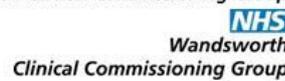


# South West London Interface Prescribing Policy 2020 – 21

## Appendix 5A: SWL Principles of Shared Care

Last updated and approved by SWL Medicines Optimisation Group: 23 January 2020

Subject to review in 2020/21



### SWL Principles of Shared Care

#### 1. Introduction

The purpose of these principles of shared care is to provide a framework for the seamless transfer of some of the care from the hospital or specialist service setting to general practice, where this is appropriate and in the best interest of the patient.

Shared care prescribing guidelines are local policies to enable general practitioners (GPs) to accept responsibility for prescribing and monitoring of medicines/treatments in primary care, in agreement with the initiating specialist service.

Where possible, shared care will be 'disease specific' rather than 'medicine specific' and will link into and complement local integrated care pathways and shared care policies.

Application of the following principles will facilitate effective shared care. However, it should be remembered that the provision of shared care prescribing guidelines does not necessarily mean the GP has to agree to and accept clinical and legal responsibility for prescribing; they should only do so if they feel clinically confident in managing that condition in line with GMC guidance "Good practice in prescribing and managing medicines and devices (2013)" (see <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/shared-care>).

#### 2. Principles of Shared Care

##### 2.1 Best interest of the patient

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. Patients should be able to decline shared care if, after due consideration of the options, they decide it is not in their best interests. Involvement of carers may be critical, especially in circumstances when it is not possible for the patient to decide, e.g. mental capacity, and where appropriate they should be included in discussions about shared care. Arrangements should never be detrimental or inconvenient for the patient.

##### 2.2 Individual, patient by patient arrangements

Patients should be at the centre of any shared care arrangements. Individual patient information and a record of the patient's (or if appropriate their carer) preferences should accompany shared care prescribing guidelines, where appropriate

##### 2.3 Reasonably predictable clinical situation

Transfer of clinical responsibility to primary care should only be considered where a patient's clinical condition is stable or predictable.

##### 2.4 Agreement of shared care between consultant/specialist and GP

Referral to the GP should only take place once the GP has agreed to this in each individual case, and the hospital or specialist will continue to provide prescriptions until a successful transfer of responsibilities. The GP should confirm the agreement and acceptance of the shared care prescribing arrangement and that supply arrangements have been finalised. The secondary/tertiary provider must supply an adequate amount of the medication to cover the transition period. The patient should then be informed to obtain further prescriptions from the GP.

The signature section on the front cover of each shared care prescribing guideline can be used to confirm that shared care has been agreed between all parties. It is suggested that the

consultant/specialist will send a signed agreement to the GP. If agreeable, the GP should confirm the agreement and acceptance of the shared care prescribing arrangement, that supply arrangements have been finalised and that all appropriate monitoring requirements will be fulfilled by signing and returning a copy of the front cover to the consultant/specialist. The secondary/tertiary provider must supply an adequate amount of medicines to cover the transition period. The patient should subsequently be informed to obtain further prescriptions from the GP.

## 2.5 Checklist for GPs when considering sharing care

GPs should only agree to prescribe if, after reading the shared care prescribing guideline, they can answer **YES** to the following questions:

- Is the patient's condition predictable or stable?
- Do you have the relevant knowledge, skills and access to equipment to allow you to monitor treatment as indicated in this shared care prescribing guideline?
- Have you been provided with relevant clinical details including monitoring data?

If the answer is **NO** to any of these questions, the GP should not accept prescribing responsibility and should write to the consultant/specialist within 14 days, outlining the reasons for NOT prescribing. If the GP does not have the confidence to prescribe, this should be discussed with the local Trust/specialist service, who will be willing to provide training and support. If the GP still lacks the confidence to accept clinical responsibility, they still have the right to decline. SWL Clinical Commissioning Group (CCG) pharmacists will assist GPs in making decisions about shared care.

The signature section on the front cover of each shared care prescribing guideline can be used to confirm that shared care has been agreed between all parties. It is suggested that the consultant/specialist will send a signed agreement to the GP. If agreeable, the GP should confirm the agreement and acceptance of the shared care prescribing arrangement, that supply arrangements have been finalised and that all appropriate monitoring requirements will be fulfilled by signing and returning a copy of the front cover to the consultant/specialist. The secondary/tertiary provider must supply an adequate amount of medicines to cover the transition period. The patient should subsequently be informed to obtain further prescriptions from the GP.

## 2.6 Involving the patient in shared care arrangements

Clinicians should clearly explain what a shared care arrangement means for the patient and why it might be an option in their case. 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 GP that prescribing is to be transferred or for informing the consultant that shared care is declined. Patients must not be placed in a position where they are unable to obtain the medicines they need because of lack of communication between primary and secondary/tertiary care.

