HUMBERSIDE LMCs
Informed and supported local practices

Shared Care - LMC Advice Sheet

What is shared care?

Shared care is a collaborative clinical arrangement between primary care and another provider e.g. secondary care, mental health. A specialist typically initiates a patient's treatment, and a GP may agree to continue prescribing and monitoring once the patient is stable. The GP can access advice and ongoing care for the patient via a distinct route to the Consultant. The model is designed to allow patients to be managed closer to home with appropriate safeguards, funding, and clearly articulated responsibilities on all sides.

Key points about shared care for GPs

- GPs are *not* contractually obliged to accept shared care.
- GPs have a professional duty to ensure they are competent, have adequate information, and feel confident before accepting responsibility under a shared care arrangement. They must keep informed about medicines prescribed for the patient, be able to recognise side effects, ensure appropriate monitoring is in place, and stay up to date with relevant guidance.
- The GP who signs the prescription assumes full clinical and legal responsibility. They must be prepared to explain and justify their decisions and actions.
- The Consultant or specialist team remains responsible for parts of the patient's care. These should be defined in the shared care agreement and usually include any changes to the medication regime, or any complications related to the medication.
- If a GP feels that it is not appropriate for any reason for them to take on shared care, then the patient's continuing care, including prescribing, would remain with the specialist service.

What factors do GPs need to consider before accepting a shared care arrangement?

GPs in a shared care arrangement assume full clinical and legal responsibility. In addition to ensuring their own competence in managing the conditions, they need to check that the proposed shared care agreement covers the following:

- Care will be truly shared with the consultant or specialist team, with this clearly defined in the shared care agreement
- The patient has been appropriately stabilised or controlled under specialist management before the GP takes responsibility for shared care maintenance
- Treatment is reviewed regularly at defined intervals and decisions around discontinuing treatment made when appropriate.
- Clear routes for communicating test results, changes in clinical condition or any other concerns are articulated.

Requests from local NHS providers

Practices should have agreed to the HNY Shared Care Local Enhanced Service (LES) specification before undertaking shared care with local NHS providers. If your practice is not signed up to the HNY Shared Care LES, you will not receive any funding for taking part in a shared care agreement but are still free to do so. However, our advice would be to not undertake shared care without this LES contract. If you are not currently signed up to this LES and wish to, please contact your ICB Place team.

What does "good" look like?

HNY ICB have created a document on the principles for sharing of care related to prescribing of medication, which you can find here. While this clearly outlines what to expect within our local system, the guidance comes from national recommendations and can be relied upon when assessing requests from out of area providers as well. It also includes template letters that practices can use to respond to requests.

We recommend having a read of this and making sure whoever in your practice deals with shared care agreements has a copy to hand.

What medications come under shared care?

Drugs that fall under shared care are locally classified as 'Amber – shared care protocol' (AMB-SCP). For a full list see Appendix B of the shared care service specification. Any drug not on this list cannot be prescribed under a shared care arrangement. The list is regularly reviewed and updated by the Area Prescribing Committee.

Other 'Amber' categories (Amber 1 and 2) exist for drugs that require either initiation by an appropriate hospital specialist or can be started on their recommendation but may not require ongoing specialist review. These drugs do not require shared care protocols because any monitoring requirements are considered as relatively standard primary care activity.

What are the grounds to refuse a shared care arrangement?

For those practices signed up to the HNY Shared Care LES, exclusion criteria are set out in the shared care service specification (3.4). These include:

- Patients being treated privately
- Patients receiving a qualifying drug but none of the prescribing or monitoring for that drug has been done by the GP practice during the relevant financial year
- The ICB does not routinely commission that drug for the specified indication.

If your practice is signed up to the Shared Care LES, you have indicated you are willing to consider shared care agreements from local NHS services. Each request must be reviewed and responded to individually. You cannot adopt a blanket position e.g. "*we don't accept shared care for X condition*" as this is potentially discriminatory against a specific group of patients.

Can I stop an existing shared care arrangement?

Yes. It is advisable that all current shared care arrangements are reviewed by your internal practice processes on an annual basis, to confirm the correct paperwork is held, that there have been no changes and there is appropriate follow up and monitoring. There are some circumstances where a practice may decide to give notice on an agreement. These include but are not limited to:

- The patient has been moved to a medication that is not on the ICBs shared care LES/ not on the formulary for GPs to prescribe
- The patient is moved to a medication that the practice feels lies outside their expertise
- There are concerns around patient concordance with monitoring and reviews
- The specialist has not completed their aspect of the agreement, or has been unresponsive/unhelpful when contacted
- There are workload pressures on the practices sufficient to impact the ability to maintain safe shared care arrangements.

