NHS Shared care and specialist guided prescribing service specification - frequently asked questions.

Hertfordshire and West Essex (HWE) shared care documents are available on the Prescribing, Policies and Pathways (hweclinicalguidance.nhs.uk) website within the Shared Care, Decision Making & Advice and Guidance (hweclinicalguidance.nhs.uk) section. Shared care protocols may be HWE wide or place specific depending on service providers.
Some medicines in the NHS Shared care and specialist guided prescribing service specification have a prescribing support document in place as opposed to a shared care protocol. These are developed and updated with the input of both secondary and primary care clinicians and published on the Prescribing, Policies and Pathways (hweclinicalguidance.nhs.uk).

Please note that the current shared care template is being reformatted as requested to allow for patient, specialist, medication, and GP details to be at the beginning of the agreement, followed by the detail of the shared care guidance for that medicine. Existing approved shared care agreements will be updated to reflect this format change.

HWE ICB Principles for Shared Care includes:
The fundamental principle of 'shared care' across primary and secondary care is to put the safety of the patient first. The best interests, agreement and preferences of the patient should be at the centre of any shared care agreement.

- When should a provider organisation request to share care?

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.

Specialist responsibilities
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.
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).

Primary care responsibilities
Prompt completion and e-mailed return of signed response about shared care agreement to the specialist within two weeks of its receipt.

- Do GP practices need to request retrospective shared care agreements when a patient is on a shared care medicine but no formal shared care agreement available?

No. Retrospective signed documents do not need to be sought. If the practice accepted the prescribing and monitoring of the medicine without a formal shared care agreement in place (it could be there was not one in existence when they took over prescribing) the practice would need to ensure the medication is still appropriate for the patient with appropriate responsibilities, monitoring and action as per the most up to date shared care protocol.
Advice and guidance or referral back to the initiating specialist may be required. Existing arrangements for safe prescribing/monitoring should continue while awaiting specialist review. Patients on shared care drugs should be under the care of both secondary and primary care. i.e. not discharged from the specialist.

- Do GP practices need to request retrospective shared care agreements if a patient is on a shared care medicine with a historic protocol in place?

No. A signed copy of the most recent shared care does not need to be sought. The shared care agreement forms do not need to be updated if the shared care protocol has been updated (these are not legal documents). Clinical information and monitoring requirements may change, therefore the most up to date shared care protocol should be followed. This is the responsibility of the clinician prescribing and monitoring the medicine, as with any medicine.

- How should a GP practice manage a patient who is on a shared care medicine that has been started by an out of area provider, but there is no shared care agreement available?

Out of area providers may have agreed prescribing/monitoring arrangements for certain medicines that differ to the local arrangements agreed within HWE. If a patient was initiated on a medication from an out of area provider (where no shared care agreement may be in in place) clinical information, responsibilities, prescribing, monitoring, and action from that provider arrangements should be followed. This information will not have been through HWE internal governance processes and may have different information from HWE shared care protocols (although for consistency areas may follow national shared care guidance on monitoring) and if the GP practice prescriber has concerns relating to the prescribing or monitoring expectations for this medicine the ICB pharmacy team can be contacted for advice: hweicbhv.medicinesoptimisationteam@nhs.net.

- Can I share care with private providers?

For any patients initiated on medication by private specialists (i.e. self-referred or referred under private self-funded arrangements), the practice should be following the Hertfordshire and West Essex ICB (HWE) local guidance on requests for NHS prescribing following a private consultation.
HWE ICB does not support requests to share care between private and NHS prescribers. Shared care between a private consultant and an NHS GP is not supported because if the private part of care is interrupted (e.g., patient unwilling or unable to pay) then the GP is left without a partner to share

care with posing a risk to the patient and prescriber. HWE ICB has published a patient information leaflet that can be used to explain this position to a patient.

- Does a practice need to go back and code all patients on shared care medicines with the ECF recommended read code?

