Dr Seb Pillon

Bolton GPST2A

How GP works

What do you want to know about GPs & primary care?

Content

History of Primary Care

A typical GP Day

GP today

What are CCGs (and ICSs)?

Negative Gossip

GP FAQs

History of General Practice

- Before the 20th century general practitioners worked as private traders.
- In 1911 Lloyd George introduced the National Insurance Act, making health insurance compulsory for working people on a low income.
  - Local insurance committees administered the scheme, contracting general practitioners to provide general medical services (GMS).
  - Doctors were paid an annual capitation fee for every insured patient who registered with them.
- When the NHS was created in 1948 everyone became eligible for free primary care.
- In 1966 a new contract improved pay and conditions, instituted a maximum list size of 2,000 patients
- The following years saw an increasing trend for group practice to become the norm.
- 1990s saw trends towards increased scrutiny and evidence-based medicine and launched an era of greater external management for general practice and introduced some performance-related pay.
- The 2004 GP contract represented a new relationship between GPs and the NHS, putting an increased emphasis on performance-related pay, as measured by the QOF.
- 2012: CCGs take on functions of PCTs
- 2019: Primary Care Networks are the start of development of Integrated Care Systems
- 2025: The 10YP: community-at-scale

A day in GP

It's time for NHS GPs to stop hiding behind their telephones

From magazine issue: 4 September 2021

Politics > Health | 27 October 2021

If you're struggling to see your GP, it doesn't mean they are "hiding" from you

Medical practices are not refusing to care, the problem is a GP recruitment and and retention crisis. There is no magic doctor tree.

By Phil Whitaker

A day in the life of a GP

0800: Arrive, log in updates

0815: Urgent tasks/labs

0830: 15 x appointment

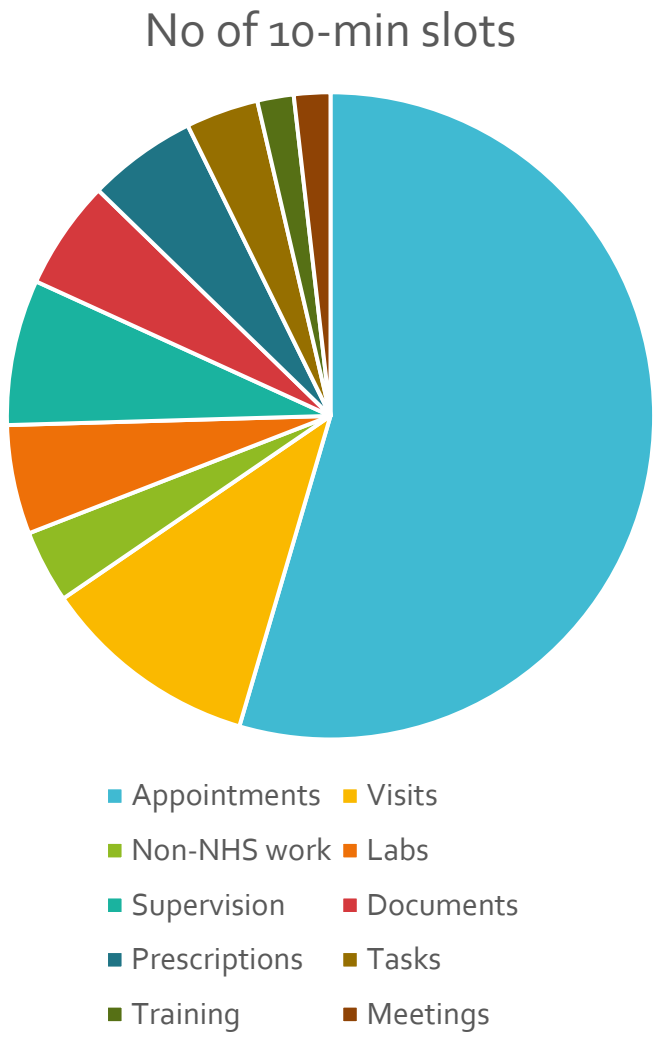
1130: 2 x visit

1230: Labs/Documents/Tasks/ Prescriptions/Non-NHS

1430: Lunch

1500: 15 x appointment

1800: Remaining admin



You can do so much in ten minutes' time. Ten minutes, once gone, are gone for good. Divide your life into 10-minute units and sacrifice as few of them as possible in meaningless activity.

Ingvar Kamprad, entrepreneur 1924

A “jack of all trades…”

“…but a master of none…”

“…is better than a master of one”

What are GPs good at?

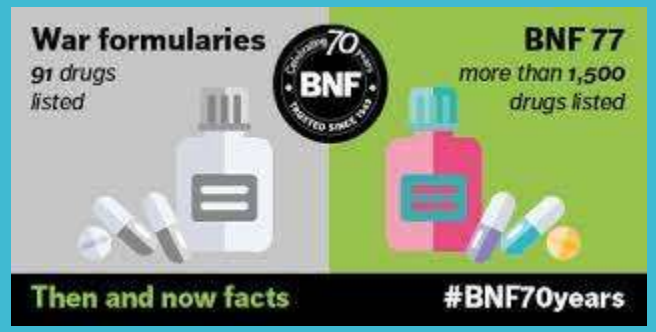
What GPs see & do…

- Communication skills
  - Our main exams are around efficient consulting and focussed examinations
- Majority of NHS patient contact
  - Often quoted as "95% of contact with 5% of budget"
- Holistic, patient centred care
- Chronic disease management specialists
- Hold the risk of missed/delayed diagnosis

What others think they see & do…

- Short consults, no time for anyone
- Just annoying gatekeepers there to do referrals to real doctors
- Just there to chat
- Not specialist enough to know anything
- Refer everything/don't refer enough

Then and now



Old time GP

- Hypertension – once diagnosed admit to ward to start ramipril
- Heart attack treatment – home visit for morphine, aspirin (and hope for the best)
- Kitchen table tonsillectomies
- Lloyd George notes
- BNF – a leaflet
- Cardigans and elbow patches!

GP 2025

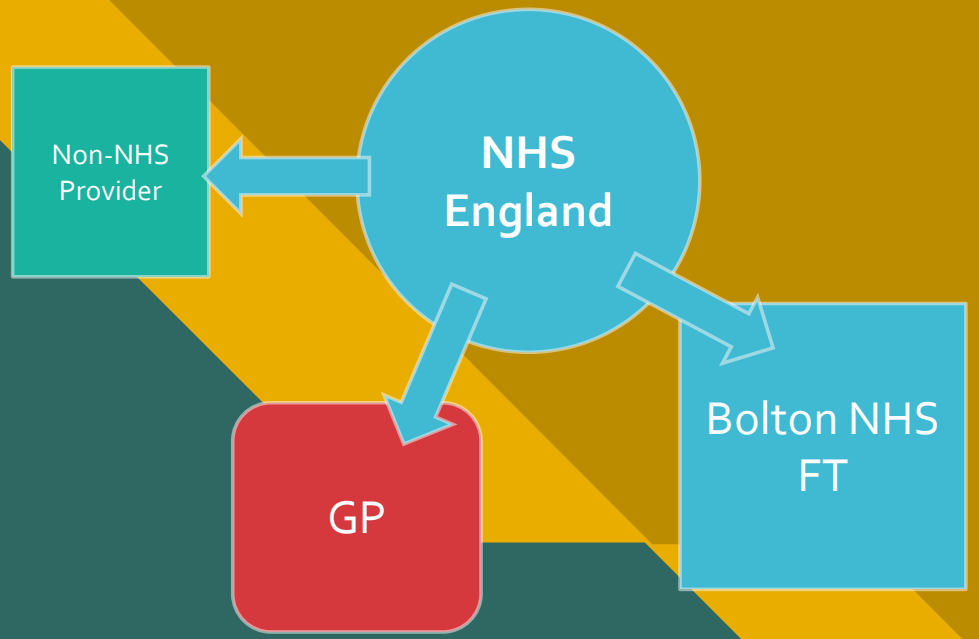
- Almost all hypertension managed by GP/nurse/pharmacist
- STEMIs sent for primary PPI in tertiary centres
- Reduced mortality rates for tonsillectomies
- Electronic Prescribing System
- BNF & BNFC online
- Scrubs and suits!

The structure of primary care delivery

GP, CCGs and the new Integrated Care Systems

What are general practices?

