NHS South West London (SWL) Interface Prescribing Policy

Appendix 5.1: Principles of Shared Care

The shared care principles within this document reflect the 'RMOC Shared Care for Medicines Guidance - A Standard Approach' principles which have been widely consulted and agreed nationally.

The principles are intended to apply to both national and local shared care guidelines and to provide a framework for the sharing of care between a hospital or specialist service setting with general practice, where this is appropriate and in the best interest of the patient.

SWL acknowledges that the national principles should be considered with following in mind:

- 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 should continue to provide prescriptions until sharing of responsibilities occurs (section 4.1).
- Resources need to be considered, and there may be impact on both primary and secondary/ specialist care (sections 1.5, 5.3 and 8.7). Section 8.7 gives more detailed information on resource needs in SWL.
- The primary care prescriber should only agree to shared care if they feel clinically confident in managing that condition in line with GMC guidance "Good practice in prescribing and managing medicines and devices (2021)" (section 8.1).

The complete South West London process for approval of shared guidelines in outlined in Section 7. Where thought to be helpful, and in discussion with local providers, additional implementation support is included in Section 8.

1. 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 and local list (appendix 2) 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 will continue to be identified by SWL Integrated Medicines Optimisation Committee SWL IMOC) (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 these guidelines. 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 (see also section 6.3.13).

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. (see also section 4.1)

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 likely to be unusual, and not in the best interests of the patient, provided the SCP in question is of high quality and in line with this guidance (see also section 8.1 and 8.7).

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 (See also section 8.1).

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 5.5) 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 (See also section 8.1).

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 2.

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 5.2.

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 5.3. See also section 4.1 and 8.3.

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 5.4. 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 (see also section 8.3).

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 (see also section 4.1).

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 (see also section 8.3).

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 (see also section 8.7).

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
- see also section 8.7

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.

7. [Local] Process for approval of shared care prescribing arrangements

7.1 SWL shared care guidelines

When the Clinical Network, Joint Formulary Committee (JFC) or a sub-group of the IMOC wish for a medicine to be prescribed in primary care, the suitability of this should in the first instance be assessed by the Clinical Network (or equivalent, e.g. with the SWL primary and secondary care clinical leads and pharmacists where a formal Clinical Network does not exist, to ensure a joint decision making process).

The Clinical Network (or equivalent) should always consider place of prescribing using the SWL Decision Support Tool (SWL Interface Prescribing Policy 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, 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 3-7 of the "Process for approval of SWL shared care prescribing arrangements" (page 14).

Recommendations on place of prescribing should be clearly documented in the Clinical Network, JFC (or equivalent) minutes to allow sharing of decisions across the sector and a record should be kept of path followed using the SWL Interface Prescribing Policy 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 ICS 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.

Engagement with the Local Medical Committee (LMC) is recommended for the development of new shared care or there is a change of red/amber/ green (RAG) rating.

The Clinical Network, JFC (or equivalent) should then share their recommendations and their rationale (using SWL Interface Prescribing Policy 2020/21 – appendix 3) with the SWL IMOC for agreement. Any clinical or financial risks should be clearly presented to SWL IMOC.

In instances where a shared care prescribing guideline is required, ideally ***all*** (but as a minimum the number required as per the Clinical Network/ JFC/ SWL IMOC terms

of reference) should agree that this is appropriate (using SWL Interface Prescribing Policy 2020/21 - appendix 3) after consideration of position of relevant members.

Before any shared care prescribing guidelines are developed, SWL IMOC should record in meeting minutes:

- Any agreement, concerns/objections raised. The aim is to develop one document that covers all relevant providers and boroughs that are using a particular medicine within the ICS.
- Nominated provider and borough coordinating pharmacist to lead the development of the shared care prescribing guideline.

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 RMOC shared care template (appendix 5.5) with full engagement from the provider's Pharmacy department, colleague clinicians that are affected by the guideline, borough co-ordinating 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 and Trusts 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 SWL IMOC.

Coordinating pharmacist will circulate final signed-off version to all 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.

*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.

7.1.1 Step by step process for approval of SWL shared care prescribing arrangements

To be used in combination with 7.1 above

a. Proposal for shared care identified at Clinical Network, Joint Formulary Committee (JFC) or a sub group of the SWL Integrated Medicines Optimisation Committee (IMOC), e.g. Mental Health Interface Forum
b. For any medicine discussed, place of prescribing should be considered using SWL decision flow chart (appendix 3) with the following possible outcomes:

Hospital (or specialist) prescribing only (note that defined specialists may prescribe in primary care settings)

- To be submitted to Clinical Network (or equivalent) for agreement and then SWL IMOC for consideration and addition to SWL Hospital /Specialist only drug list.

Suitable for development of shared care prescribing guidelines

- Proposal for shared care to be presented at Clinical Network (or equivalent) for agreement.
- Proposals supported by clinical network to be presented at SWL IMOC.
- Each provider/borough to consider recommendation (using App 3 to substantiate (alternative) position.
- Where a shared care prescribing guideline is required, ideally all (but as a minimum the number required as per the Clinical Network/ SWL IMOC terms of reference) should agree that this is appropriate after consideration of position of relevant members.
- Nominated provider and borough coordinating pharmacist to lead the development of the shared care prescribing guideline to be confirmed at SWL IMOC.

