HEALTH AND WELLBEING SCRUTINY COMMISSION

12 APRIL 2017

Report of the Leicester City Clinical Commissioning Group

Shared Care Agreements

Background

1. Shared care arrangements aim to facilitate the seamless transfer of individual patient care from secondary care to general practice. They are intended for use when complex medicines are prescribed for a sometimes complex condition and are initiated in secondary care (i.e., in hospital) and then prescribed by GP in primary care once the patient is considered stable. These medicines and conditions will require ongoing monitoring.

2. Shared care agreements were introduced through NHS Circular No 1992 (GEN) 11 *'Responsibility for Prescribing between Hospitals and GPs'* which states that a consultant should seek the agreement of the GP to share the care of a patient. Information regarding dosage, administration and monitoring should be provided by the consultant for the GP. Decisions about who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on the patient's best interests, rather than on convenience or cost of the medicine and associated monitoring or follow-up.
3. EL(91)127 "Responsibility for Prescribing between Hospitals and GPs.", from the Department of Health also states:

4. "When clinical and / or prescribing responsibility for a patient is transferred from secondary to primary care, the primary care prescriber should have the appropriate competence to prescribe the necessary medicines. Therefore, it is essential that a transfer of care involving medicines that a primary care prescriber would not normally be familiar with, should not take place without the sharing of information with the primary care prescriber and their mutual agreement to the transfer of care.

5. Examples of situations where this would apply include medicines:

    - prescribed for a potentially serious condition
    - that are complex [intended use likely to be out with the clinical experience of a GP]
    - that have relatively high adverse effect profile requiring monitoring
    - that may require specific monitoring and dose titration
    - that are new, or rarely prescribed
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6. Shared care agreements facilitate the care of patients closer to home for complex conditions and /or complex medicines and new medicines that GPs may not be familiar with. They are for conditions that a GP would not be expected to care for without secondary care input and for drugs that are not wholly appropriate for use without secondary care input to support the GP

7. Since this NHS circular every NHS organisations across the UK has shared care agreements in place. They can also be between other service providers of health, for

example Local Authority commissioned Drug and Alcohol Services and Sexual Health services.

8. Shared Care Agreements have been recognised practice in the NHS since 1992. In Leicestershire, and most other areas, there is a shared care agreement written specifically for each drug and/or condition (or groups of drugs for a condition) deemed suitable for shared care. This is so that all parties are aware of their responsibilities for sharing the care of patients.

9. Clearly defined processes and good communication are essential components to shared care. All prescribers must be aware of their responsibilities when prescribing all medicines and primary care prescribers must receive comprehensive information to allow safe and effective prescribing to take place. Primary care prescribers must feel competent to take on the prescribing, given that these are usually complex medicines for complex conditions, and therefore GP agreement is needed before care is transferred.

What is a shared care agreement?

10. Shared care is an agreement between the patient's GP and Consultant to use a certain medicine, for a given condition, in a predefined manner, where an approved guideline that has been co-authored in primary and secondary care is available.
    For example

11. Without a supporting guideline the full clinical responsibility lies with the person signing the prescription. Where is it not reasonable for the GP to take this responsibility (where the condition is complex or the drug is complex as described above) alone but with the support of a consultant team it is safe to do so, a shared care guideline is written. This is required because the prescriber signing the prescription takes full responsibility for prescribing without the shared care agreement

12. This document provides a clear framework as to what the GP will do and what the consultant will do to support the management of the patient. Therefore the GP has a document that shows that, although outside their normal area of competence, there is a safe plan in place to allow them to take clinical responsibility and sign the prescription. There must always be a quick contact route back to the consultant should there be complications that the GP does not feel competent to manage. A shared care agreement outlines ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and a primary care prescriber. Primary care prescribers are invited to participate.

13. If the GP is unable to undertake these roles, then he or she is under no obligation to do so. In such an event, the total clinical responsibility for the patient for that diagnosed condition remains with the specialist.

14. Primary care prescribers are advised <u>not</u> to take on prescribing of these medicines unless they have been requested to do so through a shared care agreement request form - which also includes their responsibilities with regards to monitoring, side effects and interactions.

15. Primary care prescribers should inform secondary care of their intentions as soon as possible by returning the completed form. Only then can transfer of care be arranged. This will ensure that there is absolute clarity as to who is taking over the prescribing, and any associated monitoring responsibilities.

16. Sharing of care assumes communication between the specialist, primary care prescriber and patient. The intention to share care is usually explained to the patient by the prescriber initiating treatment (in most cases the specialist clinician). It is important that patients are consulted about treatment and are in agreement with it. Patients should remain under regular follow-up in secondary care, where it is expected that the patients overall response to treatment, and continued need, will be monitored.