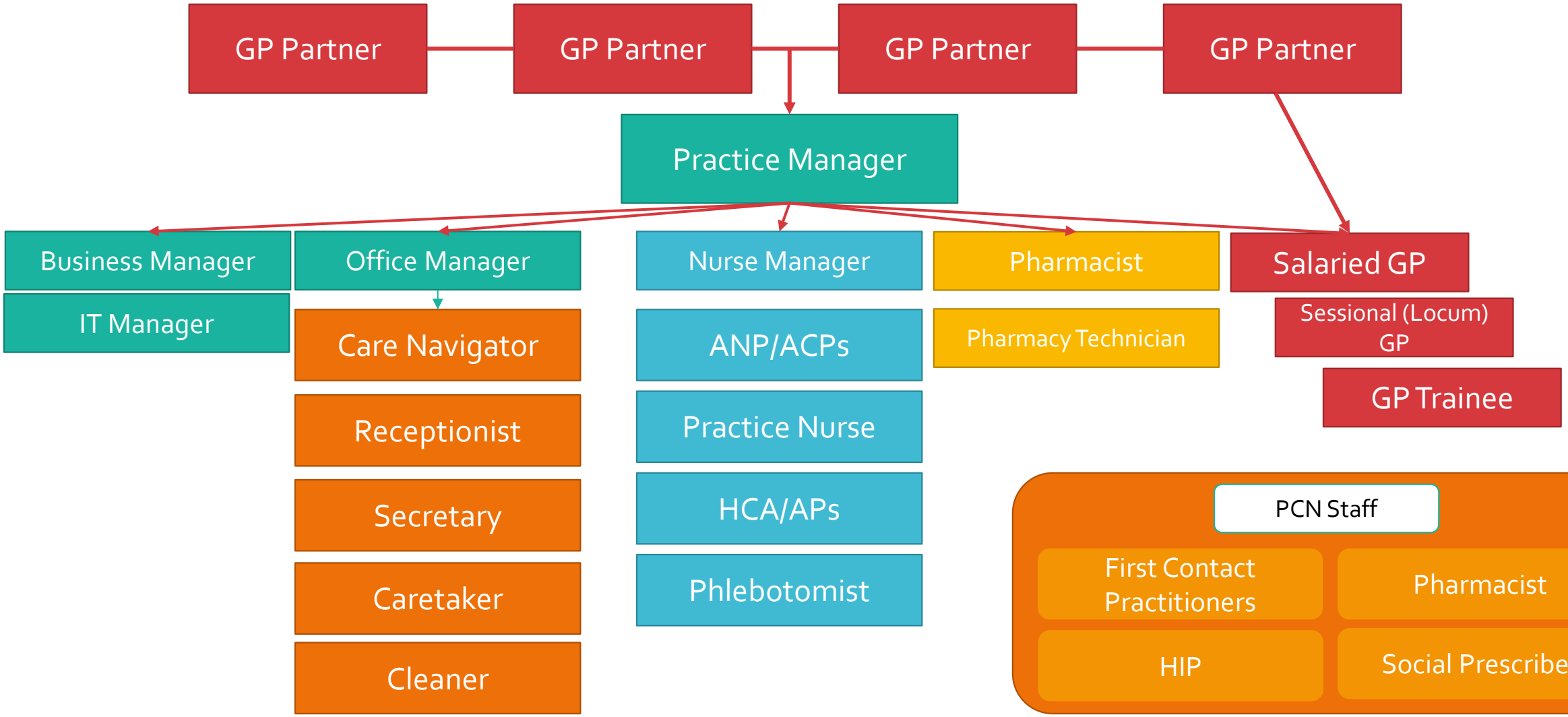
- General practices are the small to medium-sized businesses whose services are contracted by NHS commissioners to provide generalist medical services in a geographical or population area.
- While some general practices are operated by an individual GP, most general practices in England are run by a GP partnership.
- This involves two or more GPs, sometimes with nurses, practice managers and others (as long as at least one partner is a GP), working together as business partners, pooling resources, such as buildings and staff, and together owning a stake in the practice business.
- GP partners are jointly responsible for meeting the requirements set out in the contract for their practice and share the income it provides.



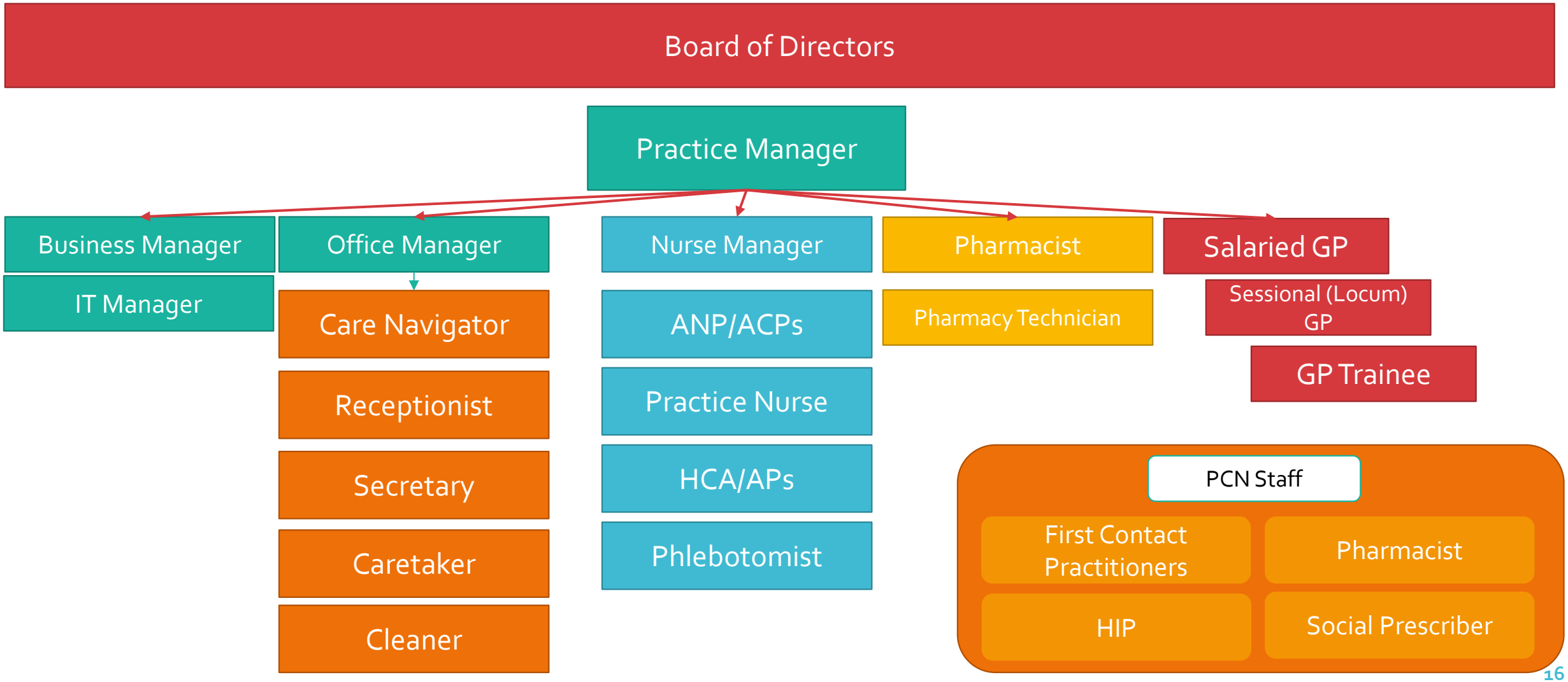
Types of GP Contract

- **GMS (General Medical Services)**
  - the national standard GP which covers around 70% of practices. This contract is negotiated nationally every year between NHS England and the General Practice Committee of the BMA. It is then used by ICBs to contract local general practices in an area.
- **PMS (Personal Medical Services)**
  - another form of core contract but unlike the GMS contract, is negotiated and agreed locally by ICBs with a general practice or practices. This contract offers commissioners more flexibility to tailor requirements to local need while also keeping within national guidelines and legislation. About 28% of practices held PMS contracts in July 2024.
- **APMS (Alternative Provider Medical Services)**
  - offers greater flexibility than the other two contract types. The APMS framework allows contracts with organisations (such as private companies or third sector providers) other than general practitioners/partnerships of GPs to provide primary care services. APMS contracts can also be used to commission other types of primary care service, beyond that of 'core' general practice. For example, a social enterprise could be contracted to provide primary health care to people who are homeless or asylum seekers. About 4% of practices have APMS contracts.

GP Practice Organisation (Partnership Model)



GP Practice Organisation (Company Model)



What's in a GP contract?

The core parts of a general practice contract:

- agree the geographical or population area the practice will cover
- require the practice to maintain a list of patients for the area and sets out who this list covers and under what circumstances a patient might be removed from it
- establish the essential medical services a general practice must provide to its patients
- set standards for premises and workforce and requirements for inspection and oversight
- set out expectations for public and patient involvement
- outline key policies including indemnity, complaints, liability, insurance, clinical governance and termination of the contract.

- In addition to these core arrangements, a general practice contract also contains a number of optional agreements for services that a practice might enter into, usually in return for additional payment.
- These include the nationally negotiated **Directed Enhanced Services (DES)** that all commissioners of general practice must offer to their practices in their contract and the locally negotiated and set **Local Enhanced Services (LES) or Locally Commissioned Services (LCS)** that vary by area.

What services can practices be contracted to provide?

