



Shared Care for Medicines Guidance

A Standard Approach

**Regional Medicines Optimisation Committee
(RMOC)**

February 2021

Live 1.0

Document Control

Document location

Copies of this document can be obtained from <https://www.sps.nhs.uk/>

Revision history

Revision date	Actioned by	Summary of changes	Version
November 2019	NECS	Prepared by the North of England Commissioning Support Unit for consideration by RMOC North	V1
November 2019	RDTC	Updated to reflect comments made by RMOC North members, for circulation to RMOC groups nationally for comment	V2
January 2020	RDTC	Updated to reflect comments by RMOC & APC members nationally	V3.0
Feb 2020	RDTC	Minor amendments prior to SCWG telecom 11 th Feb 2020	V3.1
Feb 2020	RDTC	Amended post SCWG teleconference 11 th Feb 2020	V3.2
March 2020	RDTC	Amended post RMOC North February meeting	V3.3
August 2020	RDTC	Amended post NHSE comments TC August 2020	V3.4
February 2021	RDTC	Amended post IWG consultation	V4.0
February 2021	RDTC	V4.) to working version 1 for NHSE approval	WV1

Approvals

This document must be approved by the following before distribution

Name	Date of issue	Version
RMOC North	February 2020	V3.2
NHSEI	March 2021	Live 1.0 Publishing Approval Reference: PAR481

Document review date: March 2023

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1.0 Introduction

1.1 Increasingly, patients with continuing specialist clinical needs can be cared for at home or in the community. This includes patients receiving medicines which could be prescribed by primary care prescribers if sufficient support, review criteria and information are shared between the specialist team, primary care prescriber and, most importantly, patients themselves.

1.2 This document builds on the NHS England guidance “[Responsibility for prescribing between primary and secondary/tertiary care](#)” and defines the principles for a national system of shared care for medicines. It aims to provide a framework for the seamless sharing of care between the patient, specialist service and primary care prescriber in circumstances where this is appropriate, benefits the patient, and is supported by them. This guidance does not currently cover the transfer of prescribing of highly specialised medicines which are normally NHS England-commissioned rather than primary care-commissioned (i.e. medicines prescribed by tertiary centres), although the principles of shared care for medicines presented here could be assumed to be similar. It should be remembered that care must not be transferred solely on the basis of cost, or practical considerations of supply which do not directly benefit the patient.

1.3 The characteristics of medicines suitable for shared care are described within this guidance. When prescribed in primary care, medicines included on the accompanying national list ([appendix 1](#)) should be provided via a shared care arrangement under a locally endorsed, appropriately resourced contract between primary and secondary/specialist care.

1.4 The national Regional Medicines Optimisation Committee (RMOC) system is working towards production of a suite of standard shared care protocols (SCPs) for all medicines on this national list. These SCPs are intended to provide the minimum requirement of the SCP, which can then be further developed as necessary to enable local adoption. In the interim, medicines and conditions suitable for shared care should continue to be identified by local Area Prescribing Committees (APCs) (or equivalent), with all shared care medicines clearly identified as such within formularies.

1.5 This guidance does not address commissioning of particular shared care arrangements, for example payments to GPs for monitoring and participating in shared care, as this is outside the scope of RMOC. Commissioning arrangements should be negotiated and agreed locally.

2.0 Principles of Shared Care for medicines

2.1 General

2.1.1 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. In many cases it will be the primary care prescriber who is the most appropriate clinician to provide continuing care. In terms of patient experience, those patients who are on long-term medication or are less well may prefer to avoid unnecessary hospital appointments by receiving their prescriptions closer to home."

2.1.2 Care should be provided by the service that is best placed to provide it safely, which may be in either primary or specialist care settings. Shared care will reduce the risks associated with the prescribing of these higher risk medicines through appropriate monitoring, cooperation, communication and resourcing, thereby reducing the likelihood of harm.

2.1.3 Once the specialist and patient and/or carer agree that a shared care approach should be taken, primary care prescribers undertake the majority of the management of their patient's condition and medicines. The specialist remains involved to offer advice where required. Effective communication between patient, primary and specialist care will improve the consistency of approaches to treatment.