In such situations, it is important the practice clearly documents the reasons for their decision and allows a reasonable period to notify both the patient and specialist. We recommend a minimum of 3 months' notice is given to allow transitional arrangements to take place, ideally 6 months. Practices are encouraged to contact the LMC for support in such situations as there is a high likelihood of complaints if the correct process is not followed.

Who do I contact regarding any issues with shared care?

Practices experiencing difficulties with shared care arrangements can contact the LMC for advice and support via **humberside.lmcgroup@nhs.net**. If you have specific questions regarding medication, you can also contact the ICB pharmacy team by email hnyicb.prescribingqueries@nhs.net

Requests from out of area NHS providers

GPs may be asked to agree to shared care arrangements by out of area NHS providers. This may include those working under a Right to Choose (RTC) referral system (please see our separate RTC guidance), out of area NHS secondary or tertiary centres e.g. gender identity services (see our gender prescribing guidance summary).

- GPs should be mindful of their own clinical competence and workload capacity when considering agreeing to enter into such an arrangement.
- Practice capacity to safely take on the associated workload of both prescribing and monitoring requirements should also be taken into account.

- It is important that GPs are assured that care will be truly shared with the out of area provider and that patients will be monitored satisfactorily.
- Regardless of the NHS providers location, shared care must still fulfil its purpose i.e. to provide an agreed and defined partnership in managing and monitoring a patients care. There must be clearly defined roles and responsibilities on both sides with ongoing input and support from the specialist team.

Requests from NHS Right to Choose providers

In most cases patients have the legal right to choose the hospital, service, or team they would like to go to for elective care. Many alternative NHS providers are actually independent private providers holding an NHS commissioned contract from an ICB elsewhere in the country.

Shared care requests have become increasingly common particularly with ADHD, gender, and autism referrals.

- GPs should be mindful of their own clinical competence and workload capacity when considering agreeing to enter into such an arrangement.
- Practice capacity to safely take on the associated workload of both prescribing and monitoring requirements should also be considered.
- It's important that GPs are assured that care will be shared with the out of area provider and that patients will be monitored satisfactorily.

Please see our separate guidance for further detail on Right to Choose referrals.

Requests from private providers

NHS shared care protocols do not apply to private provider., but GPs should consider extrapolating the principles of such an agreement to share care with a private provider. GPs can therefore agree if they feel competent and confident in the private provider.

The LMC has an advice sheet on the private provider interface which includes FAQs for patients requesting a private referral – download the Private Provider Interface factsheet here.

Practice approach

In the interests of fairness, consistency, and patient safety it may be useful for practices to have an agreed practice policy and review process for assessing requests for shared care with NHS or private providers.

The LMC suggests that practices may wish to consider including the following factors in their decision making when reviewing requests.

- Has the specialist sought agreement of the GP before transferring any care or prescribing?
- Are you signed up to an LES that includes this medicine? (this would only apply to NHS providers).
- Is the patient established on the treatment with a stable clinical condition?
- Do you feel that the prescribing and awareness of all side effects and complications falls within the scope of your medical practitioners' professional competence and their workload capacity?
- Are there adequate resources, training, and sufficient capacity for the work of managing safe systems for monitoring and prescribing for this medication in your practice before care is transferred?
- For NHS providers, are they locally commissioned or approved by your ICB as working in line with UK best practice and local prescribing guidelines/shared care protocols?

For private providers – note that shared care with private providers is unfunded work outside the GP core contract

- Are you satisfied that the provider has demonstrated to you that it is appropriately accredited, practicing in line with UK best practice and will prescribe and monitor patients in line with locally agreed pathways apply?
- How would you manage prescribing if a patient, for whatever reason, is unable to continue follow up with a private provider?
- Have you shared with the patient the LMC's FAQ document on receiving care from a private provider?

Appendix 1: Example Shared Care Checklist for Practices

Consideration	**Y/N**
The specialist has sought agreement of the GP and made clear the nature and responsibilities of each party of the shared care arrangement before transferring any care or prescribing and you feel assured by what you have seen.	
Are you signed up to a shared care LES that includes this medicine? (this would only apply to NHS providers).	
Is the patient established on the treatment? Is their clinical condition stable?	
Do you feel that the prescribing and associated knowledge required falls within the scope of your team's professional competence?	
Do you feel this falls within your team's workload capacity?	
Are there adequate resources and sufficient capacity for the work of managing safe systems for monitoring and prescribing for this medication in your practice?	
For NHS providers, are they locally commissioned or have they been approved by your ICB as working in line with UK best practice and local prescribing guidelines/shared care protocols?	
For private providers are you satisfied that the provider is appropriately accredited, practicing in line with UK best practice and will prescribe and monitor patients in line with locally agreed pathways?	

If the answers to all of these are satisfactory then a GP Practice would be likely to approve the request for shared care. If one or more of these considerations is not met, then it would seem sensible to decline the transfer.