- **Essential services**
- Primary care 8-6.30

- **Additional services**
- Many provide, but can opt-out (i.e. minor surgery)

- **Out of hours services**
- Can opt-out
- Commissioners responsible

- **Enhanced services**
- Nationally agreed opt-in services (some vaccines, health checks)
- PCNs

- **Locally commissioned services**
- Smoking cessation
- Homeless service

DES

- a Network Contract Directed Enhanced Service Scheme
  - to integrate care by the formation and continued operation of primary care networks in order to deliver care in a more personalised way,
- a Learning Disabilities Health Check Scheme
- a Violent Patients Scheme/Special Allocation Scheme (SAS)
- a Minor Surgery Scheme

LES/LCS examples

- Anticoagulation - DOAC monitoring
- Cardiac - 24 hr BP
- Cardiac - AF screening
- Cardiac - Non-urgent ECG
- Cardiovascular screening health checks
- Extended hours
- Hospital care - Post-op suture removal/wound care
- Hospital care - Pre and post op swabs/investigations
- Mental health - Dementia diagnosis and treatment initiation
- Mental health - Provision of depot antipsychotic medication
- Minor surgery - lumps and bumps
- Monitoring - MGUS
- Monitoring - PSA in cancer

- Pathways - A&G
- Pathways - Catheter changes and management
- Pathways - Eating disorder physical monitoring and blood monitoring
- Pathways – Dermoscopy
- Public health - Hep B catch up
- Public health - flu immunisation
- Respiratory - FENo
- Respiratory – Spirometry
- Sexual health - injectable and depo contraception
- Specialist drug monitoring
- Treatment room – Phlebotomy
- Urgent care - Management of minor injuries
- Urgent care - supporting ambulance service with advice

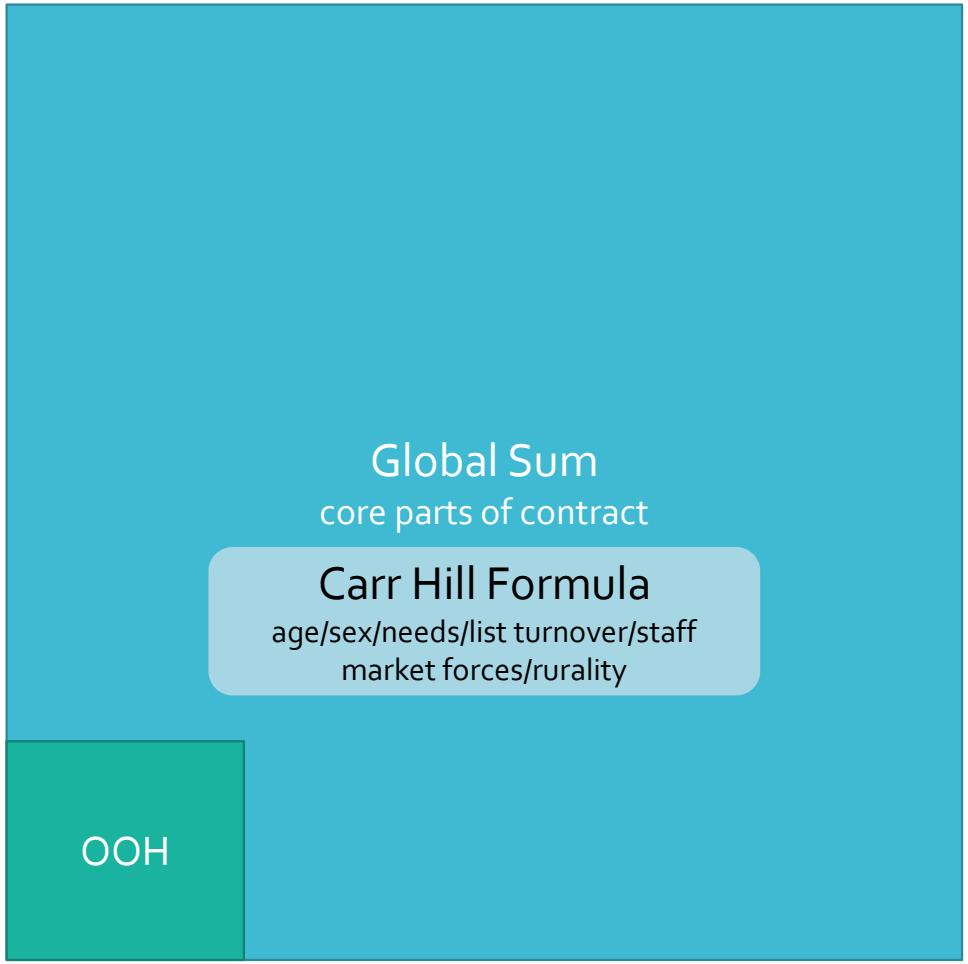
https://www.bma.org.uk/advice-and-support/gp-practices/gp-service-provision/enhanced-services-gp-practices-can-seek-funding-for

QoF

- The Quality and Outcomes Framework accounts for around 10 per cent of a practice's income.
- Voluntary programme that practices can opt in to in order to receive payments based on good performance against a number of indicators.
- 2025: The total number of points available is 564.
- One QoF Point is worth about £221

DM036. The percentage of patients with diabetes, on the register aged 79 years and under, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	27	38-90%
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12	40–90%

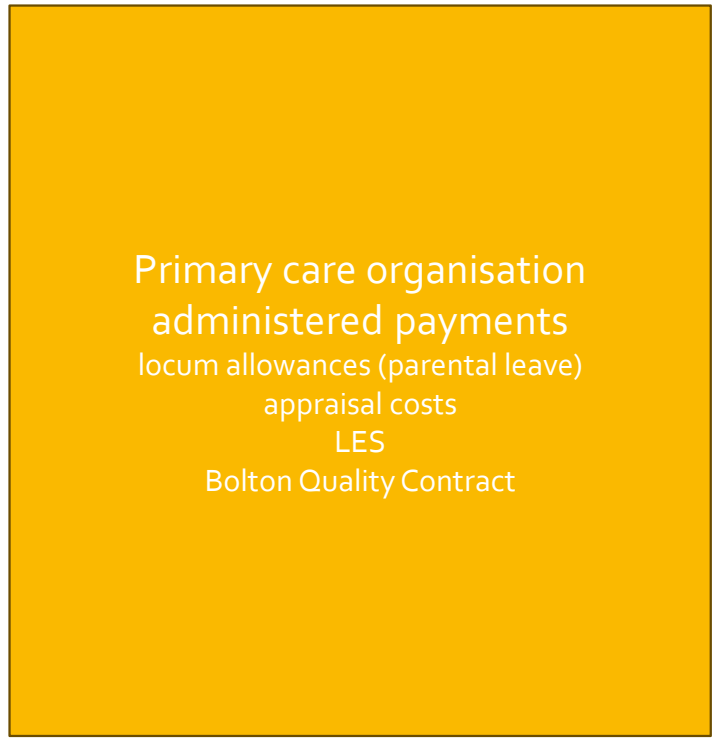
https://www.england.nhs.uk/publication/quality-and-outcomes-framework-guidance-for-2025-26/


Global Sum
core parts of contract
Carr Hill Formula
age/sex/needs/list turnover/staff
market forces/rurality
OOH

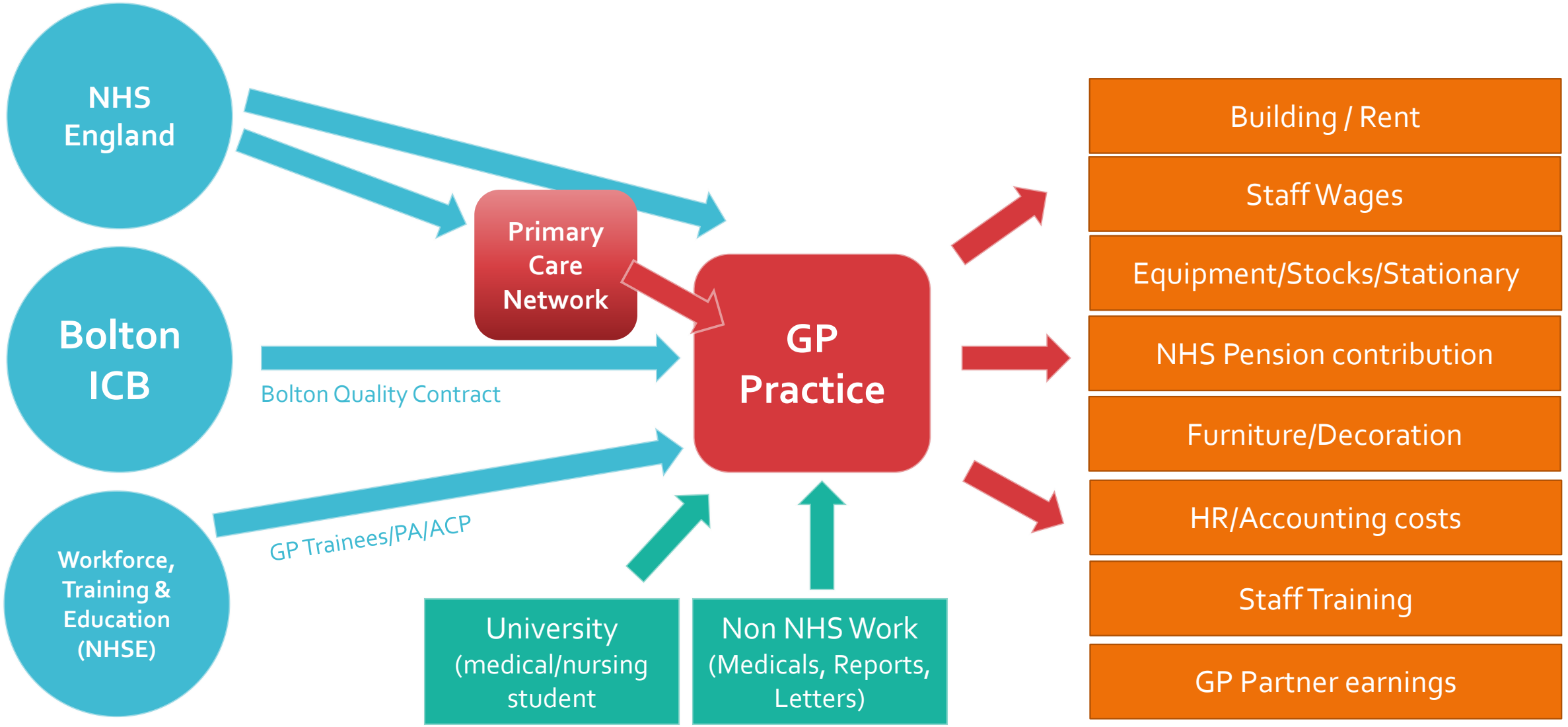

NHS Hospital Contract


QoF
Quality Outcomes
Framework


Premises Payment


Primary care organisation
administered payments
locum allowances (parental leave)
appraisal costs
LES
Bolton Quality Contract