17. Prescribers are reminded that the doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.

Shared Care in Leicester Leicestershire and Rutland

18. In Leicestershire there are two types of shared care:
    - Full shared care, where a drug requires monitoring of the drug use and condition; or
    - Simple Shared care, where the drug requires no further monitoring but is only initiated by a Specialist consultant because of place in therapy defined by national or local guidance e.g. NICE guidance or Local formulary guidance

19. Before a drug can become a shared care drug there is a robust process to be followed to determine suitability for Shared care (full or simple) which consists of a Medicines information review of the medication to allow the members of the Drugs and Therapeutics Committee (Therapeutic Advisory Service) to complete a critical appraisal of the drug and to recommend to the Joint area prescribing committee (Leicestershire Medicines Strategy Group) whether a drug should be available for shared care.

20. A shared care agreement for each drug and or conditions is written which clearly defines the responsibilities for the specialist, the GP practice and the patient. With this is a shared care request from which must be completed by the specialist for a GP to consider taking on the care. The GP returns this whether they accept the shared care or not.

What conditions are they used for?

21. All areas of medicines use shared care agreements to some extent, although some clinical areas use them more than others e.g. Rheumatology and Mental Health. They are for specific conditions and drugs and provide details of the responsibilities for the consultant the GP and the patient. More details on SCAs can be found on www.lmsg.nhs.uk.

Table 1: Full shared care drugs

Area	Drug
Paediatric physical health	Amiloride (paediatric cardiology)
	Testosterone (paediatric)
	Lisinopril (paediatric cardiology)
	Spironolactone (paediatric cardiology)
	Captopril (paediatric cardiology)
	Furosemide (paediatric cardiology)
	Enalapril(paediatric cardiology)
	Losartan
	Azathioprine (paediatric gastroenterology)
	Mercaptopurine (paediatric gastroenterology)
Paediatric Mental Health ADHD etc	Atomoxetine
	Lisdexamfetamine
	Methylphenidate (paediatric)

	Dexamfetamine
	Guanfacine
Adult Mental Health	Amisulpride
	Antipsychotics (atypical)
	Antipsychotics (atypical) in personality disorder
	Aripiprazole long acting injection
	Aripiprazole oral
	Atomoxetine
	Dexamfetamine
	Donepezil
	Lisdexamfetamine
	Methylphenidate
	Venlafaxine (high dose)
	Zuclopenthixol decanoate
	Lithium
	Flupenthixol decanoate
	Fluphenazine decanoate
	Memantine
	Risperidone long acting injection Agomelatine
	Haloperidol decanoate
	Olanzapine
	Mianserin
	Methylphenidate
	Quetiapine
	Rivastigmine
	Paliperidone palmitate long acting injection
Rheumatology	Methotrexate oral
	Penicillamine
	Gold salts
	Azathioprine
	Hydroxychloroquine
	Sulfasalazine oral
	Leflunomide
Dermatology	Ciclosporin
	Methotrexate oral
	Azathioprine
Gastroenterology	Methotrexate oral (Crohn’s disease)
	Mesalazine oral
	Risperidone oral
	Azathioprine
	Balsalazide
	Mercaptopurine (adult gastroenterology)
	Sulfasalazine oral and rectal
Cardiovascular	Aliskiren
	Apixaban (DVT and PE)
	Dalteparin
	Rivaroxaban (DVT and PE)
	Sacubitril / valsartan
Endocrinology	Cabergoline
	Testosterone
	Cinacalcet
	Denosumab

Neurology	Bromocriptine
	Riluzole
	Modafinil
	Pramipexole
	Rotigotine

Shared care agreement engagement

22. Shared care is an agreement between two clinicians facilitated by the production of shared care agreement. Responsibilities are developed by multidisciplinary teams to support the GP in assessing whether they feel competent to take on the care with the support of the shared care agreement.

23. Most practices across Leicester, Leicestershire and Rutland accept most shared care agreement requests providing:

    - the information they contain is complete
    - the request is in line with the shared care agreement criteria endorsed in Leicester Leicestershire and Rutland
    - the patient is stable
    - the GP feels competent to take on the shared care..

24. Generally, refusal for shared care requests are for the reasons above and are normally resolved by the interface pharmacist, CCG Prescribing Advisors ,the GP and the specialist involved. This means:
    - missing information is provided and the shared care agreement is then normally accepted by the GP.
    - requests outside of the criteria for shared care agreements for the condition and/or medicine are retained by the specialist.
    - shared care is normally accepted once the specialist confirms that patient is stable.
    - where the specialist supports the GP in their competency and knowledge to take on the specific shared care.
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25. There are currently two practices in the city refusing most shared care. These are being worked with to address concerns and facilitate acceptance of shared care once their concerns are addressed.