Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Hertfordshire and West Essex (HWE) ICB Principles for Shared Care

i. The fundamental principle of 'shared care' across primary and secondary 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.

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 HWE Area Prescribing Committee (APC) before they are accepted for use.

iv. HWE APC will designate shared care drugs as traffic light classification 'amber protocol'. Where a new drug is classified as amber protocol 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 the APC. For existing drugs a workplan with appropriate timescales will be developed to ensure updated shared care protocols are in place.

v. Prescribers need easy access to shared care protocols. These will be available on the ICB medicines optimisation website and Trust websites/formularies.

vi. 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 GP. 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.

vii. The initial secondary care prescriber retains responsibility for monitoring and supplying the medication until alternative arrangements are in place.

viii. GPs 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 GP will be considered an acceptance by the GP practice. If refusing to share care the GP should explain their concerns to the hospital consultant.

ix. 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.

x. 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.

xi. 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.

xii. There needs to be version control and clarity around updates to agreements.

xiii. 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. Email contacts need

to be included within the shared care protocols. Specialist team contact details need to be provided to the patient.

xiv. Responsibilities should include the role of the pharmacist supplying the medicine.

xv. 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.

xvi. It could be useful to look at successful examples from elsewhere rather than re-inventing the wheel.

xvii. Patients on shared care drugs should be looked after by both secondary and primary care. Agreement does not need to cover 'after discharge' because by definition the shared care arrangement ceases at this point.

xviii. Adequate resource must be provided for patients on shared care drugs to facilitate shared care.

General responsibilities for 'amber protocol' shared care medicines

'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.

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 GP,
   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 GP 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 GP 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 GP 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 GP 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 GP 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 GP about any clinically important changes in dose or treatment; results of adverse blood tests; or adverse effects when the Consultant wishes the GP to continue prescribing or lack of attendance in clinic. Alternatively to tell the GP 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 GPs.

17. Support any training arrangements to ensure that GPs have the skills to ensure safe practice.

The General Practitioner 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 GP 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 hospital specialist team.

7. Appropriately prompt notification to the hospital 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.Organization of urgent referral to the specialist team or A&E if severe side effects or potential overdose is apparent.

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

10. Ensuring that all GP 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 GP or specialist if (s)he subsequently does not have a clear understanding of the treatment (patient to be provided with relevant contact details for GP/specialist in and out of hours).

5. Attending for blood monitoring and follow up hospital or GP appointments.

6. If available, ensuring that the hand-held monitoring booklet and a list of all medications are brought to all GP surgery, 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 GP, specialist or pharmacist.

10. Alert GP 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 dispensing 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.

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
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. www.gmc-uk.org/guidance/ethical_guidance/14321.asp

Acknowledgement

Adapted from a document used in the Buckinghamshire health economy, with thanks

Version	v0.6 Harmonisation of Hertfordshire Medicines Management Committee (HMMC) guidance and West Essex Medicines Optimisation Programme Board (WEMOPB) guidance updates include: • Rebadging with HWE ICB and removal of ENHCCG and HVCCG headers • Review date removed and replaced with standard statement.
Approved by	HMMC and WE MOPB
Date approved/updated	October 2019 (HMMC) and February 2020 (WE MOPB) Updated: November 2023
Review date:	The recommendation is based upon the evidence available at the time of publication. This recommendation will be reviewed upon request in the light of new evidence becoming available.
Superseded version	Original v0.5 following agreements at shared care task and finish group meetings May and July 2019