GP Income in Bolton



Example Costs

- CQC Fee
  - £509 + (your patient list size ÷ 1.7545)
- iGPR
  - Records service, £600/year
- AccuRx
  - May be reimbursed by local ICB (but not mandatory)
- Stationery
  - *NHS spends £230 million/year on paper patient records*
- Tea & Coffee
  - *For an office of 50 people, about £2000/year*

How much does it cost?

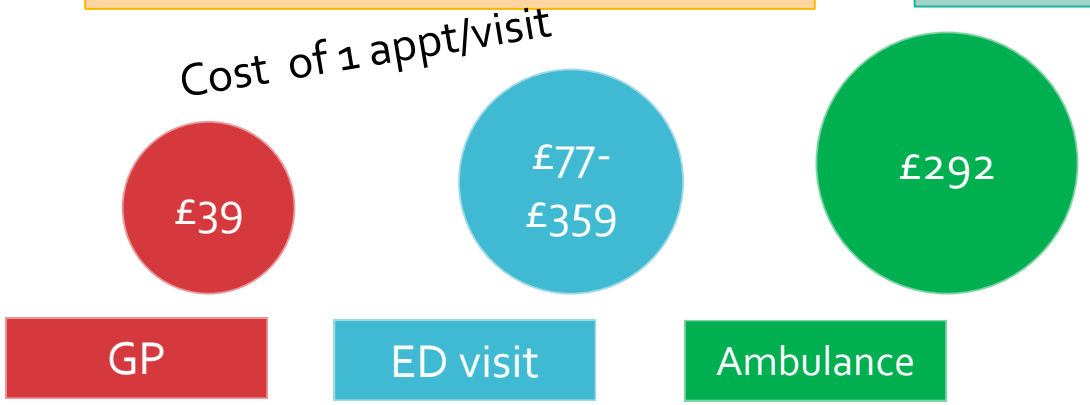
General Practice

- £118-164 per patient per year
  - (Bolton, 2025)

NHS Trusts

- Average hospital outpatient appointment cost:
  - £120 per appointment
- Average inpatient cost (ward):
  - £400 per patient per 24h

Cost of 1 appt/visit



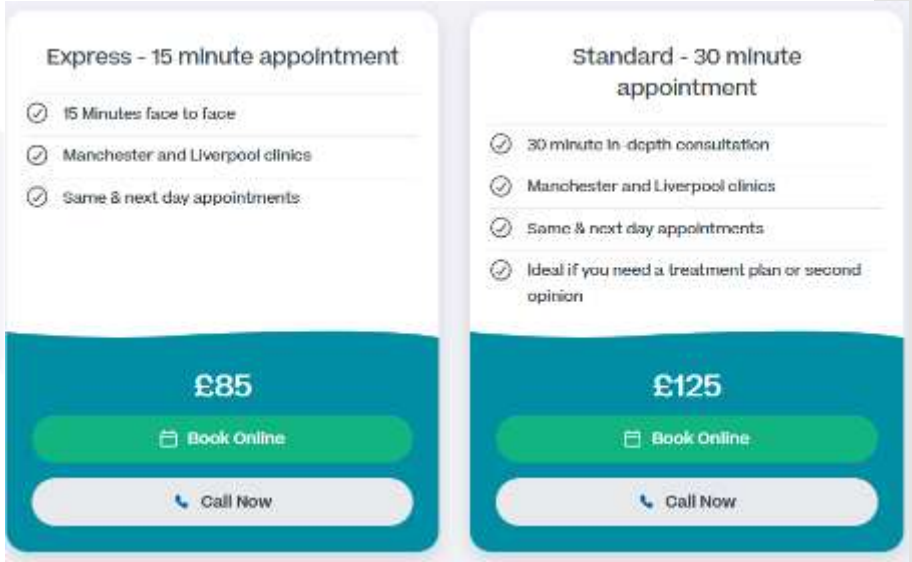
Private GP cost

15-minute appointment

Remote: £59
Face-to-face: £79

30-minute appointment

Remote: £99
Face-to-face: £140



Well Person Blood Test

- Blood count
- Kidney function
- Liver function
- Thyroid function
- Cardiac / muscle enzymes
- Iron and bone markers
- Blood glucose
- Cholesterol levels including HDL & LDL
- Prostate cancer check (for men)
- Ovarian cancer check (for women)

£220

Lifestyle Blood Test

- Full Blood Count
- ESR
- C-reactive protein
- Biochemistry (Urea & Electrolytes & Liver function tests)
- Lipids Profile (HDL/LDL (DL2L))
- Iron studies (Iron (TIBC)
- Thyroid function (Free T3/Free T4/Thyroid Stimulating Hormone)
- Bone markers (calcium, phosphate, uric acid)
- PSA for men / CA125 for women
- Haemoglobin A1C (HbA1c) test
- Minerals (Ferritin, Magnesium)
- Vitamins (B12, Serum Folate, Vitamin D)

£288

Ultimate Health Screen

- GP Consultation
- Physical Examination
- Lifestyle assessment
- Medical history
- Urine analysis
- Thyroid tests (TSH, Free T4 & Free T3)
- Blood Pressure & Pulse
- Health Promotion Literature
- A PLAC & Q-Risk3 cardiac assessment
- Detailed review of your liver and kidney function
- PSA chec
- CA125 che
- Essential 2 ideal if your suffering from weakness, fatigue or brain fog
- An advanced HbA1c diabetes test to look for signs of metobolic disease

£649

Carr-Hill Formula

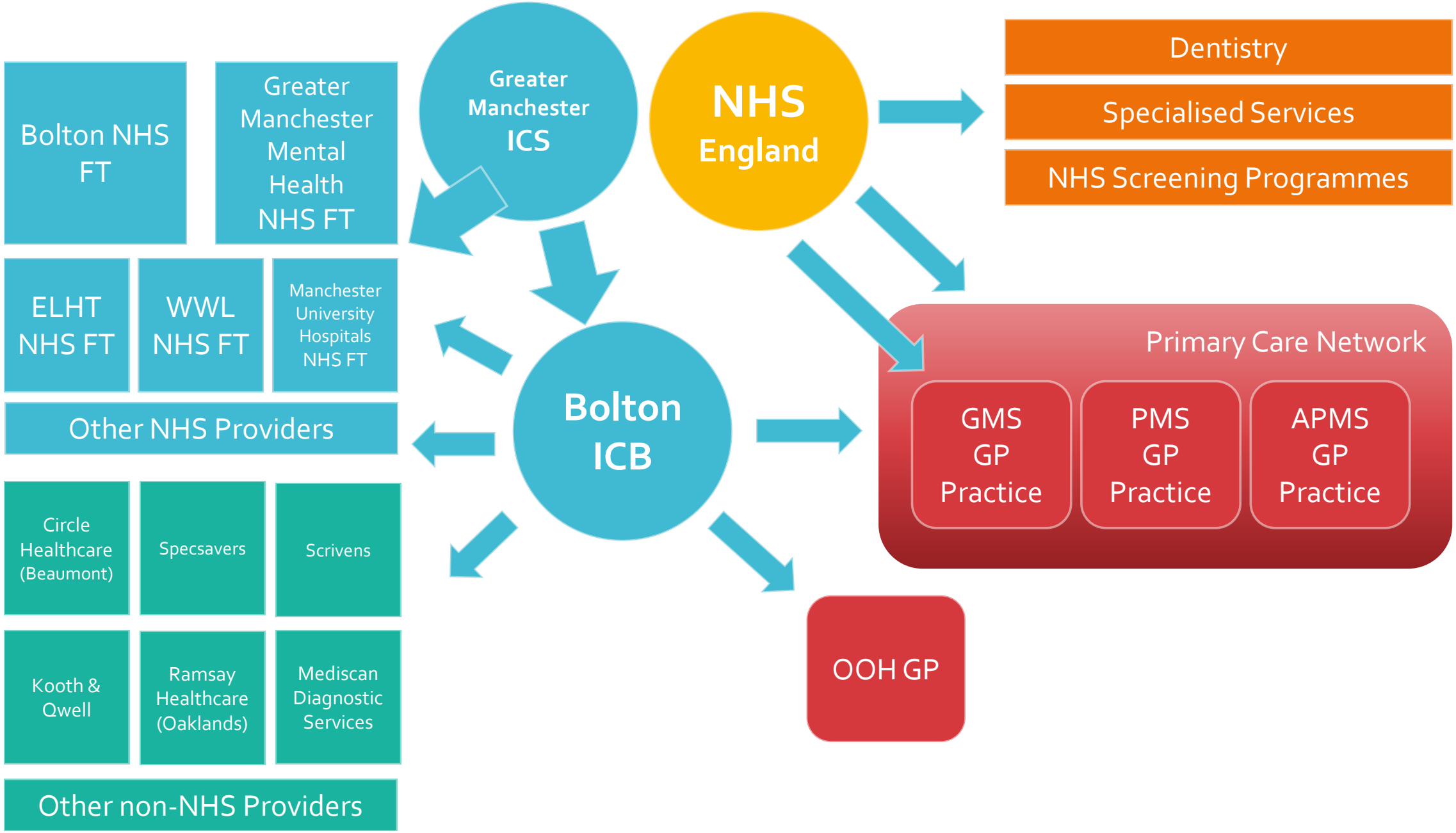
Drivers of workload	Description
Patient age and sex	Patients of different ages and sexes attract a different level of payment under the Carr-Hill formula based on a cost curve.
Additional needs of patients	Using health survey for England 1998-2000 data, the formula takes into account standardised limited long-standing illness and the standardised mortality ratio for patients under 65.
List turnover	Patients in their first year of registration in a practice tend to have more consultations than others, so require extra funding.