The shared care agreement should state 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). As part of the consent process, patients must be made fully aware of all monitoring requirements, in line with GMC guidance "Consent: Patients and doctors making decisions together" (see [https://www.gmc-uk.org/static/documents/content/Consent\\_-\\_English\\_0617.pdf](https://www.gmc-uk.org/static/documents/content/Consent_-_English_0617.pdf)).

## 2.7 Willing and informed consent of all parties, including patients and carers

This includes patients, carers and all clinicians involved in their care. Consenting parties must have sufficient, accurate, timely information in an understandable form. Consent must be given voluntarily.

Consultants and general practitioners (GPs) are encouraged to communicate directly where questions arise around shared care for a particular patient. If issues remain, after these discussions, the Chief / Senior Pharmacist at the borough and/or the provider (e.g. Hospital Trust) should be contacted for advice

## 2.8 Clear definition of responsibility

The areas of care for which each clinician has responsibility for should be clearly defined.

## 2.9 Clinical responsibility

Clinical responsibility for prescribing is held by the person signing the prescription, who must also ensure adequate monitoring.

## 2.10 Communication network and emergency support

Telephone contact details and (if appropriate) secure email addresses of both parties should be exchanged and recorded. This will enable the GP practice to access timely advice, guidance and information if problems arise, and enable secondary/tertiary care clinicians to easily contact the GP if necessary. This should include out-of-hours contact numbers e.g. how to access the on-call duty doctor. Patients and their carers should also be provided with contact details for support and help if required; both in and out of hours.

People should not be discharged from secondary/tertiary care whilst shared care is in place. The guideline should state how often the patient will be reviewed; and provide a 'route of return' should the patient's condition become less predictable (such as a return of symptoms or development of adverse effects).

## 3. Clinical information

This should include a brief overview of the disease and more detailed information on the treatment(s) being transferred including (as a minimum):

- Summary of NICE, BNF, SPC or other guidance, where applicable (and a web link to access the full guidance)
- Licensed indications and therapeutic class
- Dose, route of administration and duration of treatment
- Adverse effects (incidence, identification, importance and management)
- Cautions and contraindications
- Monitoring requirements and responsibilities
- Clinically important drug interactions and their management
- Peer reviewed references for product usage
- Contacts for more detailed information

## 4. Training

The commissioner of the service pathway should, in liaison with the secondary/tertiary care provider, ensure that adequate training and educational support is in place for the primary care multidisciplinary team, e.g. managing the disease, administration of the medicine etc. Information on how to access this should be provided in the shared care prescribing guidelines.

## 5. Resources

It should be recognised that resources available in practices are not uniform, and there may be impacts on both primary and secondary/tertiary 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 hospitals in situations where shared care is not accepted. If ongoing monitoring and prescribing are part of the shared care agreement, then the resources and capacity to ensure consistent delivery need to be determined before any shared care is implemented

## 6. Monitoring

All appropriate monitoring requirements must be fulfilled. The person delivering that aspect of the shared care agreement should ensure that the resources to do this are in place in the clinical setting in which they are delivered

## 7. Circumstances where shared care is not appropriate

[Adapted from 'Effective Shared Care Arrangements', Midlands Therapeutic Review & Advisory Committee.]

Possible circumstances where it may not be appropriate for a shared care agreement to be agreed, or where an exception to an agreement may be appropriate, so that the hospital/specialist retains responsibility for prescribing:

- Medicines requiring on-going specialist intervention and specialist monitoring.
- Patients receive the majority of on-going care, including monitoring, from the provider and the only benefit of transferring care would be to provider costs.
- Medicines which are unlicensed or are being used outside of product license (e.g. licensed medicine used for unlicensed indication or at an unlicensed dose), unless there is a recognised evidence base and/or it is standard treatment. In terms of paediatric medicines, inclusion of dosage guidance in the Children's BNF provides a suitable evidence base – see sections 12.1 and 12.2 of SWL Interface Prescribing Policy.
- Medicines which are only available through the provider, i.e. are not available on FP10, including any 'borderline' products when used outside approved indications.
- Medicines used as part of a provider-initiated clinical trial or the continuation of a provider-initiated clinical trial or compassionate use, where no arrangement has been made in advance with the commissioner to meet the extra cost of treatment.
- The GP has insufficient information to participate in a shared care prescribing arrangement where applicable.
- No shared care prescribing agreement exists
- The GP does not feel competent in taking on clinical responsibility for the prescribing of a specialist medicine.
- Medicines and other prescribable products which have not been approved for addition to the provider's formulary.
- PbR-excluded drugs and devices where shared care prescribing is not agreed.
- All anti-cancer medicines except where shared care prescribing or other agreements exist.
- Medicines subject to High-tech Hospital at Home guidance (EL(95)5).
- All other treatments funded by NHS England unless specifically agreed to be provided through a shared care prescribing agreement or other agreed process.
- Without collaboration and agreement with the patient and/or carer(s).
- Specified packages of care

