LOCAL LEICESTERSHIRE MEDICAL LEICESTER COMMITTEE RUTLAND

POSITION STATEMENT
LOCAL VARIATION FROM NATIONAL PATHWAYS
Version 1.1 (January 2026)

1. BACKGROUND

1.1 Leicester, Leicestershire & Rutland Local Medical Committee (LLR LMC) Position Statement regarding the Transfer of Clinical, Prescribing and Medico-Legal Risk from Secondary Care to General Practice through Local Pathway Variation.

1.2 This policy sets out the formal position of the LLR Local Medical Committee (LMC) regarding the increasing use of locally determined referral and management pathways that diverge from national guidance and transfer clinical, prescribing and medico-legal risk from secondary care organisations to individual GPs.

1.3 Local Medical Committees were first established under the National Insurance Act 1911 and have been continued to be recognised by subsequent legislation (currently NHS Act 2006) as the only independent representative body of general practice and have various statutory functions.

1.4 General practice should never be expected to accept transfer of risk due to secondary care capacity constraints, waiting list management, or locally imposed pathway restrictions that override national standards. This position reflects established BMA national policy that workload, liability and clinical responsibility must sit with the part of the system that controls access to care and designs the pathway, and we cannot deviate from such requirement currently being proposed[1].

2. CORE PRINCIPLES

2.1 The LMC does not support, and will not accept, pathways that:

2.1.1 Deviate from NICE guidance and NHS England referral standards

National guidance exists to ensure equitable, evidence-based and legally defensible care. Local pathway variations that restrict access to nationally mandated routes, particularly

> *Example One:*
> GPs are being required to apply locally developed cancer dysphagia scoring tools that categorise patients as “low risk” and exclude them from the NICE-defined two-week wait (2WW) upper GI pathway, despite the GP’s clinical judgement that a 2WW referral is indicated. Patients are instead diverted to routine or delayed investigations. This represents a clear departure from national guidance and transfers risk from secondary care to the referring GP.

[1] External un-resourced workload - Safe working in general practice - BMA

urgent cancer pathways, are not acceptable. In the event of an adverse outcome, complaint, or claim, NICE guidelines and NHS England standards—not local algorithms—are relied upon by regulators and the Ombudsman

2.1.2 Disregard clinical acumen and professional intuition

Referral pathways and algorithmic thresholds do not, and cannot, fully capture the value of clinical acumen/intuition and professional "gut feeling". There is a substantial evidence base demonstrating that a GP's intuitive concern about cancer risk, even in the absence of strict guideline criteria, is a significant and independent predictor of malignancy (including systematic review evidence published in the *British Journal of General Practice*[2]).

Pathways that prevent referral solely because a patient does not meet rigid scoring thresholds, despite a GP's high index of suspicion, undermine safe diagnostic practice and place clinicians at unacceptable medico-legal risk.

2.1.3 Transfer clinical and medico-legal risk for operational decisions to GPs

Where secondary care redesigns pathways to manage demand or waiting times, the associated clinical and legal risk must remain with the organisation making those decisions. Risk cannot be displaced or transferred onto individual clinicians in General Practice who do not control access to diagnostics or specialist assessment.

2.1.4 Compel prescribing beyond professional competence or confidence

The legal responsibility for prescribing lies solely with the clinician who signs the prescription. The GMC is explicit that doctors must only prescribe within the limits of their competence and must be able to justify their decisions.

> *Example Two*
> In pathways for abnormal uterine bleeding in patients on HRT, GPs are being instructed to repeatedly initiate, escalate or modify hormonal regimens as a prerequisite to referral. This places GPs in a position where they may be required to prescribe beyond their clinical confidence before being able to access specialist care. This is unacceptable and contrary to GMC *Good Medical Practice*.

[2] Smith C F et al. Understanding the role of GPs' gut feelings in diagnosing cancer in primary care: a systematic review and meta-analysis of existing evidence. BJGP 2020;m70 (698) e612-e621

GOVERNMENT VIEW ON GP PRESCRIBING ON REQUEST OF SPECIALIST SERVICES

In a recorded answer to a question raised by Kim Leadbetter MP, Stephen Kinnock MP (Minister of State for Health and Social Care) replied (3 September 2025):

"Shared care within the NHS refers to an arrangement whereby a specialist doctor formally transfers responsibility for all or some aspects of their patient's care, such as prescription of medication, over to the patient's general practitioner (GP). The General Medical Council (GMC) has issued guidance on prescribing and managing medicines, which helps GPs decide whether to accept shared care responsibilities. The GMC has made it clear that GPs cannot be compelled to enter into a shared care agreement. GP practices may decline such requests on clinical or capacity grounds. If a shared care arrangement cannot be put in place after the treatment has been initiated, the responsibility for continued prescribing falls upon the specialist clinician. This applies to both NHS and private medical care."

Stephen Kinnock MP (Minister of State for Health and Social Care)

Although this was specifically about prescribing for ADHD the principles remain the same for all conditions, in that a practice may turn down prescribing requested by a specialist service on either **CLINICAL *or* CAPACITY** grounds.

2.1.5 Restrict the right to refer when care has moved beyond primary care scope

Referral to secondary care represents the point at which a GP has determined that a patient's condition or management exceeds what can be safely delivered in the patient's General Practice. Pathways that obstruct or delay referral for non-clinical, operational reasons undermine patient safety and professional accountability.

3. LMC RED-LINE POSITION

3.1 This position is to be regarded as formal LLR LMC policy and is expected to be recognised and respected by system partners, including NHS Trusts, NHS England, ICB or any successor organisations.

3.2 In summary, the LLR LMC position is that:

- General Practice will not accept additional clinical, prescribing or medico-legal risk arising from local pathway variations introduced by secondary care.
- GPs must retain the unrestricted ability to refer patients via nationally recognised pathways, including two-week wait cancer routes, where clinical concern exists, even if locally defined scoring thresholds are not met.
- Where secondary care organisations choose to operate pathways that diverge from national guidance or restrict referral based on local algorithms, they must explicitly retain full clinical and medico-legal responsibility for patients managed within those pathways.
- Local pathways must not transfer unfunded/uncontracted work to general practice.
- LLR GPs should not be required, directly or indirectly, to prescribe treatments beyond their competence or confidence as a condition of referral.

4. ADVICE TO GPS

4.1 In line with BMA national guidance, when faced with local pathways that conflict with national standards or transfer inappropriate risk, GPs are advised to:

- Practise in accordance with NICE guidance, NHS England referral standards and GMC professional duties.
- Refer patients, including via 2WW cancer pathways, where there is significant clinical concern or professional intuition, even if local scoring tools do not trigger referral.
- Decline to prescribe treatments they do not feel competent or confident to initiate or continue.
- Decline transfer of workload which is neither contracted or funded
- Clearly document where local pathways override national guidance or constrain clinical judgement.
- Escalate concerns to the LLR LMC where patient safety, professional liability or system pressures are creating unsafe practice.

This Position Statement will be used by the LMC in all discussions with NHS Trusts, the ICB, NHS England (and any successor organisations) and the BMA regarding pathway design, workload transfer and clinical risk ownership.