Unavoidable costs	Description
Staff market forces factor	The geographical variation in staff costs.
Rurality	The impact of rurality was modelled using HMRC information on GP expenses aggregated to practice level. The impact of population density and dispersion was modelled against GP expenses, controlling for other factors.

What is an ICB?

- Integrated Commissioning Boards (ICBs) commission most of the hospital and community NHS services in the local areas for which they are responsible.
- Commissioning involves deciding what services are needed for diverse local populations, and ensuring that they are provided.
- ICBs are assured by NHS England, which retains responsibility for commissioning primary care services such as GP and dental services, as well as some specialised hospital services.
- All GP practices belong to a ICB, and all ICBs belong to an ICS

- Services ICBss commission include:
  - most planned hospital care
  - rehabilitative care
  - urgent and emergency care (including out-of-hours)
  - most community health services
  - mental health and learning disability services.


Bolton NHS FT
Greater Manchester Mental Health NHS FT
ELHT NHS FT
WWL NHS FT
Manchester University Hospitals NHS FT
Other NHS Providers
Circle Healthcare (Beaumont)
Specsavers
Scrivens
Kooth & Qwell
Ramsay Healthcare (Oaklands)
Mediscan Diagnostic Services
Other non-NHS Providers
Greater Manchester ICS
NHS England
Bolton ICB
Dentistry
Specialised Services
NHS Screening Programmes
Primary Care Network
GMS GP Practice
PMS GP Practice
APMS GP Practice
OOH GP

Who does what?

Bolton FT provides

- District Nursing
- Allied Health Professions
  - Physiotherapy, OT, SLT, Dietetics
- Adult phlebotomy*
- Children's phlebotomy
- Minor Injuries
- Cardiorespiratory investigations
  - ECG, spirometry

General Practice provides

- Primary care
  - By GPs & ACPs
- Chronic disease monitoring
  - Largely by primary care practice nursing
- Adult phlebotomy*

Section 4. The Bolton Standards

NHS
Bolton Clinical Commissioning Group

LET'S MAKE IT...

Better Bolton.

Integrated Care Systems

- **Integrated care systems (ICSs)** are new partnerships between the organisations that meet **health and care needs** across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
- NHSE say
  - "**Integrated care** is about giving people the support they need, joined up across local councils, the NHS, and other partners."
  - "It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services."
  - "In the past, these divisions have meant that too many people experienced disjointed care."

NHS
in Greater Manchester

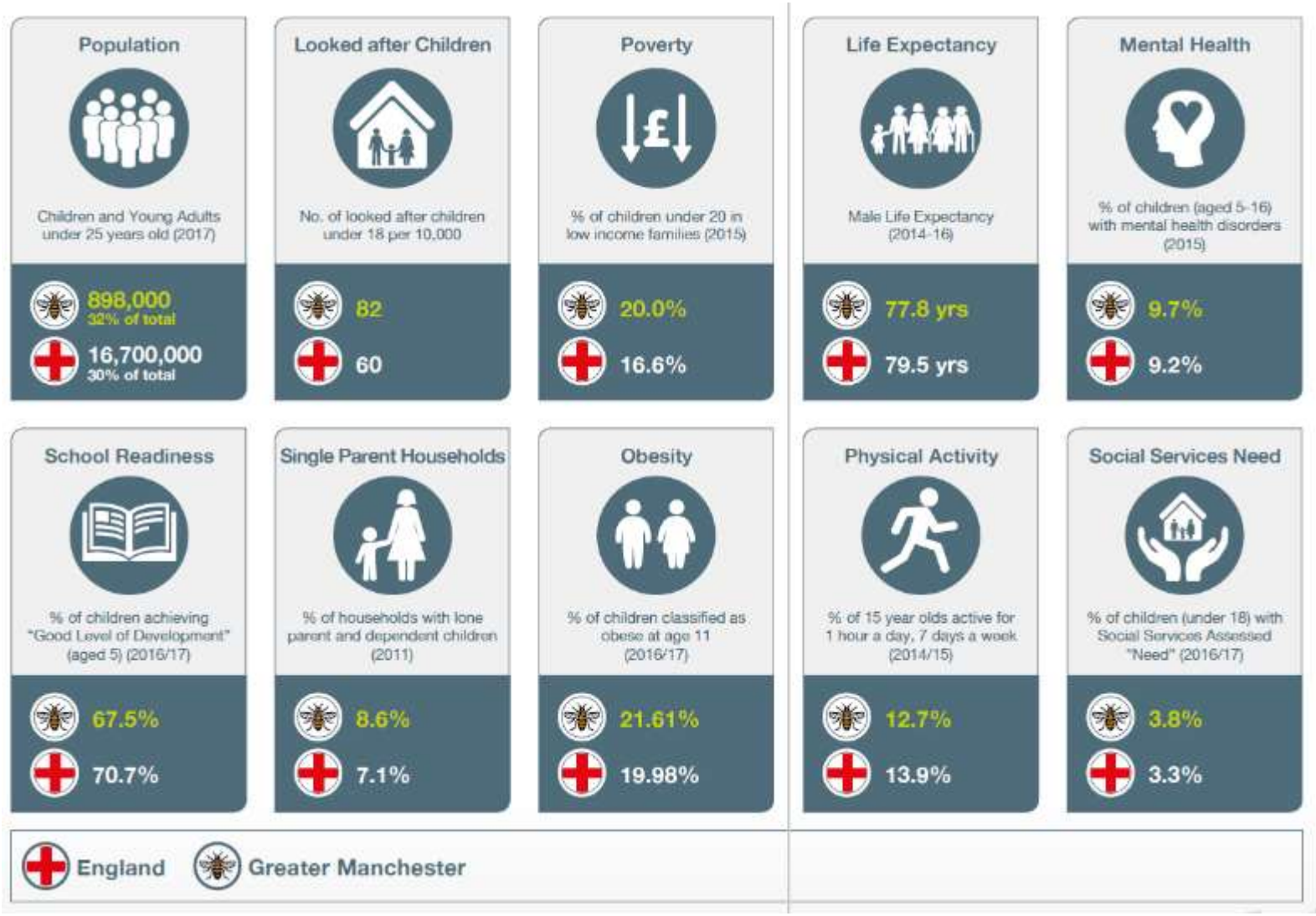
GMCA GREATER MANCHESTER COMBINED AUTHORITY

