NHS
Kent and Medway
Clinical Commissioning Group

Document history for Principles of Shared Care Agreements

Version	Created by	Date	Main Changes/Comments
1-6	JKM/CC/PS	July 2020	Reviewed shared care from K&M CCG areas and amended several times. Comments received from East Kent Prescribing Group.
7	JKM	05/08/2020	Reviewed comments from JPC
8	JKM	08/09/2020	Comments from MP after August JPC incorporated into document. **Under principles:** **2e.** For medicines which are prescribed under a share care arrangement, primary care prescribers **should have sufficient knowledge and experience to monitor, stop, or alter the dosage of the medicine in appropriate circumstances and have access to specialist advice to support them** *This also links with 3b and is a must and links in with my comment about other PCN member practices possibly taking on the role and/or persuading colleagues to do the right thing* **2h.** Primary care prescribers must seek further support from the referring specialist or CCG rather than decline shared care on the basis of lack of competence as default *Agree but we need to remember that GPs are not contractually obliged to agree. No change in wording needed.* **4d.** The person delivering that aspect of the shared care agreement should ensure that the resources to do this are in place in the clinical setting in which they are delivered *This relates to my comment about workload and funding which I agree is outside the scope for JPC but is important from a GP perspective and will also help with take up and sharing work within PCNs as well as minimising refusals.* **5b.** The JPC can recommend the approval of all shared care - *This should be a **must** and not a can* *Appendix 1-AREAS OF RESPONSIBILITY FOR SHARED CARE* First paragraph - If the GP is not confident to undertake these roles, then he or she is under no obligation to do so. *Ideally this needs to link to 2h* Third Bullet point – *For consistency should this say GP rather than primary care clinician* **5.** First Bullet point – *Consider adding the word stable i.e. " patient is stable on a regular dose"* **9.** *This should consider interactions with any and all repeat medication the patient is taking at the time of initiation.* Appendix 2 & 3 – comment from MP: *would prefer appendix 2 as the agreement as it is clear. Indication can be changed to diagnosis and an additional field for next blood monitoring review date (from Appendix 3). The reasons for refusal can be linked with the refusal letter reasons (September JPC to confirm)* **Comment from EI:** Can the specialist be asked to specify the length of treatment supplied to the patient in order to indicate to the GP when new supply will be required for forward planning (Completed – see point 5 Appendix 1)
V9	JKM	23.09.2020	Appendix confirmed at September JPC. Document recommended for Clinical Cabinet approval.

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Principles of Shared Care Agreements

Introduction

Good organisation of care across the interface between primary and secondary/tertiary care is crucial in ensuring that patients receive safe and high quality care – and in making the best use of clinical time and NHS resources in all care. Good professional practice requires care for patients to be seamless; patients should never be placed in a position where they are unable to obtain the medicines they need, when they need them. Lack of communication between primary and secondary/tertiary care and misunderstandings around the responsibilities of the professionals involved are often cited as reasons for patients not being able to get their medicines in a timely manner, despite effective collaborative working and communication being an important part of patient-centred professionalism.

1. Criteria for Classifying Drugs as Suitable for Shared Care

a. It is in the best interests of the patient for a primary care prescriber to take over prescribing, however, specialist involvement is required for:

- initiation of treatment
- on-going specialist monitoring and/or
- assessment to enable effectiveness and /or
- reducing risk of toxicity.

and/or

b. Medicines that are specifically suggested as suitable for shared care by the DH or NICE.

2. Shared Care Agreements

a. Treatment should be initiated by a specialist (which could include consultant, suitably trained specialist non-medical prescriber or GP with specialist interest within a secondary, tertiary, or primary care clinic). Clinical and prescribing responsibility should be transferred to primary care only when the patient's clinical condition is stable or predictable. This does not mean that the patient is discharged from specialist care.
NHSE guidance states that patients can be discharged, but need a fast track referral route in certain circumstances e.g. Adult ADHD.
As the CCG is not responsible for agreeing tertiary care shared care, there may be a need to consider treatment on a case by case basis.
The GP should agree in writing for each individual case and the secondary/tertiary provider must continue to provide prescriptions until successful transfer of responsibilities. Specialist advice should be available to primary care prescribers i.e. not requiring referral back to specialist as such.

b. The legal responsibility for prescribing lies with the doctor or health professional who signs the prescription and it is the responsibility of the individual prescriber to prescribe within their own level of competence. This includes responsibilities with supplying or administering the prescribed medicine and instructions to others.

c. Patients should be at the centre of the shared care agreement however where patients do not have the mental capacity to make healthcare decisions involvement of carers and/or attorneys (holding the Lasting Power of Attorney for health and welfare) should be considered prior to decisions around shared care.