2.1.4 Prescribers have a responsibility to ensure their clinical knowledge is kept up to date, and it is expected that any shared care protocol will be suitable for use by a GP or relevant primary care prescriber. Declining to participate in a shared care arrangement is expected to be exceptional and in the best interests of the patient, provided the SCP in question is of high quality and in line with this guidance.

2.1.5 In contrast to NHS England guidance "[Responsibility for prescribing between primary and secondary/tertiary care](#)", RMOC suggest that where possible shared care will be 'medicine specific' rather than 'condition specific', and will link into and complement local integrated care pathways. By being specific to a medicine the SCP can be developed to coordinate the recommended dosage and monitoring requirements for each medicine. It is recognised that there are situations where SCPs should be "condition specific", when specifics for the prescribing and monitoring deviate from recognised practice.

2.2 Definition of Shared Care for Medicines

2.2.1 Medicines considered suitable for shared care are those which should be initiated by a specialist, but where prescribing and monitoring responsibility may be transferred to primary care. Due to their potential side effects, shared care medicines usually require significant regular monitoring and/or regular review by the specialist is needed to determine whether the medicines should be continued.

2.2.2 Specialist services may include mental health services, secondary care, tertiary care, community providers, private providers, and GPs with a specialist interest. Whilst the individual specialist may not physically initiate treatment, the person initiating (e.g. specialist registrar, nurse specialist) must be under the direction of the consultant specialist.

2.2.3 Any transfer of prescribing should only happen following a successful initiation and stabilisation period and with the agreement and understanding of the patient/carer. The specialist should confirm that the patient is optimised on the chosen medication with no further changes anticipated in the immediate future. It is the responsibility of the specialist to decide with the patient and/or carer that a patient is suitable for sharing care of their medication.

2.2.4 Prior to sharing care, agreement about the patient's ongoing care must be reached under the shared care agreement, which will be sent out to primary care with the request to prescribe. It should be noted that generally shared care for a medicine does not see the patient discharged from the care of their specialist but rather that the care of the patient is shared between the patient, primary and secondary/specialist care within a clearly defined, easily understood and locally approved Shared Care Protocol (SCP).

2.2.5 National SCPs should be considered for local adoption where available. If a national SCP is not available or in production it is recommended that one should be drawn up by the initiating specialist using the national template ([appendix 5](#)) following local consultation with system prescribing leads and prescribing teams, and approved via the local APC. Supporting information should be provided to patients and carers to support them in understanding and agreeing to their responsibilities. NB: consultation with primary care prescribers and patients must be sought when developing or reviewing the protocol using established communication channels e.g. the system patient engagement team.

2.2.6 Shared care may be initiated by or at the recommendation of a specialist, which includes consultant, suitably trained specialist non-medical prescriber or GP with specialist interest within a secondary, tertiary, or primary care clinic. Each arrangement should be supported using a locally agreed shared care guideline which outlines the requirements specific for the medicine being used in the condition being treated.

2.2.7 The areas of care for which each clinician has responsibility should be clearly defined in the SCP and include any other medicine-specific responsibilities. Prescribers are responsible for developing their knowledge and skills to be able to safely prescribe.

2.3 Characteristics of Medicines Requiring Shared Care

2.3.1 A medicine is deemed suitable for shared care as per the definition above if it requires frequent monitoring which can be undertaken in the primary care setting, but is such that overarching specialist involvement is retained. RMOC has identified a number of medicines suitable for shared care, listed in [appendix 1](#).

2.3.2 Medicines initiated in the specialist setting or recommended by a specialist for initiation in primary care, which do not require ongoing oversight by a specialist but may require some monitoring within primary care, are not shared care drugs. These are often given a status of “Green plus” or “Green/Amber Specialist initiated”, e.g. monitoring of blood count, hepatic function, and renal function that is required with some antiepileptic drugs.