Case Study

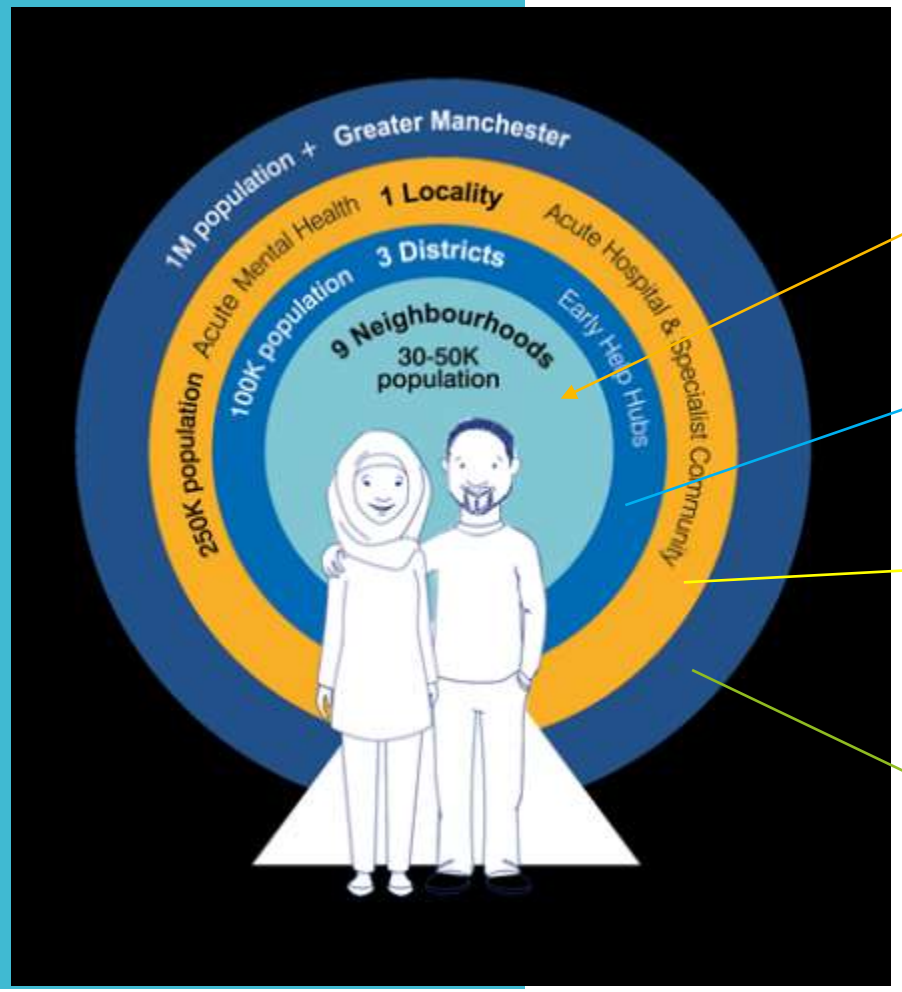
Hundreds of children in South Yorkshire get timely emergency surgery during pandemic thanks to new integrated pathway

- **What was the problem?**
  - The pandemic saw workforce pressures increase, trusts converting operating theatres into critical care beds, and anaesthetists re-allocated to focus on intubation of critical patients. Clinicians recognised this environment may impact negatively on care for children.
- **What was the solution?**
  - A new integrated care pathway saw children assessed on pickup by the ambulance crew, supported remotely by a clinician at Sheffield Children's Hospital to help decide where to take them. This ensured children got timely emergency surgery and freed up space in general hospitals for COVID patients and elective care.
  - All children under 16 needing emergency surgery went to Sheffield Children's Hospital; those needing time-critical surgery continued to the nearest district general hospital emergency department. Any patients walking into their local ED or GP practice were assessed and transferred to Sheffield Children's Hospital if they needed surgery.

- **Growing up in Greater Manchester is more challenging than most parts of England.**



Integrated Care System



- **GP Practices**
  - 1 000-20 000 registered patients with defined boundary
- **Neighbourhoods**
  - 30-50 000 people
  - "cornerstone of integrated care"
- ***Districts***
  - *100 000 people*
  - *Bolton specific*
- **Places / Locality**
  - Matches natural geography/boundaries
  - Place-based commisioning
  - 250-500 000 people
- **Systems**
  - 1-3 million people
  - Overall planning

Bolton Council

Bolton CVS

NHS Bolton NHS Foundation Trust

Bolton HEALTH AND CARE PARTNERSHIP

Building a brighter future with you in mind

NHS Greater Manchester Mental Health NHS Foundation Trust

NHS Bolton

Primary Care

Primary Care Networks (Neighbourhoods)

Each neighbourhood is different and people living in Farnworth will experience different health challenges to those living in Turton. The aim for each neighbourhood will be to improve the health of its population and to ensure a better experience for patients.

Colleagues

I’ve come to A&E because GPs are useless, they don’t do anything except refer and they missed my friend’s possible cancer so I want to be seen by a proper doctor


SCHRÖDINGER'S CAT IS
ALIVE


WANKERS
DOCTORS HERE DON'T GIVE A SHIT

Negative Gossip

- Controlling for negative affect, negative gossip is positively related to burnout.
- Negative gossip is negatively related to job engagement.
- Controlling for burnout, negative gossip is positively related to suboptimal care.
- Controlling for burnout, negative gossip is negatively related to patient safety.

- Georgantaa K, Panagopouloub E, Montgomery A (2014); **Talking behind their backs: Negative gossip and burnout in Hospitals**; Burnout Research 1(2): 76-81

- Gossip creates a feeling of connection with everyone else who is struggling similar feelings of frustration
- We use gossip as a way to collect evidence that confirms our beliefs, satisfying our confirmation bias
- When we get confirmation for our existing beliefs, and the satisfaction that comes from "being right"
- The flood of adrenaline and dopamine that accompanies "feeling right" becomes addictive

- Ask yourself or others why you need someone else's confirmation about a behaviour that you're noticing in a third person
- Create a feedback-rich environment around you.

If you seek, you shall find…

Positive GP experience

Wow, even though they're busy I still got an appointment

It only took 2 ten-minute appointments for them to diagnose and treat me

Typical, you can never get an appointment

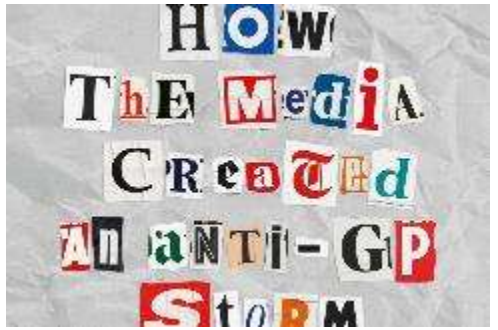
They had no idea when I first went to see them – I had to make a second appointment to get a treatment

Negative GP experience

Don't reinforce incorrect beliefs

Consider whether the story is true

Promote realistic expectations



Why are they "hiding"?

The art of diagnosis lies mainly in the history

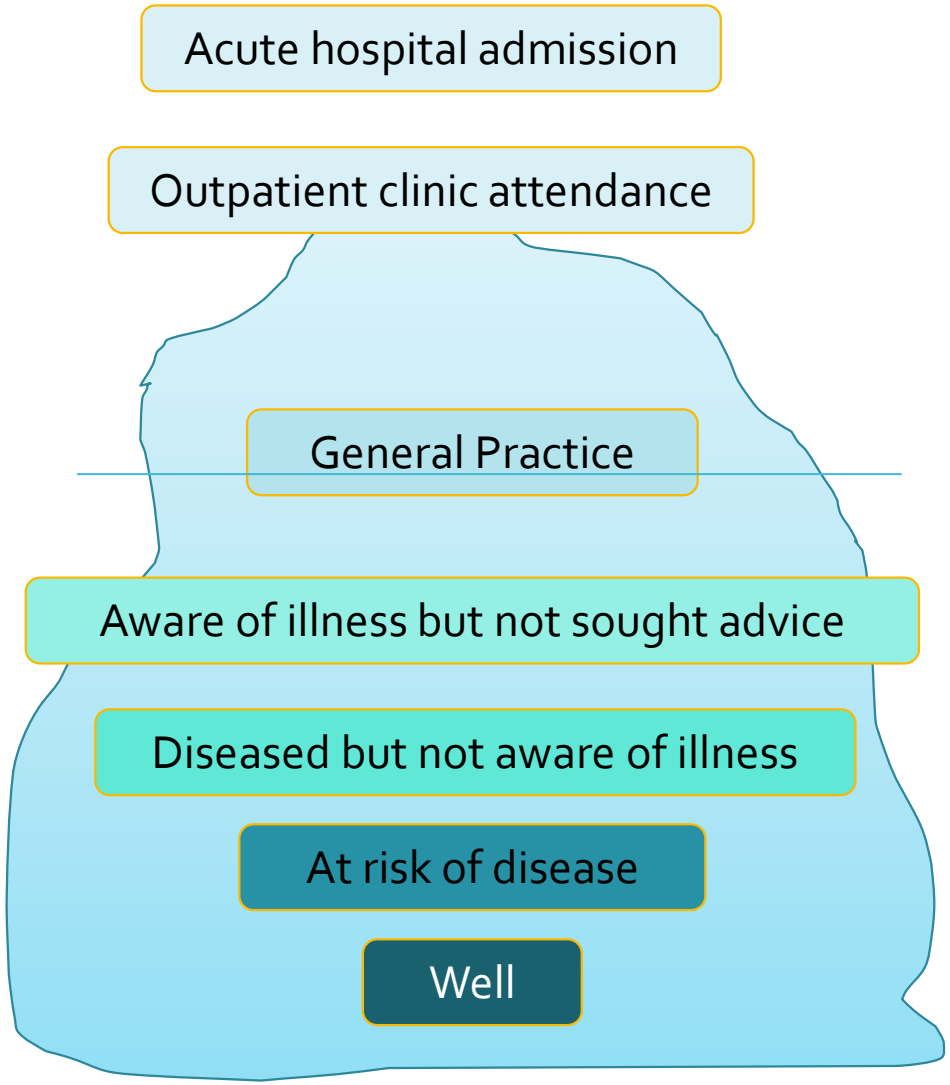
Think about the diagnosis of a simple mole vs melanoma

Examination forms a small part of consultations

- Unexpected findings are unusual
- Management plans usually derive from the story
- Examination is often part of the "theatre" of a consultation

Pre-pandemic drive for remote consulting

- GP at Hand/Babylon
- Many patients want convenience


Acute hospital admission
Outpatient clinic attendance
General Practice
Aware of illness but not sought advice
Diseased but not aware of illness
At risk of disease
Well

Prescribing in Primary Care

An Urgent Request

An Urgent Request

"Urgent" telephone triage request

"I've seen the specialist, they want me to start a new medication straight away, is it ready yet?"