Medicine suitable for GP prescribing (may be supported by an information sheet and/or "Transfer of Care form" (appendix 6)

- To be submitted to Clinical Network (or equivalent) for agreement and then SWL IMOC for consideration and approval.

c. Recommendation on place of prescribing should be clearly documented in the minutes of Clinical Network, JFC or similar equivalent, and a record should be kept of path followed using appendix 3. Engagement with the LMC is recommended for new shared care or if a change in RAG rating is recommended. The proposal should then be brought to SWLIMOC for agreement before taking forward (see below). Please note that this decision should have input from primary and secondary/ tertiary care clinicians and pharmacists.
d. 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 RMOC shared care template in appendix 5.5) with full engagement from:
    - Provider (e.g. Hospital Trust) Chief Pharmacist
    - Colleague clinicians that are affected by the guideline
    - Borough co-ordinating Pharmacist
    - Healthcare professional from a nominated borough (usually a GP)
e. Coordinating pharmacist to circulate the draft shared care prescribing guideline directly to Clinical Network (or equivalent), relevant boroughs, relevant providers in the sector or the Mental Health Interface Prescribing forum for comments, and other stakeholders (deadline for response max 2 months even if "no comments").
f. Coordinating pharmacist to submit draft 2 with any outstanding issues (e.g. commissioning arrangements or other incompatibilities) for discussion and resolution to SWL IMOC or Mental Health Interface Prescribing Forum.
g. Final version approved at SWL IMOC.

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

7.2 National shared care guidelines

On behalf of the national RMOC system, RMOC (North) is leading on the development of national shared care protocols. A pharmacist from SWL should be a member of the RMOC shared care working group to ensure the ICS is sighted on the work under development.

Consultations on draft shared care guidelines should be shared with Clinical Networks, SWL IMOC, relevant borough and Trust pharmacists to share within their networks. Any comments received should be shared with the RMOC shared care working group within the specified timeframes.

Once a final version is produced, this should be discussed with relevant Clinical Networks, borough and Trust pharmacists for sharing within their networks, for consideration of any local adaptions required. Engagement with the LMC is recommended for new shared care or if a change in RAG rating is recommended. Recommendations should then go to SWL IMOC for approval

The SWL RMOC shared care working group member will circulate the final signed-off version to all boroughs and providers. Borough/provider's Chief Pharmacists will ensure that all relevant clinicians and Clinical Networks are informed, ensure implementation and mediate/intervene in cases of non-compliance.

7.2.1 Step by step process for approval of national shared care prescribing arrangements

To be used in combination with 7.2 above

a. Consultations on draft shared care guidelines shared with Clinical Networks, SWL IMOC, relevant borough and Trust pharmacists to share within their networks.
b. Any comments to be shared with the RMOC shared care working group within the specified timeframes.
c. Final version to be discussed with relevant Clinical Networks, relevant borough and Trust pharmacists for sharing within their networks, for consideration of any local adaptions required. Engagement with the LMC is recommended for new shared care or if a change in RAG rating is recommended. Recommendations to go to SWL IMOC for approval.
d. SWL RMOC shared care working group member will circulate final signed-off version to all boroughs and providers. 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.

8.[Local] Implementation support

Application of the principles of shared care will facilitate effective shared care The following is additional guidance to help support local implementation and should be used in conjunction with the principles of shared care.

8.1 The primary care prescriber should only agree to shared care if they feel clinically confident in managing that condition in line with GMC guidance "Good practice in prescribing and managing medicines and devices (2021)"

8.2 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 "Decision making and consent". Transfer of clinical responsibility to primary care should only be considered where a patient's clinical condition is stable or predictable.

8.3 The primary care prescriber should confirm the agreement and acceptance (or decline where appropriate) the shared care, *ideally* within 14 days of the request, wherever possible.

8.4 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.

8.5 Consultants and primary care prescribers 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.

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

8.7 Resources need to be considered, and there may be impact on both primary and secondary/ specialist care. It is acknowledged that sufficient resources are required to support the additional workload and training which may be associated with some shared care. Commissioning arrangements should be negotiated and agreed locally

8.7.1 Participation will depend on adequate resources being available to support work being transferred to primary care

8.7.2 Prescribers are not expected to be asked to participate in shared care where there are insufficient resources available to support the additional workload associated with shared care

8.7.3 Any training associated with implementing a shared care protocol will be appropriately resourced.

See also South West London Interface Prescribing Policy

Appendix 2	Shared Care Prescribing Guidelines and Transfer of Care Agreements in place (national and SWL)
Appendix 3	Decision support tool to determine place of prescribing

Appendix 5.2 -5.4	available via Shared Care for Medicines Guidance – A Standard Approach (RMOC) or via the following direct links:
Appendix 5.2	RMOC letter from secondary to primary care
Appendix 5.3	RMOC primary care agreement letter
Appendix 5.4	RMOC primary care refusal letter
Appendix 5.5	RMOC template shared care protocol
Appendix 6	SWL Transfer of Care template

Document History

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