2.3.3 Some medicines are not suitable for shared care and responsibility for their prescribing should be retained by the specialist and not requested in a primary care setting. These drugs are often given a “red” status, and are ordinarily medicines which:

- Require ongoing specialist intervention and specialist monitoring of efficacy or toxicity. Some medicines may require a different status when prescribed for different indications, e.g. ciclosporin and mycophenolate would only be suitable for shared care when used as disease-modifying antirheumatic drugs (DMARDs), but would be considered “red” for prevention of transplant rejection.
- Are unlicensed and/or are being used outside of product license (e.g. licensed medicine used for unlicensed indication or at an unlicensed dose), unless there is recognised evidence base (e.g. recommended by NICE or other recognised body such as a Royal College or professional society) and/or it is standard treatment. In terms of paediatric medicines, the inclusion of dosage guidance in the Children’s BNF provides a suitable evidence base. Where unlicensed drugs are considered suitable for shared care this should be documented in the patient’s notes, along with details of patient awareness of the unlicensed status and consent to receive this treatment where appropriate (see GMC guidance).
- Are designated as “hospital only” by nature of the product, or are only available through specialist routes, i.e. not available on FP10. This includes any ‘borderline’ products when used outside approved indications.
- Are being used as part of a hospital based clinical trial.
- Cannot be safely administered in primary care.
- An electronic communication and monitoring system is not available, and there is no effective alternative system of communication

3.0 Patient Centred Care

3.1 The best interest, agreement and preferences of the patient should be at the centre of any shared care agreement and their wishes followed wherever possible. Clinicians should clearly explain what a shared care arrangement means for the patient and why it might be an option in their case.

3.2 The patient or their carers should have the opportunity to ask questions and explore other options if they do not feel confident that shared care will work for them. They should be fully involved in, and in agreement with, the decision to move to a shared care model for their ongoing care. Importantly, patients should never be used as a conduit for informing the Primary Care Prescriber that prescribing is to be transferred.

3.3 Patients should be able to decline shared care if, after due consideration of the options, they decide it is not in their best interests.

3.4 Involvement of carers may be critical, especially in circumstances when it is not possible for the patient to make a decision, for example due to mental capacity. Where appropriate, carers should be included in discussions about shared care.

3.5 It would not normally be expected that a primary care prescriber would decline to prescribe based on medicine cost, unless there is a clinically suitable, cost-effective alternative available. Likewise, if the patient is to receive the majority of their on-going care through secondary/specialist care then prescribing should remain within the specialist setting. Care must not be transferred solely on the basis of cost or practical considerations of supply which do not directly benefit the patient.

3.6 Individual patient information and a record of their preferences should accompany shared care prescribing guidelines, where appropriate. The patient should be provided with clear information written in plain English and provided in an accessible format, to support this decision.

4.0 Acceptance of Shared Care for medicines

4.1 Sharing of care for a medicine with the primary care prescriber should only take place once the prescriber has agreed to the prescribing and monitoring request in each individual case. **The specialist will continue to provide prescriptions until sharing of responsibilities occurs.** This should be done using the template letter in [appendix 2](#).

4.2 The primary care prescriber should confirm the agreement and acceptance of the shared care prescribing arrangement within 14 days of request and confirm that supply arrangements have been finalised. This should be done using the template letter in [appendix 3](#).

4.3 The specialist provider must supply an adequate amount of the medicine to cover the transition period. The patient should then be advised to obtain further prescriptions from the primary care prescriber. Under no circumstances should acceptance be presumed until written agreement (which may be electronic) has been received.

4.4 If the primary care prescriber refuses to accept shared care then the requesting specialist should be notified in writing by the primary care prescriber within 14 days of request, giving the reason for refusal. This should be done using the template letter in [appendix 4](#). Where there is no agreement on arrangements for prescribing, responsibility for prescribing for new patients' remains with the specialist until resolved. Transfer of prescribing responsibility to a primary care prescriber without prior agreement is not appropriate.

Refusal by a primary care prescriber to share care and prescribing responsibilities should not prevent a clinically appropriate therapy being prescribed by a specialist. Patients must not be placed in a position where they are unable to obtain the medicines they need because of lack of communication between the specialist and primary care. In line with [GMC Guidance "Good practice in prescribing and managing medicines and devices"](#) if the primary care prescriber feels unable to take on responsibility for the patient's continuing care they should explain this to the other clinician and to the patient, and make appropriate arrangements for their continuing care.