- No fax/letter received
- Patient unsure what medication is

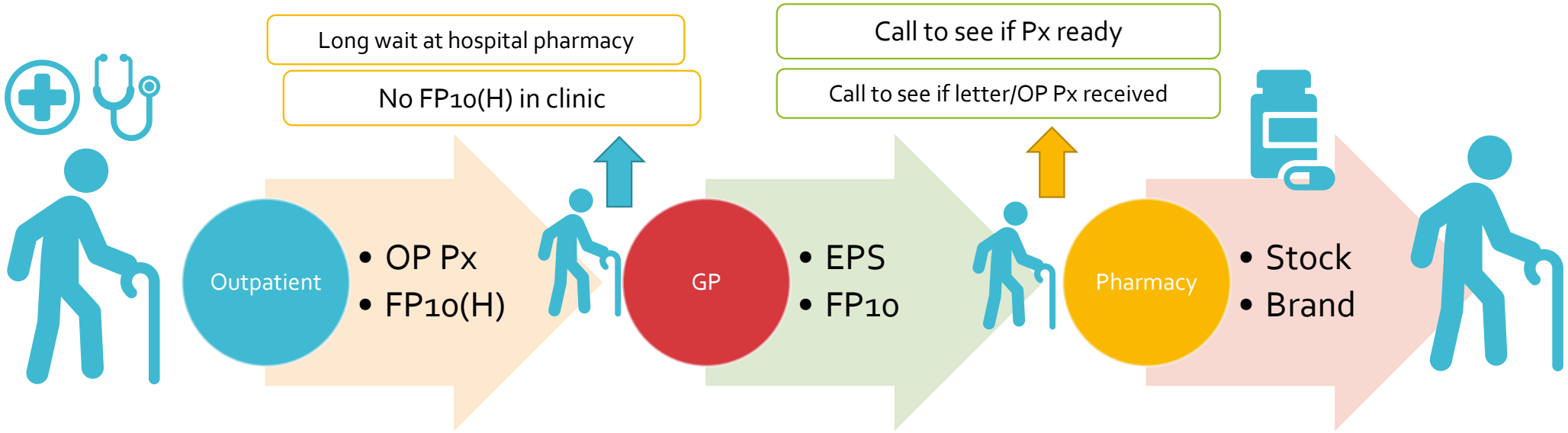
Call to clinic, message left and call back later

- Irate patient

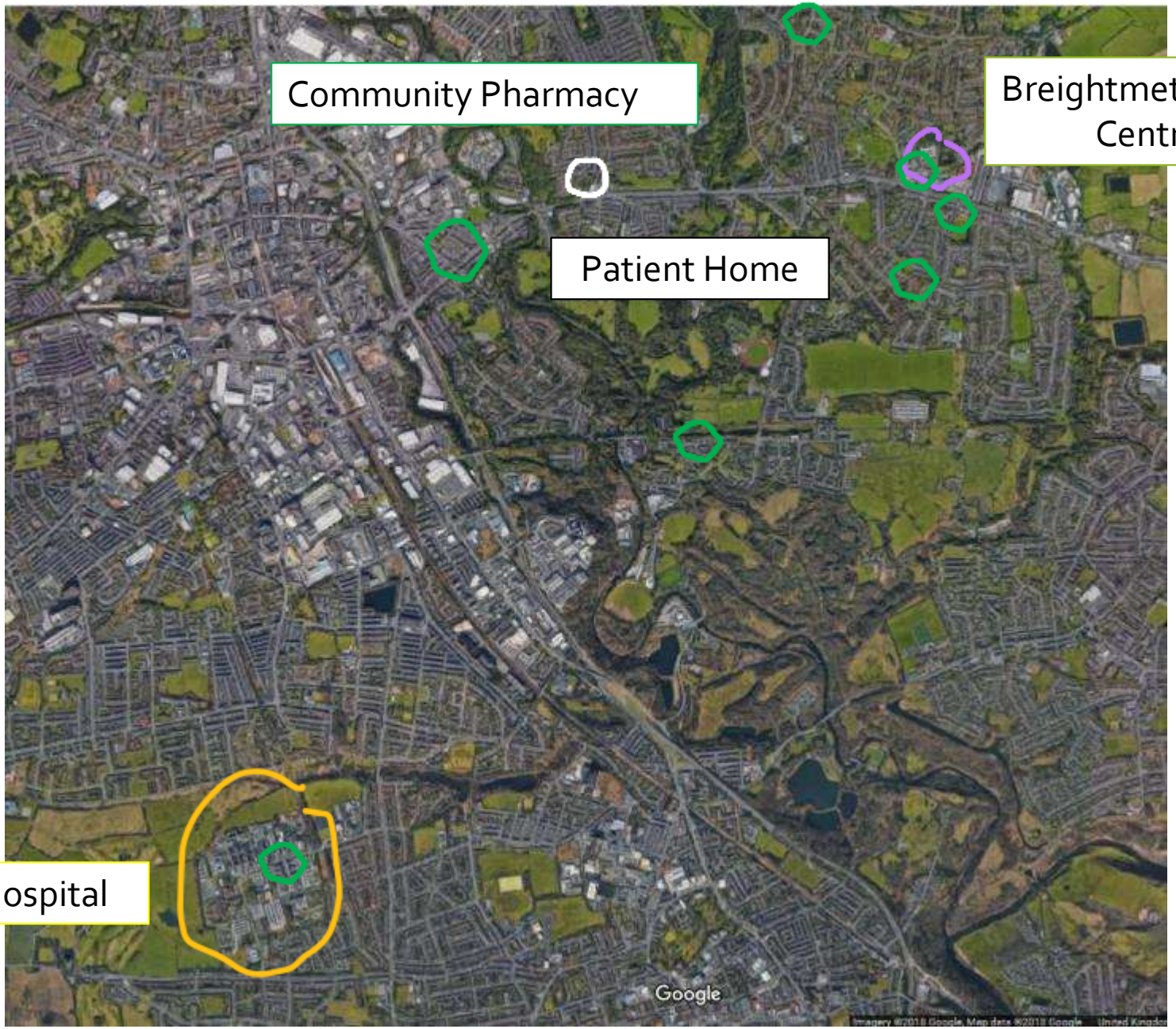
Prescription issued via EPS later that day.

- Collected by patient 2 days later

Urgent means "requiring immediate action or attention"



Clinic ←→ GP
GP ←→ Patient
GP ←→ Pharmacy
Patient ←→ Pharmacy


Community Pharmacy
Breightmet Health Centre
Patient Home
Royal Bolton Hospital
Google

A Home visit

Home visit

Visit to Betty, 82 and "can't move as dizzy"

Diagnosis of a flare of BPPV

- Needs a prescription for betahistine

No carers, relatives or neighbours

EPS (electronic Prescription Service)

- EPS has saved the NHS £130 million over three years (2014-2017)
  - Practices save an average of **43 minutes per day** by not having to locate paper prescriptions
  - Practice staff save an average of **39 minutes every day** by not having to wait for GPs to sign urgent paper prescriptions
  - Pharmacists reported on average they were saving around 54 minutes a day as result of faster dispensing

Community Pharmacy

Pharmacy contractors receive funding via their contract to the NHS:

Establishment Payment	Practice Payment (staffing*)	Reimbursement for items at a set drug tariff	a professional fee for each item dispensed (currently 90p per item)

NHSE/Local CCG may also provide funding to encourage dosette boxes, medication reviews, common ailment schemes etc

*based on number of dispensed items/month

Shared care

Shared care

- Peter attends reception to collect medication for his borderline personality disorder.
- The clinic has emailed across the following request.

NHS

Dear Dr,

Re: Peter Brown; 01/01/1980

Peter was seen in clinic today. A full letter will follow, but please start:

aripirazole and titrate dose upwards for this patient.

Yours sincerely,

Dr Psychiatrist

http://gmmmg.nhs.uk/

GMMMG Greater Manchester Medicines Management Group

NHS

Home | Joint Formulary | RAG | Shared Care | GMMMG Guidance | Meetings

search

Links

- Paediatric RAG List
- DNP and Grey Lists
- UKMI Drug Monitoring document (external link)
- Information Leaflets for Green (following specialist initiation) Drugs

Latest additions or changes to the Adult RAG list

May

New

Glecaprevir-pibrentasvir
Metformin
Pitolisant
Sofosbuvir-velpatasvir-voxilaprevir

Updates

Pirfenidone
Triptorelin

Current Adult Red Amber Green (RAG) List

On this page you will find our Red Amber Green list for Adults (scroll down to see the list). The entries can be filtered by status plus BNF Chapter and we also provide a printable version of the list - click on the printer image. Documents that have been added or updated within the last three months are flagged on the left-hand-side of the list.

Please note that drugs appear individually alphabetically and are not grouped by class (unless indicated). If an indication is not stated then the designated status relates to licensed indications only.

Please check Paediatric RAG list for those drugs/indications which are used only in children.