## 8. **Process for approval of shared care prescribing arrangements (see page 7)**

When an Acute/Mental Health Trust\* or other specialist centre wish for a medicine to be prescribed in primary care, the suitability of this should in the first instance be assessed by members of the local Trust/borough Drugs and Therapeutics Committee, Medicines Management Committee, Mental Health Interface Prescribing Forum (MHIPF) or equivalent committee. These committees should always consider place of prescribing using the SWL Decision Support Tool (SWL Interface Prescribing Policy 2020/21 appendix 3) for any new medicine application and medicines already in use. This discussion should involve **primary and secondary/tertiary care clinicians and pharmacists** with the following possible outcomes:

- Hospital (or specialist) prescribing only (Note that defined specialists may prescribe in primary care settings)
- Suitable for development of a shared care prescribing guideline.
- Medicine suitable for GP prescribing. This may be supported by an information sheet or "Transfer of Care form" (see also SWL Interface Prescribing Policy 2020/21, section 15 and appendix 6). The process for developing information sheets or transfer of care forms is similar to the development of shared care prescribing guidelines shown in step 3-8 of the "Process for approval of SWL shared care prescribing arrangements" (page 7).

Recommendations on place of prescribing should be clearly documented in the minutes to allow sharing of decisions across the sector and a record should be kept of path followed using the SWL Interface Prescribing Policy 2020/21 appendix 3.

Any proposals for new shared care prescribing guidelines will require consideration of impact on the total care pathway, including any financial implications. As such providers will be expected to present relevant data as part of any new proposals before these can be considered. Anything with significant financial implications cannot be implemented unless considered and approved as part of the prioritisation round for the following year. SWL CCG will endeavour to ensure that any prescribing is in the most appropriate setting and that financial implications will be considered but should not normally be a barrier to achieving this.

The borough and provider should then share their joint recommendation and their rationale (using SWL Interface Prescribing Policy 2020/21 – appendix 3) with the CSU ISPS (Interface Secondary Care Prescribing Support) team, other boroughs and providers in the sector through the SWL Medicines Optimisation Group or alternative method if the decision falls in between committee meetings.

In instances where a shared care prescribing guideline is required ideally all, but as a minimum 3, SWL boroughs should agree that this is appropriate (using SWL Interface Prescribing Policy 2020/21 - appendix 3) after consideration of position of relevant SWL boroughs. Where 2 or less boroughs agree, the medicine should remain to be classed as hospital (or specialist) prescribing only and hence prescribing responsibility remains with the Trust or specialist service.

Before any shared care prescribing guidelines are developed, the SWL Medicines Optimisation Group should record in meeting minutes:

- Participating providers and boroughs. The aim is to develop one document that covers all relevant providers and boroughs that are using a particular medicine.
- Nominated provider and coordinating borough or CSU ISPS pharmacist (hereafter referred to as coordinating pharmacist) to lead the development of the shared care prescribing guideline. For non-mental health medicines this is usually the ISPS pharmacist unless there are mitigating circumstances.

Once it has been agreed that shared care prescribing would be appropriate, the Acute/Mental Health\* Trust or other specialist centre is responsible for producing the shared care prescribing guideline using the SWL Shared Care Prescribing Guideline template (see SWL Interface Prescribing Policy 2020/21 appendix 5B) with full engagement from the provider's Pharmacy department, colleague clinicians that are affected by the guideline, CSU ISPS team, borough Chief/Senior Pharmacist and borough nominated healthcare professional (usually a GP).

Once all above parties are in agreement, the coordinating pharmacist will subsequently circulate the shared care prescribing guideline to all relevant boroughs in the sector or the Mental Health Interface Prescribing Forum for comments (deadline for response max 2 months even if "no comments"). The document will have a version control (action control sheet) managed by the coordinating pharmacist and all participating organisations will be required to acknowledge the action control sheet and use tracked changes to indicate comments in the document.

The coordinating pharmacist will circulate the second draft with any outstanding issues or final version for subsequent approval and sign off through the relevant Acute Trust/borough Drugs and Therapeutics (or Medicines Management) Committee, or equivalent committee. Chief Pharmacists for the boroughs are responsible to coordinate sign off for own organisation and host provider and provide written (e-mail) confirmation back to the coordinating pharmacist. Note that documents should be signed off by borough and provider's Chief Pharmacists who will take the ultimate responsibility for accuracy of the document.

Coordinating pharmacist will circulate final signed-off version to all participating boroughs and providers. Borough/provider's Chief Pharmacists will ensure that all relevant clinicians are informed, ensure implementation and mediate/intervene in cases of non-compliance.

