outside of their remit

What does the GMC say about shared care ?

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care

extracted below on 12.5.23

74
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.

75
Shared care requires the agreement of all parties, including the patient. It's essential that all parties communicate effectively and work together.

Prescribing at the recommendation of a colleague

76
If you prescribe based on the recommendation of another doctor, nurse or other healthcare professional, you must be satisfied that the prescription is needed, appropriate for the patient and within the limits of your competence.

77
If you delegate the assessment of a patient's suitability for a medicine, you must be satisfied that the person you delegate to has the qualifications, experience, knowledge and skills to make the assessment. You must give them enough information about the patient to carry out the assessment. You must also make sure that they follow our guidance on 'Decision making and consent' in paragraphs 42 to 47.

78
In both cases (paragraphs 76 – 77), you will be responsible for any prescription you sign.

Recommending medicines for a colleague to prescribe

79
If you recommend that a colleague, for example a trainee doctor or GP, prescribes a particular medicine for a patient, you must consider their competence to do so. You must be satisfied they have sufficient experience (especially in the case of trainee doctors) and knowledge of the patient and the medicine in order to prescribe. You should be willing to answer their questions and otherwise assist them in caring for the patient, as required.

Shared care prescribing

80

If you share responsibility for a patient's care with a colleague, you must be competent to exercise your share of clinical responsibility. You should:

a. keep yourself informed about the medicines that are prescribed for the patient
b. be able to recognise serious and frequently occurring adverse side effects
c. make sure appropriate clinical monitoring arrangements are in place and that the patient and healthcare professionals involved understand them
d. keep up to date with relevant guidance on the use of the medicines and on the management of the patient's condition.

81

In proposing a shared care arrangement, specialists may advise the patient's GP which medicine to prescribe. If you are recommending a new or rarely prescribed medicine, you should specify the dosage and means of administration, and agree a protocol for treatment. You should explain the use of unlicensed medicines and departures from authoritative guidance or recommended treatments. You should also provide both the GP and the patient with sufficient information to permit the safe management of the patient's condition.[21]

82

If you are uncertain about your competence to take responsibility for the patient's continuing care, you should ask for further information or advice from the clinician who is sharing care responsibilities or from another experienced colleague. If you are still not satisfied, you should explain this to the other clinician and to the patient, and make appropriate arrangements for their continuing care.