LMC

GUIDE:

Guidance for Practices: Right to Choose and Shared Care

This guidance summarises the key contractual and professional considerations for practices on NHS Right to Choose (RTC), ADHD and ASD referrals, and shared care prescribing arrangements.

With thanks to Dr Gill Farmer
GPC/ LMC Interface

Right to Choose (RTC): Key Principles

What is Right to Choose?

Right to Choose is a patient choice right within NHS England. It allows eligible patients to choose an alternative provider for elective outpatient mental or physical healthcare where:

- the patient is registered with a GP practice in England
- the GP agrees a referral is clinically appropriate
- the chosen provider holds a qualifying NHS contract for the required service

Right to Choose applies in England only and does not apply in Scotland, Wales or Northern Ireland.

The decision to refer remains a clinical decision for the GP. Once a referral is agreed, the patient has the right to choose the provider for that referral.

Exclusions

RTC does not apply where patients are:

- already receiving care for the same condition following an elective referral
- accessing urgent or crisis care
- detained under the Mental Health Act
- in secure settings including prisons and immigration detention
- accessing services commissioned directly by local authorities
- serving members of the armed forces

ADHD and ASD Services

Many Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) assessment services are now delivered by independent sector organisations providing NHS-funded care under NHS contracts.

Patients may, therefore, request referral to:

- NHS trusts
- independent providers commissioned under NHS Standard Contracts
- providers commissioned by another ICB or NHS England

Patients cannot choose providers that do not hold a qualifying NHS contract.

Comissioner Responsibilities

Under the NHS Choice Framework and associated regulations, commissioners have legal obligations to:

- fund eligible patient chosen providers
- fund on a Non-Contractual Basis. Commissioners must arrange payment under an NHS Standard Contract to the chosen provider if the provider holds a written contract with any NHS commissioner in England for that specific service.
- permit referrals to any qualifying provider in England
- avoid imposing local vetoes or prior approval systems
- establish clear processes for qualification and contracting
- ensure patient information on choice is publicly available
- secure quality and safety oversight through NHS Standard Contracts at the earliest opportunity

Importantly:

- commissioners are still required to fund care even where there is no pre-existing local contract
- the absence of a local contract does not invalidate a lawful RTC referral

Shared Care Prescribing: Core Principles

Shared care prescribing:

- is an entirely voluntary, non-core activity for general practice
- is dependent on agreement by all parties, including the GP practice and the patient
- can be declined by the GP practice

NHSE acknowledge that there is:

- no legal obligation or mandatory requirement for GP practices to enter into shared care arrangements.

The rationale for refusing to enter into shared care arrangements should be applied consistently and be framed by a set of clear practice principles to avoid discrimination against any specific patient groups.

Shared Care Prescribing: Core Principles

Practices may choose to decline shared care where:

- there is insufficient clinical capacity
- clinicians lack confidence or competency in the specialist medication despite training
- specialist support is inadequate
- governance arrangements are unclear (always more challenging if the provider is not commissioned by the NHS)
- monitoring requirements are excessive or unfunded
- patient safety concerns exist

Policy passed at UK LMC Conference 2025 states that **'any shared care prescribing arrangement with a private provider is unsafe, not enduring, and widens health inequalities, and demands that GPC UK adopts a firm position statement to reject this'.**

A January 2025 report from the Centre for Health and the Public Interest (CHPI), highlighted concerns regarding parts of the NHS-funded ADHD provider market, including rapid growth in private sector provision, inconsistent contracting arrangements, variable regulatory oversight, providers operating without direct NHS contracts, and concerns around governance and quality assurance.

The report's findings support policy passed at UK LMC Conference 2025 and Practices are advised to question whether:

- the provider has a valid NHS contract
- the provider is CQC registered where appropirate
- prescribing and monitoring arrangements are safe and sustainable
- there is enduring specialist input
- governance and escalation arrangements are sufficiently robust

The BMA have produced a useful template letter to support practices in declining shared care which can be found HERE.

GMC Guidance

The GMC "Good practice in proposing, prescribing, providing and managing medicines and devices" guidance states that:

- 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.

Minimum Requirements for Shared Care

Prior to any agreed transfer of prescribing responsibility or shared care arrangement with general practice, GPs should expect (and may wish to request evidwnce or agreement from the provider) of:

1 Appropriate Specialist Assessment and Diagnosis

The specialist provider should:

- hold appropriate NHS commissioning arrangements
- provide evidence of robust governance and clinical quality assurance
- ensure clinicians are appropriately qualified

2 Stabilisation Prior to Transfer

Medication should:

- be initiated and titrated by the specialist
- be clinically stabilised prior to transfer
- meet any agreed stabilisation period in local shared care protocols

3 Ongoing Specialist Involvement

There should be:

- continuing specialist follow-up
- timely access to specialist advice as needed
- clear arrangements for specialist review, dose adjustment and adverse event management

4 Clear Monitoring Arrangements

Shared care agreements should define:

- who is responsible for physical monitoring
- what monitoring is required
- how results are communicated and acted upon
- escalation arrangements where abnormalities occur

5 Funded Pathways

Any significant additional monitoring or workload transferred into general practice should be:

- formally commissioned (often through a medicines monitoring local enhanced service)
- appropriately funded (through negotiation with LMCs)

A clear, well-documented shared care arrangement protects patients, supports general practice and ensures safe, high-quality care.
But, remember it is entirely voluntary and not a core activity for practices!

Practice Checklist following a request for Shared Care

	KEY POINTS	YES	NO
	1. **The practice's refual or acceptance of a shared care agreement is framed by a clear set of principles to avoid challenges of discrimination.**		
	2. **The patient has advised prior to referral that the practice may choose not to prescribe under a shared care arrangement and the patient has been advised of 'next step's in this scenario.**		
	3. **The practice has made an informed decision to accept/ not accept shared care based on BMA and GMC guidance and has documented the reason for this.**		
	4. **Advice has been sought from the LMC regarding any existing medicines monitoring LESs or local shared care policies.**		
	5. **Further information has been requested from the provider where necessary to inform decision making.**		
	6. **A letter has been sent to the provider and the patient outlining the final decision and a copy is in the patient record.**		

Right to Choose gives patients a legal right to choose the provider for an appropriate NHS referral. Right to Choose does not create:

- an automatic obligation on GP practices to prescribe
- an obligation to participate in shared care
- an obligation to undertake unfunded specialist monitoring

These remain separate clinical, contractual and governance decisions for practices.

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Please let us know if you have any questions and/ or if we can help you with anything.

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