Any non-participating providers subsequently seeking shared care arrangements for the same intervention can adapt the agreed shared care prescribing guideline for local use and agree this with their host borough who will have to follow step 8 of the process described on page 7 (if no change other than adding contact details) or step 4-8 (if changes are made to the original document).

\*Please note that shared care prescribing guidelines produced by South West London and St. Georges (SWL StG) Mental Health Trust through the Mental Health Interface Prescribing Forum will only apply to the relevant boroughs of the SWL CCG.

**9. Documentation of agreements**

The “SWL Hospital/Specialist only drug list” and the list of “SWL Shared Care Prescribing Guidelines in place” can be found on [www.swlmcg.nhs.uk](http://www.swlmcg.nhs.uk). Both lists are being updated on a bimonthly basis. The presentation of these lists is subject to change.

**10. Review**

Shared care prescribing guidelines will be reviewed every 3 years or sooner if indicated.

# Process for approval of SWL shared care prescribing arrangements

Subject to review in 2020/21

Provider's/Borough Drugs and Therapeutics (or Medicines Management) Committee, Mental Health Interface Prescribing Forum (MHIPF) or other equivalent committee will consider place of prescribing for all medicines discussed and approved as follows:

1. For any medicine discussed, place of prescribing should be considered using SWL decision flow chart (App 3) with the following possible outcomes:
  - Hospital (or specialist) prescribing only (*note that defined specialists may prescribe in primary care settings*)
  - Suitable for development of shared care prescribing guidelines
  - Medicine suitable for GP prescribing (may be supported by an information sheet and/or "Transfer of Care form" (App 6))Recommendation on place of prescribing should be clearly documented in the minutes and a record should be kept of path followed using App 3.  
*Please note that this decision should have input from primary and secondary/ tertiary care clinicians and pharmacists.*

2. Relevant borough and provider to share their joint recommendation with the CSU ISPS team who will share with other boroughs and relevant providers in the sector.

**Hospital (or specialist) only prescribing:**  
To be submitted to SWL MOG for consideration and addition to SWL Hospital /Specialist only drug list.

**Suitable for development of shared care prescribing guideline:**

Each provider/borough to consider recommendation and respond to ISPS team within 2 months (using App 3 to substantiate (alternative) position). ISPS pharmacist to collate responses for submission to SWL MOG. Shared care prescribing guidelines will only be developed if 3 or more boroughs have agreed it is appropriate (using App 3) after consideration of position of relevant boroughs. Participating providers/boroughs, lead-provider and borough/CSU coordinating pharmacist (hereafter called coordinating pharmacist) who will develop document to be confirmed at SWL MOG.

**Medicines suitable for GP prescribing:**

SWL boroughs to consider and respond within 2 months if recommendation is considered inappropriate (using App 3).

SWL MOG = SWL Medicines Optimisation Group

3. If suitable for development of shared care prescribing guideline. Nominated Acute / Mental Health\* Trust(s) or specialist service provider produces draft shared care prescribing guideline (using template in App 5B) with full engagement from:
  - ISPS team Pharmacist
  - Provider (e.g. Hospital Trust) Chief Pharmacist
  - Colleague clinicians that are affected by the guideline
  - Healthcare professional from a nominated borough (usually a GP)

4. Coordinating pharmacist to circulate the draft shared care prescribing guideline directly to participating boroughs and relevant providers in the sector or the Mental Health Interface Prescribing forum for comments (deadline for response max 2 months even if "no comments").

5. Coordinating pharmacist to submit draft 2 with any outstanding issues (e.g. commissioning arrangements or other incompatibilities) for discussion and resolution to SWL Medicines Optimisation Group or Mental Health Interface Prescribing Forum.

6. Coordinating pharmacist to circulate final version to all participating boroughs and providers for sign-off.

7. Approve shared care prescribing guideline through the relevant Acute / borough Drugs and Therapeutics (or Medicines Management) Committee, Mental Health Interface Prescribing Forum or equivalent committee. Sign off by participating borough and provider Chief Pharmacists and lead clinicians. Chief Pharmacists for the borough to coordinate sign off for own organisation and host provider and provide written (e-mail confirmation) back to co-ordinating pharmacist.

8. Coordinating pharmacist to circulate final signed off version to all participating boroughs and providers. Chief Pharmacists to ensure that all relevant clinicians are informed. Guideline published via website.

Each shared care prescribing guideline should be reviewed every 3 years or sooner if indicated.

See also [www.swlmcg.nhs.uk](http://www.swlmcg.nhs.uk) for South West London Interface Prescribing Policy 2020 - 21

- Appendix 2: SWL Shared Care Prescribing Guidelines and Transfer of Care Agreements in place
- Appendix 3: Decision Support tool to determine place of prescribing
- Appendix 5B: Shared Care Prescribing / Transfer of Prescribing and Monitoring Guideline template
- Appendix 6: Transfer of Care template