In this case then the specialist will need to continue to prescribe and monitor.

Appendix 2: Shared Care Agreement Letter (Primary Care Prescriber to Specialist)

Primary Care Prescriber Response

Dear *[insert Doctor's name]*

Patient *[insert Patient's name]*

NHS Number *[insert NHS Number]*

Identifier *[insert patient's date of birth and/oraddress]*

Thank you for your request for me to accept prescribing responsibility for this patient under a shared care agreement and to provide the following treatment:

Medicine	Route	Dose & frequency

I can confirm that I am willing to take on this responsibility from *[insert date]* and will complete the monitoring as set out in the shared care protocol for this medicine/condition.

Primary Care Prescriber signature: ______________________________

Date: ___________

Primary Care Prescriber address/practice stamp

Source: What Good Looks Like/ Principles for Sharing of Care Relating to Prescribing of Medication – Shared Care Protocols (Humber and North Yorkshire Integrated Care Partnership Area Prescribing Committee)

Appendix 3: Shared Care Refusal Letter (Primary Care Prescriber to Specialist)

Re*:*
Patient *[insert Patient's name]*

NHS Number*[insert NHS Number]*

Identifier *[insert patient's date of birth and/oraddress]*

Thank you for your request for me to accept prescribing responsibility for this patient.

In the interest of patient safety NHS *[insert ICB name]***,** in conjunction with local acute trusts have classified *[insert medicine name]*as a Shared Care drug and requires a number of conditions to be met before transfer can be made to primary care.

I regret to inform you that in this instance I am unable to take on responsibility due to the following:

		Tick which apply
1.	**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.** As the patient's primary care prescriber, I do not feel clinically confident to manage this patient's condition because *[insert reason]*. I have consulted with other primary care prescribers in my practice who support my decision. This is not an issue which would be resolved through adequate and appropriate training of prescribers within my practice. **I have discussed my decision with the patient and request that prescribing for this individual remain with you as the specialist, due to the sound clinical basis given above.**	
2.	**The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement.** As the medicine requested to be prescribed is not included on the APC list of shared care drugs, I am unable to accept clinical responsibility for prescribing this medication at this time.	

	Until this medicine is identified either nationally or locally as requiring shared care, the responsibility for providing this patient with their medication remains with you	
3.	**A minimum duration of supply by the initiating clinician** As the patient has not had the minimum supply of medication to be provided by the initiating specialist, I am unable to take clinical responsibility for prescribing this medication at this time. Therefore, can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. ***Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.***	
4.	**Initiation and optimisation by the initiating specialist** As the patient has not been optimised on this medication, I am unable to take clinical responsibility for prescribing this medication at this time. Therefore, can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. ***Until the patient is optimised on this medication, the responsibility for providing the patient with their medication remains with you.***	
5.	**Shared Care Protocol not received** As legal responsibility for clinical care lies with the clinician who signs the prescription, I need to ensure that I am in possession of sufficient clinical information for me to be confident to prescribe this treatment for my patient and it is clear where each of our responsibilities lie to ensure the patient is safely managed**.** For this reason, I am unable to take clinical responsibility for prescribing this medication at this time, therefore would you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. ***Until I receive the appropriate SCP, the responsibility for providing the patient with their medication remains with you.***	
6.	**Workload levels in general practice** As a practice we follow the British Medical Association's Safe Working Guidance. This guidance recognises practices are operating within limited resources, but also the need to stay within the requirements of the GMS/PMS contract. This allows us to prioritise our limited capacity to deliver safe, high-quality care. We make individualised decisions based on the collective needs of our patients and practice. Unfortunately, at this time as we are unable to accept your request due	

	to our workload levels. ***The responsibility for providing this patient with their medication therefore remains with you.***	
7.	**Other (***Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted***)**	

I would be willing to consider prescribing treatment for this patient once the above criteria have been met or if the situation alters.

NHS England 'Responsibility for prescribing between Primary & Secondary/Tertiary care' guidance (2018) states that "when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore essential that a transfer involving medicines with which GPs would not normally be familiar should not take place without full local agreement, and the dissemination of sufficient, up-to-date information to individual GPs." In this case we would also see the term GP being interchangeable with the term Primary Care Prescriber.

Please do not hesitate to contact me if you wish to discuss any aspect of my letter in more detail and I hope to receive more information regarding this shared care agreement as soon as possible.

Yours sincerely

Primary Care Prescriber signature: ______________________________

Date: ___________

Primary Care Prescriber address/practice stamp

Appendix 2 & 3 sourced from: What Good Looks Like/ Principles for Sharing of Care Relating to Prescribing of Medication – Shared Care Protocols (Humber and North Yorkshire Integrated Care Partnership Area Prescribing Committee)

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