No. The code does not have to be applied retrospectively. It is acknowledged that a different code may have been used in the past. The coding is not used for service specification payment as payment is on a capitation-based method. The coding is to support practices to have an up-to-date list/register of patients, including new patients on shared care medicines. Practices may code patients not previously coded, and a pragmatic approach could be to apply the code when reviewing the patient.

- Changes to the list of medicines within the service specification

There are no changes to the list of medicines included in the 25/26 service specification compared to 24/25 service specification. There have been some minor amendments to the monitoring parameters for some of the medications which are highlighted in yellow in the summary table within the specification. These amendments have all been decreases in monitoring frequencies and clarification of responsibilities. These have been made following updates and development of shared care protocols and prescribing support documents which have been discussed and approved at the area prescribing committee (APC).

The service will be reviewed annually to consider any new recommendations made by the Hertfordshire and West Essex Area Prescribing Committee (APC) that may impact on the list and levels of included drugs.

The service can be reviewed in year if there are new medicine(s) identified by APC requiring shared care monitoring or a meaningful change of monitoring for existing shared care medicine(s).

All prescribing pathways that may include shared care arrangements are discussed at APC and are sent for consultation to community, primary, and secondary care colleagues as well as the LMC. The APC incudes system wide stakeholders (that receive consultation papers and are invited to meetings) including provider consultants, GPs, patient representatives and LMC representatives.

Liaison with LMC will be undertaken before any changes to the list and service are considered at the primary care commissioning committee including payment amendments where appropriate.

- We are having issues with certain shared care medicines in certain patients, how can this be resolved?

Each individual shared care protocol has contact details for the secondary care clinicians involved in the patient's care. In the first instance please refer to the original shared care protocol which should be available in the patients notes, and the shared care/ prescribing support templates which can be found on the Prescribing, Policies and Pathways (hweclinicalguidance.nhs.uk) website.

If after contacting the initiating clinical team there are still unresolved issues please email hweicbhv.medicinesoptimisationteam@nhs.net with specific queries which can be referred to be raised at interface meetings. These meetings are attended by primary and secondary care clinicians and can help to facilitate resolution.

If the provider does not fulfil their responsibilities as per the agreed shared care protocols, then the patients will be returned back to the provider to manage as per the route of return as outlined in the protocol.

- Do any of the medicines in the NHS shared care and specialist guided prescribing medicine service delivery specification require primary care to undertake ECGs?

None of the medicines included within the shared care and specialist guided prescribing enhanced service include routine ECG monitoring requirements by primary care.

Amiodarone and dronedarone shared care has been developed and implemented. Whilst an ECG is required to monitor these medicines, primary care is not required to undertake the ECG (it is the responsibility of the specialist), however in the interests of patient safety, primary care should nevertheless confirm it is undertaken by the specialists as per frequencies specified.

Ivabradine prescribing support has been developed and implemented and primary care are not required to undertake routine ECGs (where irregular pulse is detected, consider ECG and/or seek advice from specialist team).

- Why would primary care need to ensure the specialist has undertaken the ECG?

These medications may cause a worsening of treated arrythmias/onset of new arrhythmias therefore regular ECGs are required to ensure the medication is still safe to continue to prescribe for the patient.

- How can I prepare for a CQC inspection in relation to high-risk drug monitoring?

Ardens reports are available for a significant number of searches for central alerting system (CAS) and MHRA alerts, prescribing safety, and CQC inspection searches. These searches can be used by GP practices to identify patients who are potentially at risk from not having care delivered in line with national guidance. **These searches should not be relied upon by GP practices as their only governance process.** See the Ardens CQC website for more information about how to access these searches in collaboration with the CQC - GP mythbuster 12: Accessing medical records during inspections - Care Quality Commission (cqc.org.uk). **Clinicians and relevant practice staff should additionally refer to local shared care protocols for guidance on monitoring and review requirements.**

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