5.0 Content to be included within a Shared Care Protocol

5.1 A locally approved SCP should be available for each medicine in a written format, and should be discussed by the specialist with the patient. This should include a brief overview of the condition and more detailed information on the medicine(s) being transferred including the following points as a minimum:

- A clinical summary, which should include a brief overview of the condition
- The licensed indications of the medicine, therapeutic classification, dose, route of administration, duration of treatment, adverse effects (including their incidence, identification and management), clinically relevant medicines interactions and their management, cautions contraindications and exclusions, storage and product reconstitution instructions.
- Peer-reviewed references for product use, and contacts for more detailed information should be included and a summary of NICE, BNF, SPC or other guidance where applicable (hyperlinked to full guidance)
- Define the responsibility of the specialist and the primary care prescriber for monitoring and adjusting treatment.
- Define the referral procedure from hospital to primary care prescriber.
- Define how often the patient will be reviewed and provide a 'route of return' should their condition change (such as a return of symptoms, or a development of adverse effects).
- Communication network & emergency support. Define the back-up facilities available to the primary care prescriber from the specialist with whom the agreement is made. Telephone details and (if appropriate) secure email addresses of the specialist and primary

care prescriber should be exchanged and recorded. This will enable the practice to access timely advice, guidance and information if problems arise, and also enable secondary/specialist care clinicians to easily contact the primary care prescriber if necessary. This should include out-of-hours contact numbers, e.g. how to access the on-call duty clinician. Patients and their carers should also be provided with contact details for support and help if required; both in and out of hours.

- Include explicit criteria for review and discontinuation of the medicine, with emphasis that these criteria should be communicated to the patient.
- Any treatment algorithm should be simple and easy to follow, highlighting when a medicine should be started, changed or stopped.
- A review date. A shared care protocol will usually be approved for three years, after which time a review should take place and necessary amendments incorporated. Any changes in national guidance or new safety concerns should prompt a review of the protocol at an earlier date.

5.2 Training – In liaison with the specialist service provider the commissioner of the service pathway should ensure that adequate training and educational support is in place for the primary care multidisciplinary team, e.g. managing the condition, administration of the medicine etc. Information on how to access this support should be provided in the shared care prescribing guidelines. This should also be the case for the patient and/or carer if expected to self-administer under this arrangement.

5.3 Resources - It should be recognised that resources, for example monitoring / testing arrangements available in primary care are not consistent across the country, and there may be impacts on both primary and secondary/ specialist care. 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 specialist provision in situations where shared care is not accepted.

6.0 Responsibilities of those involved in Shared Care

6.1 Roles and Responsibilities of the Patient

- 6.1.1 To provide their informed consent for sharing of their care with the specialist and primary care prescriber. Consenting parties must have sufficient, accurate, timely information in an understandable and accessible format. Consent must be given voluntarily and must be documented in the patient's notes. Supporting information is available from NICE [“Making decisions about your care”](#)
- 6.1.2 To take their medication as agreed, unless otherwise instructed by an appropriate healthcare professional.
- 6.1.3 To meet all necessary monitoring arrangements to ensure the safe prescribing of their medication, and to alert the prescriber where these arrangements are not met.

- 6.1.4 To attend all follow-up appointments with the primary care prescriber and specialist. If the patient is unable to attend any appointments, they should inform the relevant practitioner as soon as possible and arrange an alternative appointment.
- 6.1.5 Inform healthcare professionals of their current medications prior to receiving any new prescribed or over-the-counter medication.
- 6.1.6 Report all suspected adverse reactions to medicines to their primary care prescriber.
- 6.1.7 Store their medication securely away from children and according to the medication instructions.
- 6.1.8 Read the information supplied by their primary care prescriber, specialist and pharmacist and contact the relevant practitioner if they do not understand any of the information given.