RAG list entries with a NEW flag or UPDATED flag may be subject to a lag period to allow for commissioning approval and implementation by Trusts/CCGs. Please check with your individual Trust or CCG.

Please read the supporting information contained within the RAG list opening page and the Guidelines on Defining Red, Amber Green Status prior to submitting any queries or applications to GMMMG.

Red Amber Green Classifications

Red	Drugs designated red are considered to be specialist medicines and prescribing responsibility for these medicines should normally remain with the consultant or specialist clinician. These drugs should not be initiated or prescribed in primary care. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy, this may include arranging for supply via a home care company.
Amber	Drugs designated amber are suitable for shared care arrangements under a shared care protocol. Prescribing may be transferred from secondary to primary care once the patient is stabilised and agreed shared care arrangements have been established. Alternatively primary care may initiate under the supervision of secondary care if this option is given in the shared care document. It is recommended that shared care arrangements should be drawn up following local discussion and agreement by prescribing parties.
Green specialist initiation	Drugs designated green with specialist initiation are suitable for on-going prescribing within primary care. Little or no monitoring is required. Transfer of prescribing should occur after initiation and an initial review (unless specified) in secondary care.
Green following specialist recommendation	For drugs that can be initiated by primary care following written or verbal advice from a specialist and can then subsequently be safely prescribed in primary care with little or no monitoring required.

http://gmmmg.nhs.uk/

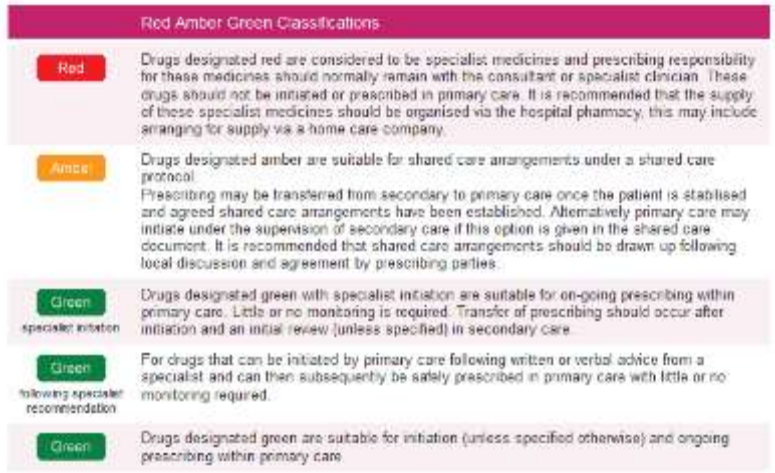
RAG List

The RAG list provides a framework for defining where clinical/prescribing responsibility should lie through categorisation of individual drugs.

The criteria used for defining status are based on:

- the specialist nature of the drug,
- the complexity of the assessment and monitoring arrangements required for the care of the patient,
- clinical responsibility and competency associated with the prescribing of a medicine

They are not based on the cost of a medication.



Red Amber Green Classifications	
Red	Drugs designated red are considered to be specialist medicines and prescribing responsibility for these medicines should normally remain with the consultant or specialist clinician. These drugs should not be initiated or prescribed in primary care. It is recommended that the supply of these specialist medicines should be organised via the hospital pharmacy, this may include arranging for supply via a home care company.
Amber	Drugs designated amber are suitable for shared care arrangements under a shared care protocol. Prescribing may be transferred from secondary to primary care once the patient is stabilised and agreed shared care arrangements have been established. Alternatively primary care may initiate under the supervision of secondary care if this option is given in the shared care document. It is recommended that shared care arrangements should be drawn up following local discussion and agreement by prescribing parties.
Green specialist initiation	Drugs designated green with specialist initiation are suitable for on-going prescribing within primary care. Little or no monitoring is required. Transfer of prescribing should occur after initiation and an initial review (unless specified) in secondary care.
Green following specialist recommendation	For drugs that can be initiated by primary care following written or verbal advice from a specialist and can then subsequently be safely prescribed in primary care with little or no monitoring required.
Green	Drugs designated green are suitable for initiation (unless specified otherwise) and ongoing prescribing within primary care.

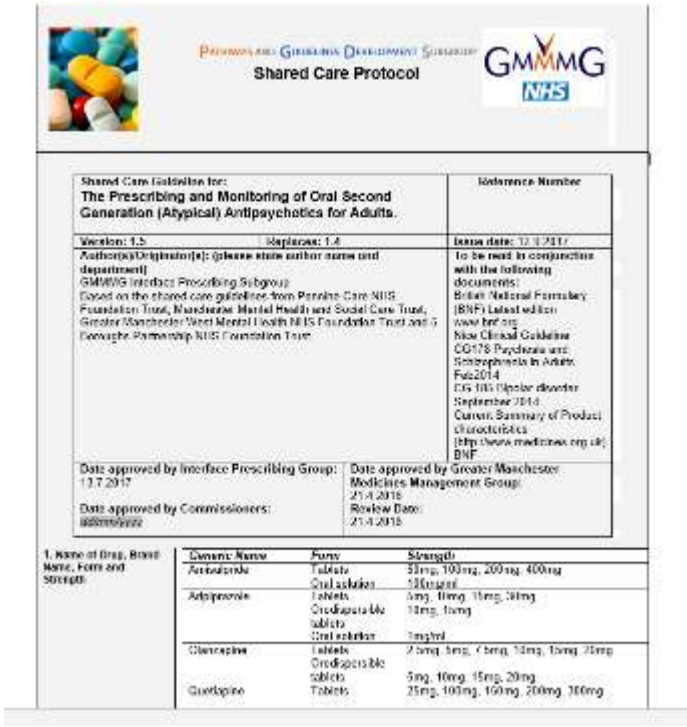
Safe prescribing

- Medication errors account for approximately 20% of all clinical negligence claims against doctors in both primary and secondary care.
- The costs associated with adverse events and inappropriate prescribing has been estimated at more than £750 million per year.

- It is common for GPs to be asked to continue prescribing a medication started in the secondary care setting. The following information needs to be communicated from specialist to GP before prescribing :
  - Aim of treatment
  - Mechanism of action
  - Dose and frequency
  - Risks and benefits
  - Any monitoring that is required
  - Potential side effects
  - What the patient has been told.

Shared Care Guidelines

- A shared care guideline outlines ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and a primary care prescriber.
- Primary care prescribers are invited to participate. If they are unable to undertake these roles, then he or she is under no obligation to do so.
  - In such an event, the total clinical responsibility for the patient for that diagnosed condition remains with the specialist.



Shared Care Protocol

GMMMG NHS

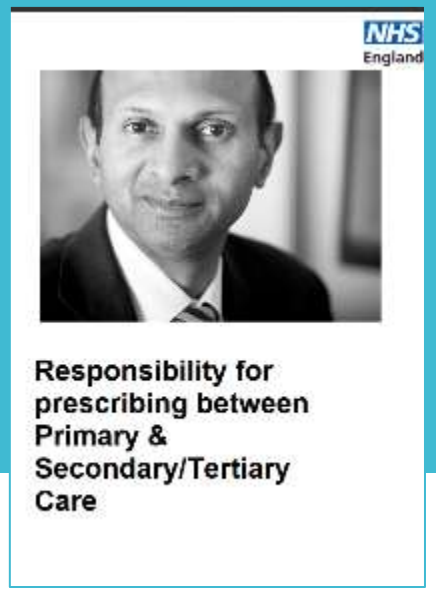
The Prescribing and Monitoring of Oral Second Generation (Atypical) Antipsychotics for Adults.

A Discharge Letter

A Discharge Letter

- Patient admitted for 3 days, told to see GP after discharge for medication review, brings discharge summary:
  - Diagnosis unclear; states NSTEMI, but later states coronary spasm
  - Started on dual antiplatelet therapy
- How long should he be on it?
  - No angiography/stent mentioned
- What is the diagnosis?

Transfer of care



Before the transfer of responsibility of prescribing takes place from secondary to primary care, the patient's condition must be stable or predictable. Primary care must consent to take on that responsibility and training and resources need to be in place.

Legal responsibility for prescribing lies with the health professional who signs the prescription and it is the responsibility of the individual prescriber to prescribe within their own level of competence.

Hospitals should provide patients with enough medicine to last a **minimum of seven days** after discharge, or until a communication can be provided to enable safe ongoing prescribing.[1]

1. NHSE (2018) Responsibility for prescribing between Primary & Secondary/Tertiary Care

How much?

Prescription costs

1. Atorvastatin 80mg tablets, ONE taken each day
2. Ramipril 10mg capsules, ONE taken each day
3. Bisoprolol 2.5mg tablets, ONE taken each day
4. Aspirin 75mg tablets, ONE taken each day
5. Omeprazole 20mg capsules, ONE taken each day

One-third of people with long-term conditions not exempt from charge don't collect their prescription

Prepayment certificate

- £9.90 per item (as of April 2025)
- Secondary Prevention [Tariff]:
  - Aspirin 75mg [£1.13]
  - Atorvastatin 80mg [£1.77]
  - Ramipril 10mg [£1.29]
  - Bisoprolol 2.5mg [£0.61]
  - Omeprazole 20mg [£0.75]
- = £49.50 Prescription Charge

Pre-Payment Certificate	
3 months	£32.05
12 months	£114.50