**Humber and North Yorkshire Integrated Care Partnership**

**Area Prescribing Committee**

**What Good Looks Like/ Principles for Sharing of Care Relating to Prescribing of Medication – Shared Care Protocols**

**Contents**

[Introduction 1](#_Toc193898605)

[Benefits of Shared Care 2](#_Toc193898606)

[Key Aspects of Shared Care 2](#_Toc193898607)

[Main Principles/What Good Looks Like 2](#_Toc193898608)

[Glossary/Definitions 5](#_Toc193898609)

[What do we mean by a 'specialist'? 5](#_Toc193898610)

[Appendix 1: Shared Care Request letter (Specialist to Primary Care Prescriber) 6](#_Toc193898611)

[Appendix 2: Shared Care Agreement Letter (Primary Care Prescriber to Specialist) 7](#_Toc193898612)

[Appendix 3: Shared Care Refusal Letter (Primary Care Prescriber to Specialist) 9](#_Toc193898613)

[References: 11](#_Toc193898614)

# **Introduction**

**Shared care** is a collaborative approach to healthcare where the responsibility for a patient's treatment is shared between different healthcare providers, typically between specialists\* (e.g., a hospital consultant) and primary care providers (e.g., general practitioners, GPs).

\*See 'Glossary/Definitions'

'Shared care' can apply to all care; these shared care principles specifically relate to the sharing of care regarding medicines and prescribing, as per medicine and disease-specific shared care protocols.

**Disclaimer**

This document, 'What Good Looks Like/ Principles for Sharing of Care Relating to Prescribing of Medication – Shared Care Protocols,' is a guide. The specifics should be agreed between the primary care provider and the specialist provider organisation.

Each Share Care Protocol contains the specific details of the responsibilities of both the primary care clinician and the specialist.

Professional clinical judgement should be applied, considering the needs of the patient.

Any concerns about the sharing of care relating to the prescribing of medication should, in the first instance, be discussed between the primary care provider and the specialist, with a collaborative approach to healthcare/ the responsibility for a patient's treatment

# **Benefits of Shared Care**

* **Improves access to specialised treatments.**
* **Enhances continuity of care.**
* **Reduces inappropriate attendance at hospital settings, aligns with 'care closer to home'.**
* **Provides a holistic approach by involving the GP practice in ongoing patient management.**

# **Key Aspects of Shared Care**

1. **Coordination between Providers: The patient’s care is jointly managed, with clear communication between the GP practice and the specialist. This ensures that the treatment is consistent and that both providers are aware of the patient's progress.**
2. **Role Clarity: The responsibilities of each provider are clearly stated.**
3. **Patient-Centred Care: The shared care model aims to provide the patient with the best possible care by leveraging the expertise of different healthcare providers, ensuring continuity, and reducing the need for repeated visits to specialists.**

# **Main Principles/What Good Looks Like**

1. **The ICB expects shared care for medication to a) follow the locally agreed shared care medication list and follow the locally agreed shared care protocol, as approved by the local** [Humber and North Yorkshire Area Prescribing Committee](https://humberandnorthyorkshire.org.uk/area-prescribing-committee-apc/#:~:text=The%20Humber%20and%20North%20Yorkshire%20Area%20Prescribing%20Committee%20(HNY%20APC,APC%20and%20subgroup%20paperwork.) **(HNY APC).**
2. **The ICB expects the specialist to be appropriately qualified, working in a CQC-registered organisation. Any concerns about specialist requests should be raised directly with specialists in the first instance. The ICB Pharmacy and Medicines Optimisation Team can provide advice if required.**
3. **Ideally, all communication should be completed electronically and using automated systems where possible/available. Communication should be directly between the specialist and the GP practice; the patient should also be kept informed via a copy but not treated as a conduit for sharing communication between specialists and GP Practices.**
4. **Shared care is a joint responsibility and, hence, a joint sharing of risk. Patient safety should be the number one priority, this includes considering where & how patients receive their medication. Medication prescribed via EPS from a general practice repeat template is currently the safest way of prescribing. The IT systems of specialist providers are currently not advanced enough to support repeat prescribing that is fully integrated with the primary care prescribing system.**
5. **The shared care protocol must be up to date. HNY APC is responsible for reviewing and approving all shared care protocols.**
6. **The shared care protocol should make it clear who is responsible for what, i.e. what is the role of the specialist and what is the role of the general practice clinician.**
7. **The specialist should initiate the prescribing AND prescribing should remain with the specialist until the patient is stable.**
* **What do we mean by 'stable'? – There is no set duration of time; it is defined by the specific drug and set out in the shared care protocol, usually expecting the specialist to prescribe for approximately 12 weeks/3 months AND the patient has satisfactory investigation results for at least 4 weeks. The dose titration should be complete with evidence of stable monitoring, within the required parameters. i.e. normal, no action required.**

**For example, the shared care protocol will state:**

*Transfer of monitoring and prescribing to primary care is normally after the patient has been treated for 12 weeks, the dose has been optimised, and with satisfactory investigation results for at least 4 weeks.*