6.2 Roles and Responsibilities of the Specialist

- 6.2.1 To obtain patient informed consent for sharing of care between the specialist, primary care prescriber and patient. Consenting parties must have sufficient, accurate, timely information in an understandable form. Consent must be given voluntarily and must be documented in the patient's notes.
- 6.2.2 To confirm the working diagnosis.
- 6.2.3 To confirm that the patient's condition has a predictable course of progression and the patient's care can be suitably maintained by primary care, following their medicine being optimised with satisfactory investigation results for at least 4 weeks.
- 6.2.4 If shared care is considered appropriate for the patient, the patient's treatment regimen is confirmed, and benefit from treatment is demonstrated, the specialist will contact the primary care prescriber to initiate shared care.
- 6.2.5 Following the request to the patient's GP to initiate shared care; to ensure that the patient has an adequate supply of medication (usually 28 days) until shared care arrangements are in place. Further prescriptions will be issued if, for unforeseen reasons, arrangements for shared care are not in place at the end of 28 days. Patients should not be put in a position where they are unsure where to obtain supplies of their medication.
- 6.2.6 To ensure that the primary care prescriber has sufficient information to enable them to monitor treatment, identify medicines interactions, and prescribe safely. This should include access or direction to a current copy of the SCP, and contact details for the initiating specialist.
- 6.2.7 The specialist will provide the patient's primary care prescriber with the following information:
 - diagnosis of the patient's condition with the relevant clinical details
 - details of the patient's specialist treatment to date
 - details of treatments to be undertaken by primary care prescriber (including reasons for choice of treatment, medicine or medicine combination, frequency of treatment, number of months of treatment to be given before review by the specialist)
 - the date from which the GP should prescribe the treatment

- details of other specialist treatments being received by the patient that are not included in shared care
 - details of monitoring arrangements
- 6.2.8 Whenever the specialist sees the patient, he/she will:
- send a written summary within 14 days to the patient’s primary care prescriber
 - confirm that ongoing treatment with the monitored medicine is appropriate
 - record test results on the patient-held monitoring booklet if applicable confirm the current dosage and clearly highlight any changes made both to the patient and in writing to the patient’s primary care prescriber who will action any them as required
- 6.2.9 The specialist team will:
- provide training, advice and guidance (as appropriate) for primary care prescribers if necessary to support the shared care agreement
 - provide contact details for both working and non-working hours
 - supply details for fast track referral back to secondary/specialist care
 - provide the patient with details of their treatment, follow up appointments, monitoring requirements and, where appropriate, nurse specialist contact details
- 6.2.10 Prior to transfer of prescribing, the specialist will:
- Ensure that patients (and their caregivers, where appropriate) are aware of and understand their responsibilities to attend appointments and the need for continued monitoring arrangements.

6.3 Roles and Responsibilities of the Primary Care Prescriber

- 6.3.1 To prescribe within their own level of competence. The General Medical Council (GMC) guidance on [“Good practice in prescribing and managing medicines and devices”](#) states that doctors are responsible for the prescriptions they sign and their decisions and actions when they supply and administer medicines and devices, or authorise or instruct others to do so. They must be prepared to explain and justify their decisions and actions when prescribing, administering and managing medicines.
- 6.3.2 To confirm that the patient or carer consents to sharing of care between the specialist, primary care prescriber and patient. Consenting parties must have sufficient, accurate, timely information in an understandable form. Consent must be given voluntarily and must be documented in the patient’s notes.
- 6.3.3 To confirm whether they accept or decline shared care, and to inform the specialist of this decision, in writing, within 14 days.
- 6.3.4 Ensuring that he/she has the information and knowledge to understand the therapeutic issues relating to the patient’s clinical condition.
- 6.3.5 Undergoing any additional training necessary in order to carry out the prescribing and monitoring.
- 6.3.6 Agreeing that in his/her opinion the patient should receive shared care for the diagnosed condition unless good reasons exist for the management to remain within secondary/specialist care.

