Mid and South Essex Health and Care Partnership

NHS

Mid and South Essex Health and Care Partnership's Principles for 'shared care'

i.	The fundamental principle of 'shared care' across specialist services and primary care is, to put the safety of the patient first. The best interest, agreement and preferences of the patient should be at the centre of any shared care agreement. Specialist services includes secondary care, mental health services, community providers, private providers and tertiary care.
ii.	Patients should be fully involved in, and in agreement with, the decision to move to a shared care model for their ongoing care.
iii.	Shared care protocols should be agreements and not diktats. All shared care protocols will be approved by the Mid and South Essex Medicines Optimisation Committee (MSEMOC) before they are accepted for use.
iv.	Shared care protocols are only acceptable for use within the MSE system when the drug(s) it relates to are on formulary
v.	MSEMOC will designate shared care drugs as traffic light classification 'amber'. Where a new drug is classified as amber but a shared care protocol is not in place, the drug will default to 'red' status until the associated shared care protocol is developed and subsequently approved by MSEMOC. For existing drugs a workplan with appropriate timescales will be developed to ensure updated shared care protocols are in place.
vi.	Prescribers need easy access to shared care protocols. These will be available on the MSEMOC website and Trust websites/formularies.
vii.	Transfer of clinical responsibility to primary care should only be considered where the person's clinical condition is stable or predictable. The initial secondary care prescribing period should be enough for adverse effects associated with initiation of the drug to occur; to allow stabilisation of the patient's condition if sick; to allow stabilisation and achievement of a suitable therapeutic dose; and to allow time for communication and acceptance of shared care at this point with the patient's primary care clinician. This will usually be 12 weeks unless otherwise stated within the agreed individual shared care protocol. For some medications the stabilisation period could be as short as 4 weeks, if stated in the protocol. Primary care clinicians includes GPs and all primary care non-medical prescribers
viii.	The initial secondary care prescriber retains responsibility for monitoring and supplying the medication until alternative arrangements are in place.
ix.	Patients will remain on the hospital consultants case load to ensure that primary care clinicians will have continued access to specialist advice and support without the need to re-refer the patient.
x.	Primary care clinicians need to formally accept or refuse transfer to shared care in each individual case and have the right to refuse if they do not feel confident in managing the medicine / patient. Acceptance by a primary care clinician will be considered an acceptance by the practice. If refusing to share care the primary care clinician should explain their concerns to the hospital consultant.
xi.	The person responsible for prescribing should also have responsibility for ensuring adequate monitoring (securing and reviewing blood test results) to ensure it is safe to continue to prescribe. These functions should not be separated. This would not preclude flexible arrangements in terms of where blood tests are undertaken to suit the patient. If separated because of patient preferences, there must be assurance that test results are normal before prescribing. For out of area patients this already works effectively. Electronic reporting of results and access to those records is sufficient.
xii.	A protocol should include the range of dosages within which the shared care arrangement is maintained. It needs to cover adjustment of doses when appropriate. If there are any safety alerts that are relevant these should be highlighted in the protocol. In general GPs may reduce doses (under specialist guidance) but specialists should increase doses.
xiii.	Monitoring protocols should be consistent across all relevant specialties without unnecessary variation in monitoring regimes between specialties. There would usually be one protocol per drug.
xiv.	There needs to be version control and clarity around updates to agreements.
xv.	Protocols need to be complete – for example with direct contact details for all specialties. Contact information needs to be robust for both in usual working hours and out of hours.
xvi.	Email contacts need to be included within the shared care protocols. Specialist team contact details need to be provided to the patient.
xvii.	Responsibilities should include the role of the pharmacist supplying the medicine.
xviii.	Protocols need to be clear, concise and consistent with the agreed principles and template. There should be a common template which is as short as possible.
xix.	It could be useful to look at successful examples from elsewhere rather than re-inventing the wheel.
xx.	Patients on shared care drugs should be looked after by both specialist services and primary care. Agreement does not need to cover 'after discharge' because by definition the shared care arrangement ceases at this point.
xxi.	Adequate resource must be provided for patients on shared care drugs to facilitate shared care

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General responsibilities for 'amber' shared care medicines

NHS England guidance "Responsibility for prescribing between primary and secondary/tertiary care" states that: "Clinical responsibility for prescribing should sit with those professionals who are in the best position and appropriately skilled to deliver care which meets the needs of the patient."

'Shared care' is 'The joint participation of GPs, hospital consultants and patients in the planned delivery of care…. informed by an enhanced information exchange over and above the routine clinic, discharge and referral letters' (Hickman et al 1994).

This document should be read in conjunction with the medicine-specific protocol, the Summary of Product Characteristics (SPC) and the BNF. All protocols are for use in adult patients unless otherwise specified.

An amber shared care medicine is defined as a medicine that is recommended for prescribing but only considered suitable for initial prescribing by specialists in secondary and tertiary care with prescribing continued by primary care clinicians in conjunction with a shared care agreement or relevant equivalent or (where appropriate) with patient specific information provided by the hospital specialist.

The patient would normally be stabilised before prescribing responsibility is devolved. A shared care guideline is required detailing the prescribing clinicians' responsibility. These medicines require additional blood tests/ clinical monitoring for safe prescribing which are/is considered to be over and above the level of monitoring expected for safe medication prescribing under essential services.

The difference between amber shared care and yellow is that amber drugs require more routine monitoring (at least every six months).

Responsibilities

The Specialist will be responsible for:

1. Confirmation of diagnosis and indication for medicine treatment.
2. Pre-treatment assessment and initiation of the appropriate medicine.
3. Pre-treatment counselling and documentation of the discussion in patient's records, for example including (a checklist may be used):
    a) Rationale for the medicine,
    b) Benefits of the medicine,
    c) Time to expected response from the medicine,
    d) Potential side effects of the medicine,
    e) Precautions required whilst and after taking the medicine,
    f) The essential need for, and frequency of, reviews and regular blood tests to allow continued supply of the medicine to the patient,
    g) Written information about the medicine (PIL),
    h) Involvement of the patient in shared care arrangements - what a shared care arrangement means for the patient and why it might be an option. Shared care arrangement with the patient's primary care clinician.
    i) Obtaining agreement and consent to treatment and shared care.
4. Recording baseline and on-going blood results and dosages in the patient held monitoring booklet (if available).
5. Provision of specialist and patient signatures on the shared care agreement form.
6. Provision of any additional instructions on monitoring and / or dose adjustments on the agreement and protocol e.g. if a patient is taking more than one DMARD.

7. Request for primary care clinicians confirmation of acceptance of shared care by secure emailing of the shared care protocol and completed agreement form, allowing 2 weeks for response.

    a. For most patients primary care clinician continuation will take place when stable e.g. 12 weeks after specialist initiation unless otherwise stated within the agreed individual shared care protocol (check specific protocol for details).

    b. "In exceptional cases, for patients out of area who cannot travel to hospital, special arrangements will need to be agreed with the primary care clinician on an individual case basis."

8. Provision of a prescription for the initial stabilisation period as specified in the protocol

9. Organisation of appropriate blood test monitoring in accordance with the specific protocol.

10. Review of patient in line with the relevant shared care protocol.

11. Receipt and recording in electronic records/notes that the primary care clinician has / has not accepted shared care and ensuring appropriate action if not.

12. Continuation of appropriate and regular follow up in the Outpatient clinic to review disease activity and adverse effects of treatment and to make / advise on dose adjustments where appropriate.

13. Notifying the primary care clinician of any failure to attend specialist clinics and advise on action(s) to take.

14. Appropriately prompt (by secure email or telephone) communication with the primary care clinician about any clinically important changes in dose or treatment; results of adverse blood tests; or adverse effects when the Consultant wishes the primary care clinician to continue prescribing or lack of attendance in clinic. Alternatively to tell the primary care clinician the hospital specialist will be taking back prescribing responsibility.

15. Deciding when to stop treatment.

16. Providing clear arrangements for back-up advice and support for patients and primary care clinician.

17. Support any training arrangements to ensure that primary care clinician have the skills to ensure safe practice.

18. Reporting any adverse effect in the treatment of the patient to the specialist team, and via the MHRA Yellow Card Scheme https://yellowcard.mhra.gov.uk/

The primary care clinician will be responsible for:

1. Prompt completion and e-mailed return of signed response about shared care agreement to the specialist within two weeks of its receipt.

2. Organisation of routine blood monitoring according to the relevant shared care protocol and ensuring that results are acted upon promptly.

3. Prescribing and adjustment of dose according to the relevant shared care protocol or on specialist advice after test results are known to prescriber.

4. Recording of blood test results and medicine dosages in the patient held monitoring booklet (where available) and patient notes. If there is no common electronic results system then there should be reciprocal sharing of blood test results between the primary care clinician and specialist.

5. Ascertaining the reasons for non-completion of routine blood testing, if one test is missed.

6. Re-iterating with the patient that non-attendance for blood testing may lead to withdrawal of the medication. Further help and advice can be sought from the specialist team.

7. Appropriately prompt notification to the specialist of any significant and relevant changes in the patient's condition, medication dose, or of an adverse reaction according to the protocol and if the patient fails to attend for blood monitoring.

8. Reporting any adverse effect in the treatment of the patient to the specialist team, and via the MHRA Yellow Card Scheme https://yellowcard.mhra.gov.uk/

9. Organization of urgent referral to the specialist team or A&E if severe side effects or potential overdose is apparent.

10. Liaising with the initiating clinician if the medicine becomes less effective.

11. Ensuring that all primary care practice staff involved in the provision of this service have the relevant knowledge and skills.

The patient will be responsible for:

1. Being fully involved in, and in agreement with, the decision to move to a shared care model for their ongoing care.
2. Confirming understanding of the shared care agreement.
3. Completion of the consent form.
4. Reporting to the primary care clinician or specialist if (s)he subsequently does not have a clear understanding of the treatment (patient to be provided with relevant contact details for primary care clinicians/specialist in and out of hours).
5. Attending for blood monitoring and follow up hospital or primary care appointments.
6. If available, ensuring that the hand-held monitoring booklet and a list of all medications are brought to all primary care, outpatient and A&E consultations.
7. If available, ensuring the hand-held monitoring booklet is kept up to date.
8. Reporting any change in symptoms and adverse effects promptly to the clinician who is currently prescribing.
9. Ensure no new medicines are started (including over the counter preparations) unless this has been discussed with the primary care clinician, specialist or community pharmacist.
10. Alert primary care clinician and/or specialist of any changes of circumstance which could affect management of disease e.g. plans for pregnancy; plans to move/change GP practice

The community pharmacist will be responsible for:

1. Confirming that the patient has received verbal and written patient counselling / information and provide additional counselling should this be required.
2. Check the patient is having appropriate regular monitoring to ensure that it is safe to dispense prescriptions including using patient held monitoring booklets where available.
3. Fulfil legal prescriptions for medication for the patient unless they are considered unsafe
4. Know where to access locally agreed SCPs (MSEMOC website) to aid professional clinical check of prescription prior to dispensing
5. Advise patients suspected of experiencing an adverse reaction to their medicines to contact their primary care prescriber or specialist/specialist nurse team.

References	1. Hickmann M, Drummond N, Grimshaw J: A taxonomy of shared care for chronic disease. Journal of Public Health Medicine 1994; 16:4 :-447-454 https://pubmed.ncbi.nlm.nih.gov/7880576/ 2. Responsibility for prescribing between Primary and Secondary / Tertiary Care, NHS England January 2018. Accessible via: https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility- prescribing-between-primary-secondary-care-v2.pdf 3. General Medical Council's Good practice in prescribing and managing medicines and devices Accessible via https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care 4. Regional Medicines Optimisation Committee (RMOC) Shared Care for Medicines Guidance A Standard Approach February 2021 https://www.sps.nhs.uk/wp-content/uploads/2020/01/RMOC-Shared-Care-for-Medicines-Guidance-A-Standard-Approach-Live-1.0.pdf
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