1. **The specialist writes to the patient's GP Practice with all the required information, including a reference to the shared care protocol AND information on how to contact the specialist, if required. The minimum information included is described below as a template – see Appendix 1.**
2. **Specialists must ensure they provide the patient with enough medication to last until the GP practice can take on the shared care and prescribe. We consider 14 calendar days' supply to be the absolute minimum, but this duration of supply will be provider-specific and should be discussed as part of the initiation of sharing of care.**
3. **GP practice accepts prescribing under shared care. GP can actively do this by completing e.g. Appendix 2 (or equivalent) and sending it back to the specialist OR it is implied as accepted. If the GP does not accept the prescribing under shared care, they must actively decline by contacting the specialist, as soon as possible, bearing in mind the duration of initial supply provided by the specialist. A specific reason for declining shared care should be given. Ideally, the GP practice should respond within 14 days. If no response from the GP Practice is provided after 28 days, it will be assumed that the GP Practice has accepted the shared care.**
4. **Appendix 3 is a recommended template for declining shared care with a clear explanation. If the shared care protocol or these principles have not been adhered to, it should be explicitly stated. Ideally, the primary care provider and the specialist can resolve the issues by discussing them. If it requires escalation, please contact the ICB Pharmacy and Medicines Optimisation Team.**
5. **Both the primary care provider AND the specialist should identify themselves clearly as part of the process – i.e., name, professional registration, contact information, etc.**
6. **GP practice can prescribe and complete routine monitoring, as per the shared care protocol, if the patient is a) stable, i.e. the condition/indication is 'managed' appropriately, monitoring is within normal parameters, and b) the patient remains on the same dose that the specialist recommended.**
7. **If the patient is not stable, i.e. the condition/indication is not managed appropriately, the monitoring is not within normal parameters, or the dose of the medicine needs to change, the patient will be 'referred' back to the specialist and the specialist will review the shared care, as appropriate. This may be via Advice and Guidance; it may be referral back to the specialist clinic or another route, but the specialist must be available to adequately support general practice. The patient has not been discharged from the specialist service. The specialist may advise on any prescribing changes if necessary or take over the prescribing again until the patient is stable, as described above.**
8. **The specialist should respond promptly\* to any concerns raised by GP practice about shared care. \*Promptly depends on the nature of the risk/need of the patient. There should be a clear route defined for GP practices to contact specialists to raise concerns about shared care.**
9. **The APC is responsible for determining the traffic light formulary classification of each individual drug per indication. The APC considers the risk/benefits appropriate for shared care, and a clear rationale will be provided as to why the drug and indication is appropriate for shared care or not.**
10. **It is best practice to add any specialist-prescribed drug to the GP practice clinical system, even if it is a 'red' drug, i.e. specialist use only. A guide on how to do this is** [here](https://www.valeofyorkccg.nhs.uk/seecmsfile/?id=6531&inline=1&inline=1)**.**

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# **Glossary/Definitions**

# **What do we mean by a 'specialist'?**

* In terms of formulary traffic light status, a 'specialist' is typically any prescribing healthcare professional/ clinician with advanced expertise in a particular medical field. Their role involves diagnosing conditions, initiating specific treatments, and managing complex aspects of patient care.
* A specialist may be a doctor, a dentist or another registered healthcare professional with a non-medical prescribing qualification, for example, a nurse or pharmacist.
* The specialist service may be hosted by the NHS, for example, acute trusts, mental health providers, and community providers, or it may be a private provider or Local Authority, etc.
* We acknowledge that GMC defines 'specialist' in terms of the GMC ['Specialist Register'](https://www.gmc-uk.org/registration-and-licensing/our-registers/a-guide-to-our-registers/specialist-registration) and there is current debate regarding General Practitioners being recognised as specialists.
* Within the definitions for RAG status and shared care, a specialist is a particular medical condition/umbrella of conditions passing care to another healthcare professional in a primary care setting. The healthcare professional in primary care may also be a specialist but it is not a requirement of RAG/shared care.

# **Appendix 1: Shared Care Request letter (Specialist to Primary Care Prescriber)**

**Specialist contact information**

Name: *[insert name]*

Role and specialty: *[insert role and specialty]*

Daytime telephone number: *[insert daytime telephone number]*

Email address: *[insert email address]*

Alternative contact: *[insert contact information, e.g. for clinic or specialist nurse]*

Out of hours contact details: *[insert contact information, e.g. for duty doctor]*

Dear *[insert Primary Care Prescriber's name]*

Patient name:*[insert patient's name]*

Date of birth: *[insert date of birth]*

NHS Number*: [insert NHS Number]*

Diagnosis: *[insert diagnosis]*

As per the agreed *[insert APC name]*shared care protocol for *[insert medicine name]* for the treatment of *[insert indication],* this patient is now suitable for prescribing to move to primary care.

The patient fulfils criteria for shared care, and I am therefore requesting your agreement to participate in shared care. Where baseline investigations are set out in the shared care protocol, I have carried these out.