- 6.3.7 Prescribing the maintenance therapy in accordance with the written instructions contained within the SCP or other written information provided, and communicating any changes of dosage made in primary care to the patient. It is the responsibility of the prescriber making a dose change to communicate this to the patient.
- 6.3.8 Where applicable, keep the patient-held monitoring record up to date with the results of investigations, changes in dose and alterations in management and take any actions necessary. It is the responsibility of the clinician actioning the results from monitoring in accordance with the SCP (and thereby prescribing for the patient), to complete the patient's record with the necessary information.
- 6.3.9 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/>.
- 6.3.10 The primary care prescriber will ensure that the patient is monitored as outlined in the SCP and will take the advice of the referring specialist if there are any amendments to the suggested monitoring schedule.
- 6.3.11 The primary care prescriber will ensure a robust monitoring system is in place to ensure that the patient attends the appropriate appointments for follow up and monitoring, and that defaulters from follow up are contacted to arrange alternative appointments. It is the primary care prescriber's responsibility to decide whether to continue treatment for a patient who does not attend appointments required for follow up and monitoring, and to inform the specialist of any action taken.
- 6.3.12 Primary care prescribers must provide written confirmation (which may be electronic) to the specialist of acceptance of patient care under the shared care agreement prior to the sharing of prescribing responsibilities.
- 6.3.13 Primary care prescribers are not expected to be asked to participate in a shared care arrangement where:
- no locally approved SCP exists, or the medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care agreement
 - 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
- 6.3.14 Where community nurse involvement is required in the administration of medicines under a SCP, nurses should be provided with adequate information and guidance by the prescriber or the specialist. Arrangements should be made in good time for any potential problems to be resolved to ensure that patient care is not compromised.

6.4 Roles and Responsibilities of the Community Pharmacist

- 6.4.1 Know where to access locally agreed SCPs (e.g. from local APC websites) to aid professional clinical check of prescription prior to dispensing.
- 6.4.2 Professionally check prescriptions to ensure they are safe for the patient and contact the primary care prescriber if necessary to clarify their intentions. It is good practice to check the patient held record book to ensure the correct dose is dispensed.
- 6.4.3 Fulfil legal prescriptions for medication for the patient unless they are considered unsafe.
- 6.4.4 Counsel the patient on the proper use of their medication.

6.4.5 Advise patients suspected of experiencing an adverse reaction to their medicines to contact their primary care prescriber or specialist/specialist nurse team.

Review date:
Version:

Appendix 1: Medicines Suitable for Shared Care

The following medicines have been identified as being suitable for shared care as defined within this policy. Shared care protocols will be developed for the agents listed below.

Medicines not listed below may still be suitable for shared care but have not been identified for national shared care protocol development at the current time.

Drug	Specialist initiation recommended	Medicine is suitable for primary care prescribing	Medicine requires regular monitoring, which can be carried out in primary care but may require the advice of a specialist
Amiodarone	✓	✓	✓
Atomoxetine	✓	✓	✓
Azathioprine	✓	✓	✓
Ciclosporin	✓	✓	✓
Dexamfetamine	✓	✓	✓
Dronedarone	✓	✓	✓
Guanfacine	✓	✓	✓
Hydroxycarbamide	✓	✓	✓
Hydroxychloroquine	✓	✓	✓
Leflunomide	✓	✓	✓
Lithium	✓	✓	✓
Lisdexamfetamine	✓	✓	✓
Mercaptopurine	✓	✓	✓
Methotrexate	✓	✓	✓
Methylphenidate	✓	✓	✓
Mycophenolate	✓	✓	✓
Riluzole	✓	✓	✓
Sulfasalazine	✓	✓	✓

Appendix 2: Shared Care Request letter (Specialist to Primary Care Prescriber)

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

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: date must be at least 1 month from initiation of treatment.

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

Please could you reply to this request for shared care and initiation of the suggested medication to either accept or decline within 14 days.

Appendix 3: 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/or address]*

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 4: 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/or address]*

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

In the interest of patient safety NHS *[insert CCG 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.	<p>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</p> <p>As the patients primary care prescriber I do not feel clinically confident to manage this patient's condition because <i>[insert reason]</i>. 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.</p> <p>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.</p>	
2.	<p>The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement</p> <p>As the medicine requested to be prescribed is not included on the national list of shared care drugs as identified by RMOC or is not a locally agreed shared care medicine I am unable to accept clinical responsibility for prescribing this medication at this time.</p> <p>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</p>	
3.	<p>A minimum duration of supply by the initiating clinician</p> <p>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.</p> <p>Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.</p>	
4.	<p>Initiation and optimisation by the initiating specialist</p> <p>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.</p> <p>Until the patient is optimised on this medication the responsibility for providing the patient with their medication remains with you.</p>	
5.	Shared Care Protocol not received	