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d. Shared care must be in accordance to the Shared Care template (Appendix 1). Communication between the specialist and the primary care prescriber should include the letters of request and agreement/refusal (Appendix 2).

e. For medicines which are prescribed under a share care arrangement, primary care prescribers should have sufficient knowledge and experience to monitor, stop, or alter the dosage of the medicine **in appropriate circumstances and have access to specialist advice to support them** (details should be made available within Share Care Agreements i.e. not requiring referral back to specialist as such). The degree of control, which they have over this prescribing, and 'a route of return' to specialist care will form part of the shared care agreement.

f. Agreements for shared care must not be used nor declined for cost shifting purposes.

g. It is the responsibility of the Joint Prescribing Committee (JPC) to ensure that adequate support, education and information is made available to primary care prescribers who "share care" of patients with a specialist in order for treatment to be managed safely in primary care.

h. GP/Primary care prescribers must seek further support from the referring specialist or CCG rather than decline shared care on the basis of lack of competence as default.

i. Explicit criteria for review need for monitoring and discontinuation of the medicine should be included; this should also be communicated to the patient.

j. Patients should never be used as a conduit for informing the GP that prescribing is to be transferred nor to inform the specialist that shared care has been declined. They should never be placed in a position where they are unable to obtain the medicines they need because of lack of communication between primary and secondary/ tertiary care.

3. Circumstances where shared care is not appropriate

In some situations the use of shared care is not appropriate and in these cases the hospital/specialist should retain responsibility for prescribing. Whilst the situations may be broad and diverse the following would be examples:

a. Patients receiving the majority of ongoing care, including monitoring, from the specialist service.

b. Where the primary care prescriber does not feel competent in taking on clinical responsibility for the prescribing of the medicine despite taking steps (as stated in point 2e above) to seek further support from the specialist.

c. Where a drug requires specialist intervention, stabilisation and monitoring on an ongoing basis.

d. Where patients have declined the shared care option following informed discussions with the specialist prescriber.

e. Where insufficient information has been provided to proceed with shared care and/or no Shared Care Agreement or protocol exists.

f. Unlicensed medicines unsuitable for use in primary care or being used 'off-label' for an indication with no established evidence base.

g. Where drugs are being used as part of a hospital-initiated clinical trial.

h. Where the drug is new, only available through hospitals or has not been approved for addition to the current primary care formulary.

i. The indication for prescribing is contrary to NICE guidance and the use of the drug has not been approved on an 'exceptional basis'.

j. A medicine for which the JPC considers there to be poor evidence base or lack of cost effectiveness compared to alternative commissioned treatments.

k. Black Triangle Medicines (unless there is a large body of evidence supporting use e.g. BNF, NICE).

l. There is a NICE recommendation that the medicine should not be prescribed on the NHS for the condition specified.

m. Medicines subject to High-tech Hospital at Home guidance (EL (95)5).

n. All other treatments funded by NHS England unless specifically agreed to be provided through a shared care prescribing agreement, or other process as agreed by the JPC.

o. There is a clear NHSE/I Specialised Commissioning or JPC decision to not routinely fund usage of the medicine or NHSE considers the drug not suitable for shared care.

p. Shared care should not be approved with non-NHS funded providers as no guarantee patients will continue to fund themselves.

4. Funding Issues

a. Each shared care protocol submission must include an estimate of the number of patients affected.

b. Commissioners should take account of the operational and resource implications of shared care, and of the fact that this should also extend to the requirements and sustainability of hospitals in situations where shared care is not accepted.

c. If the treatment is likely to produce significant cost pressures (i.e. it cannot be managed within the existing prescribing budget), then agreement needs to be reached with JPC and if supported, appropriate funds identified.

d. All appropriate monitoring requirements (e.g. phlebotomy, ECG, height/weight checks) must be fulfilled. The person delivering that aspect of the shared care agreement should ensure that the resources to do this are in place in the clinical setting in which they are delivered (for example within a Primary Care Network (PCN)).

e. The requirement for the appropriate resource will need to be considered by commissioners, based on the likely workload implications of the transfer of care i.e. from secondary/tertiary to primary care.

5. Approval and Review of Shared Care protocols

a. Consultation with primary/secondary/tertiary care prescribers must be sought when developing or reviewing a shared care protocol or supporting prescribing guideline.

b. The JPC must recommend the approval of all shared care protocols before they can be distributed for use between primary and secondary care.

c. A shared care protocol or supporting prescribing guideline will usually be approved for two years after which time an up-dated version should be submitted by the author for re-approval. Any major changes in national guidance or any significant issue that arises should prompt a review of the shared care protocol or supporting prescribing guideline at an earlier date.

References

- Responsibility for Prescribing between Primary and Secondary/Tertiary Care. NHS England. Jan 2018.
- SPS - Shared Care Guidance - A Standard Approach - Regional Medicines Optimisation Committee (RMOC) October 2019 V2
- Good Practice in Prescribing and Managing Medicines and Medical Devices. General Medical Council Guidance. 2013.

Appendix 1

Shared Care Protocol template

(Medicine) for patients with (Condition)

AREAS OF RESPONSIBILITY FOR SHARED CARE

This shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of **medication** can be shared between the specialist and general practitioner (GP). GPs are invited to participate. If the GP is not confident to undertake these roles, then he or she is under no obligation to do so *(please refer to Principles of Shared Care Agreements in point 2h)*. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. Refer to Principles of Shared Care document for full details, in summary:

- Transfer of monitoring and prescribing to Primary care is normally after the patient is on regular dose and with satisfactory investigation results for at least 4 weeks
- The duration of treatment will be determined by the specialist based on clinical response and tolerability.
- All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the GP/primary care clinician
- Termination of treatment will be the responsibility of the specialist.

PRESCRIBING INFORMATION

1. Background

2. Indications (*Please state whether licensed or unlicensed)*

3. Pharmaceutical aspects

Route of administration:

Formulation:

Administration details:

Other important information:

4. Exclusions or contraindications

Please note this does not replace the Summary of Product Characteristics (SPC) and should be read in conjunction with it.

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5. Initiation and ongoing dose regime (by specialist)

Note -

- *Transfer of monitoring and prescribing to Primary care is normally **after the patient is stable on a regular dose** and with satisfactory investigation results for period of time as agreed by the specialist.*
- *The duration of treatment will be determined by the specialist based on clinical response and tolerability.*
- *Specialist to specify the length of treatment supplied to the patient in order to indicate to primary care when new supply will be required for forward planning.*
- *All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician*
- *Termination of treatment will be the responsibility of the specialist.*

6. Specialist responsibilities for monitoring (including frequency)

At initiation:

At review:

7. GP responsibility

Monitoring (including frequency):

Review/follow up:

8. Dose Management (by primary care)

Results	Management

9. Significant medicine interactions – *prescriber must consider interactions with any and all repeat medication the patient is taking at the time of initiation*

10. Adverse effect management

Specialist to detail action to be taken upon occurrence of a particular adverse event as appropriate. Most serious toxicity is seen with long-term use and may therefore present first to GPs.

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11. Advice to patients and carers

The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice

12. Pregnancy and breast feeding

It is the responsibility of the specialist to provide advice on the need for contraception to male and female patients on initiation and at each review but the ongoing responsibility for providing this advice rests with both the GP and the specialist.

13. Specialist contact information

Trust	Specialist name	Contact details
Medway Maritime Hospital (MFT)		
Maidstone and Tunbridge Wells (MTW)		
Darent Valley Hospital (DVH)		
East Kent Hospitals University NHS Foundation Trust (EKHUFT)		

14. Additional information

15. References

Appendix 2
REQUEST TO SHARE CARE AND AGREEMENT FORM

Shared care title and document version

The expectation is that this information, along with the full shared care protocol, provides sufficient information to enable GP* to be confident to take on clinical and legal responsibility for prescribing and monitoring. GP* to review and must respond to provider trust request to share care within (tbc) weeks, using form provided.
*****_This may be any primary care prescribing clinician._

For completion by specialist (with shared care agreement form)			
Patient name			
DOB			
NHS Number			
Patient weight (kg)			
Drug (s) Dose, frequency, and route at handover			
Diagnosis (please indicate if unlicensed or "off-label"			
Date of first prescription by specialist			
Date of the next blood monitoring review date			
Estimated date for prescribing responsibility to be with GP* (at least 28 days after first prescribing)			
Special prescribing advice for this patient, to include any other medication patient is taking for same condition			
KEY PRIMARY CARE INFORMATION (refer to full shared care guideline for full details)			
GP* Responsibilities			
MONITORING (as per Shared Care document unless stated below)			
Frequency of GP* monitoring			
Frequency of specialist review			
TEST	NORMAL RANGE	Pre-Treatment Baseline Result (specialist responsibility)	Initiation of treatment Result (specialist responsibility)
ACTION TO BE TAKEN IF ABNORMAL RESULT			
TEST	RESULT	ACTION	

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SHARED CARE AGREEMENT FORM

This form is used to agree shared care between specialist, patient and GP*.

Specialist and patient agreement

By signing below we accept:

- The Kent and Medway CCG shared care principles
- The requirements and responsibility defined in this drug specific shared care protocol
- To provide medication for the transition period (at least 28 days)

Specialist name:	Patient name:
Designation:	DOB:
Provider Trust:	NHS number:
Direct telephone number:	
Email:	
Specialist signature:	Patient signature:
Date:	Date:

GP* response to shared care request

Please return to specialist within **2 weeks** of receipt of request to share.
This form is to be completed by the GP* who is requested to share care.

I agree to accept shared care as set out in this shared care protocol and KMCCG shared care principles. ☐

I have not received adequate support to take over prescribing therefore I do not accept shared care for this patient. ☐

My reasons for not accepting are:

Please note that GP agreement is voluntary, with the right to decline to share care if for any reason you do not feel confident in accepting clinical responsibility.

GP* name	
Designation	
Direct telephone number	
Email	
Practice address	
GP* signature	
Date	

Specialist to retain a copy in the patients' hospital notes
Copy to be given to patient
GP* to retain a copy in primary care notes

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