I can confirm that the following has happened with regard to this treatment:

|  |  |
| --- | --- |
|  | **Specialist to complete** |
| *The patient has been initiated on this therapy and has been on an optimised dose for the following period of time:* |  |
| *Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory* | *Yes / No* |
| *The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care* | *Yes / No* |
| *The risks and benefits of treatment have been explained to the patient* | *Yes / No* |
| *The roles of the specialist/specialist team/* *Primary Care Prescriber / Patient and pharmacist have been explained and agreed* | *Yes / No* |
| *The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments* | *Yes / No* |
| *I have enclosed a copy of the shared care protocol which covers this treatment/the SCP can be found here (insert electronic/ web link)* | *Yes / No* |
| *I have included with the letter copies of the information the patient has received* | *Yes / No* |
| *I have provided the patient with sufficient medication to last until* |  |
| *I have arranged a follow up with this patient in the following timescale* |  |

Treatment was started on *[insert date started]* and the current dose is *[insert dose and frequency]*.

If you are in agreement, please undertake monitoring and treatment from *[insert date]* NB: The date must be at least <e.g. 12 weeks> from the initiation of treatment.

The next blood monitoring is due on *[insert date]* and should be continued in line with the shared care guideline.

Please respond to this request for shared care, in writing, within 14 days of the request being made, where possible.

## **Appendix 2: Shared Care Agreement Letter (Primary Care Prescriber to Specialist)**

**Primary Care Prescriber Response**

Dear *[insert Doctor's name]*

Patient *[insert Patient's name]*

NHS Number *[insert NHS Number]*

Identifier*[insert patient's date of birth and/oraddress]*

Thank you for your request for me to accept prescribing responsibility for this patient under a shared care agreement and to provide the following treatment:

|  |  |  |
| --- | --- | --- |
| Medicine | Route | Dose & frequency |
|  |  |  |

I can confirm that I am willing to take on this responsibility from *[insert date]* and will complete the monitoring as set out in the shared care protocol for this medicine/condition.

Primary Care Prescriber signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Prescriber address/practice stamp

## **Appendix 3: Shared Care Refusal Letter (Primary Care Prescriber to Specialist)**

**Re*:***

Patient *[insert Patient's name]*

NHS Number *[insert NHS Number]*

Identifier *[insert patient's date of birth and/oraddress]*

Thank you for your request for me to accept prescribing responsibility for this patient.

In the interest of patient safety NHS *[insert ICB name]***,** in conjunction with local acute trusts have classified *[insert medicine name]*as a Shared Care drug and requires a number of conditions to be met before transfer can be made to primary care.

**I regret to inform you that in this instance I am unable to take on responsibility due to the following:**

|  |  |  |
| --- | --- | --- |
|  |  | **Tick which apply** |
| **1.** | **The prescriber does not feel clinically confident in managing this individual patient’s condition, and there is a sound clinical basis for refusing to accept shared care.**As the patient's primary care prescriber, I do not feel clinically confident to manage this patient’s condition because *[insert reason]*. I have consulted with other primary care prescribers in my practice who support my decision. This is not an issue which would be resolved through adequate and appropriate training of prescribers within my practice.**I have discussed my decision with the patient and request that prescribing for this individual remain with you as the specialist, due to the sound clinical basis given above.** |  |
| **2.** | **The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement.**As the medicine requested to be prescribed is not included on the APC list of shared care drugs, I am unable to accept clinical responsibility for prescribing this medication at this time. **Until this medicine is identified either nationally or locally as requiring shared care, the responsibility for providing this patient with their medication remains with you**  |  |
| **3.** | **A minimum duration of supply by the initiating clinician**As the patient has not had the minimum supply of medication to be provided by the initiating specialist, I am unable to take clinical responsibility for prescribing this medication at this time. Therefore, can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.***Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.*** |  |
| **4.** | **Initiation and optimisation by the initiating specialist**As the patient has not been optimised on this medication, I am unable to take clinical responsibility for prescribing this medication at this time. Therefore, can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.***Until the patient is optimised on this medication, the responsibility for providing the patient with their medication remains with you.*** |  |
| **5.** | **Shared Care Protocol not received.**As legal responsibility for clinical care lies with the clinician who signs the prescription, I need to ensure that I am in possession of sufficient clinical information for me to be confident to prescribe this treatment for my patient and it is clear where each of our responsibilities lie to ensure the patient is safely managed***.***For this reason, I am unable to take clinical responsibility for prescribing this medication at this time, therefore would you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.***Until I receive the appropriate SCP, the responsibility for providing the patient with their medication remains with you.*** |  |
| **6.** | **Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted)** |  |

I would be willing to consider prescribing for this patient once the above criteria have been met for this treatment.

[NHS England ‘Responsibility for prescribing between Primary & Secondary/Tertiary care’ guidance (2018)](https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/) states that “when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore essential that a transfer involving medicines with which GPs would not normally be familiar should not take place without full local agreement, and the dissemination of sufficient, up-to-date information to individual GPs.” In this case we would also see the term GP being interchangeable with the term Primary Care Prescriber.

Please do not hesitate to contact me if you wish to discuss any aspect of my letter in more detail and I hope to receive more information regarding this shared care agreement as soon as possible.

Yours sincerely

**Primary Care Prescriber signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Prescriber address/practice stamp**

## **References:**

<https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/>