	<p>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.</p> <p>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.</p> <p><i>Until I receive the appropriate SCP, responsibility for providing the patient with their medication remains with you.</i></p>	
6.	<p>Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted)</p>	

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) 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

Appendix 5: Template Shared Care Protocol

(Medicine Name) for patients within (Service Name)									
1. Background									
2. Indications (Please state whether licensed or unlicensed)									
3. Locally agreed off-label use	To be agreed and completed locally (include supporting information)								
4. Contraindications and cautions Please note this does not replace the Summary of Product Characteristics (SPC) and should be read in conjunction with it.	<p>Contraindications:</p> <p>Cautions: Please see SPC for comprehensive information.</p>								
5. Initiation and ongoing dose regime Note - <ul style="list-style-type: none"> •Transfer of monitoring and prescribing to primary care is normally after the patient's dose has been optimised and with satisfactory investigation results for at least 4 weeks •The duration of treatment & frequency of review 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 primary care clinician •Termination of treatment will be the responsibility of the specialist. 	<p><u>Initial stabilisation:</u></p> <p>The loading period must be prescribed by the initiating specialist.</p> <p><u>Maintenance dose (following initial stabilisation):</u></p> <p>The initial maintenance dose must be prescribed by the initiating specialist.</p> <p><u>Conditions requiring dose adjustment:</u></p>								
6. Pharmaceutical aspects	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Route of administration:</td> <td></td> </tr> <tr> <td>Formulation:</td> <td></td> </tr> <tr> <td>Administration details:</td> <td></td> </tr> <tr> <td>Other important information:</td> <td></td> </tr> </table>	Route of administration:		Formulation:		Administration details:		Other important information:	
Route of administration:									
Formulation:									
Administration details:									
Other important information:									
7. Significant medicine interactions	The following list is not exhaustive; please see SPC for comprehensive information and recommended management.								

For a comprehensive list consult the BNF or Summary of Product Characteristics. SPC		
8. Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist	<p>Baseline investigations:</p> <ul style="list-style-type: none"> • Initial monitoring: <ul style="list-style-type: none"> • Monitoring at baseline and during initiation is the responsibility of the specialist, only once the patient is optimised on the chosen medication with no anticipated further changes expected in immediate future will prescribing and monitoring be transferred to the GP. <p>Ongoing monitoring:</p> <ul style="list-style-type: none"> • 	
9. Ongoing monitoring requirements to be undertaken by primary care.	Monitoring	Frequency
See section 10 for further guidance on management of adverse effects/ responding to monitoring results.		
10. Adverse effects and managements	Result	Action for GP
Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme www.mhra.gov.uk/yellowcard		
11. Advice to patients and carers	<p>The patient should be advised to report any of the following signs or symptoms to their GP without delay:</p> <ul style="list-style-type: none"> • 	
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, including patient information leaflets on individual medicines.		
12. Pregnancy, paternal exposure and breast feeding	<p><u>Pregnancy:</u></p> <p><u>Breastfeeding:</u></p>	
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	<p>Name: <i>[insert name]</i></p> <p>Role and specialty: <i>[insert role and specialty]</i></p> <p>Daytime telephone number: <i>[insert daytime telephone number]</i></p> <p>Email address: <i>[insert email address]</i></p> <p>Alternative contact: <i>[insert contact information, e.g. for clinic or specialist nurse]</i></p> <p>Out of hours contact details: <i>[insert contact information, e.g. for duty doctor]</i></p>	
14. Additional information	Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed.	
15. References	<ul style="list-style-type: none"> • Include hyperlinks to the original sources and access dates 	

16. To be read in conjunction with the following documents	<ul style="list-style-type: none"> • RMOC Shared Care Guidance • NHSE/NHSCC guidance – items which should not be routinely prescribed in primary care: guidance for CCGs • NHSE policy- Responsibility for prescribing between Primary & Secondary/Tertiary Care
17. Local arrangements for referral Define the referral procedure from hospital to primary care prescriber & route of return should the patient's condition change.	To be agreed and completed locally

APC board date:
Last updated: