Approved date: January 2014
Review date; January 2016

PROCESS FOR DEVELOPMENT AND APPROVAL OF SHARED PRESCRIBING ARRANGEMENTS ACROSS SOUTH EAST LONDON

Need for Shared care identified

- Requirement for shared prescribing identified by South East London Area Prescribing Committee (SEL APC) New Drug's Panel (NDP) or the triage panel following consideration of formulary request, using "to share or not to share care" flowchart as a guide.
- The requirement will fall into one of three categories: (i) Full Shared Care Guideline (ii) Transfer of Care agreement (iii) Single information sheet for GP practices. **The term "shared care" is used in this document as reference to all three categories.**

Development of shared care

- Where a drug is supported by the NDP as amber, the applicant will be advised that implementation will be dependent on development of shared care guidance. The drug will **not** be added to the formulary until shared care guidance is approved.
- The process for commenting on and approving shared care guidance should take no longer than **3 months.** This timescale will start once a **first draft** of the document is available.
- Hospital and CCG leads will be nominated at the NDP meeting to lead and support development of shared care.
- Requesting clinician and lead Trust pharmacist to lead development of shared care document (using appropriate template) and to liaise **from the beginning** with identified CCG lead during the development process.
- Authors to keep SEL APC informed and updated on progress via the monthly NDP meetings.

Development Considerations

Draft document stage:

- All SEL member organisations **must** be consulted and feedback should be documented using the "comments tracker". Individual NDP members should facilitate this process.
- The draft must be consulted on and signed off by the six individual CCGs in SEL to allow consideration of local implementation issues. This should help facilitate implementation of shared care, for example, by improving the willingness of practices to participate in shared care at a borough level.
- The CCG lead involved in development of the guidance will be responsible for co-ordinating and collating comments from other SEL CCGs using the comments tracker. This results in a more streamlined process for sharing comments with the document authors and will help prevent duplication. Feedback from CCGs should be returned **within 1 month**.
- Comments should be addressed by authors using the comments tracker. Comments should be addressed **within 1 month** of being received, and the NDP could be used to help resolve specific issues.

Final document stage:

- Once comments have been addressed, the final document should be taken to the next appropriate SEL NDP meeting for sign off, with a copy of the completed comments tracker.

Final Approval

- Final document approval will be via SEL APC, meetings are held quarterly but once final approval is received from the NDP, APC approval could be completed through Chair's action to expedite the process if required.
- SEL APC logos will be added to the final documentation.

Once approved

- Organisations should take the document to their individual Medicines Management Committees (or equivalent) for information.
- Process for implementing the shared care guidance to be agreed internally by individual Trusts. This includes inclusion of shared care guidelines on organisational websites.

Audit and Review

- Shared care related documents should be reviewed every 3 years or earlier if issues are identified through use of the shared care guidance or there is a change in practice, prescribing advice or the evidence base.
- From February 2014, the APC will be responsible for managing a database of shared care guidelines and their expiry dates.
- The review process should start **6 months** before the guideline is due to expire and will follow the process described for initial approval.
- The Trust (document owners) will take responsibility for updating the document, with CCG support.
- CCG medicines management teams will consider any audit and monitoring requirements for individual shared care guidelines.

What is shared care?

Shared care is not necessary for all medicines. It may be required for medicines initiated by a hospital specialist and prescribed for potentially serious conditions. Some medicines have a relatively high adverse–effect profile and require specific monitoring and dose titration, for example methotrexate. These medicines may be the subject of shared care guidelines requesting the transfer of prescribing to a primary care prescriber. A shared care agreement outlines clear definition of responsibilities for managing the prescribing of a complex medicine between the specialist, a prescriber in primary care and the patient. All shared care should be discussed with the patient from the start. Effective communication is vital for shared care to work. **See BOX 1 & 2.**

To share care or not to share care in South East London?

Is the drug going to be taken through SEL APC processes?

NO → Contact your Trust Formulary Pharmacist or, for CCG queries, contact relevant CCG Chief Pharmacist for further advice

YES → What are the patient numbers associated with the use of this drug?

LOW (<2 patients /100,000 population) → **Shared care not appropriate.** Consider alternative management strategies, such as an individualised management plan that is agreed between the specialist and the individual patient's GP.

HIGH → Does the drug require **specialist** involvement for patient selection, initiation, stabilisation and monitoring?

NO → Are there concerns about the drug e.g. safety, affordability for local health economy*?

YES → Is monitoring required on a regular, on-going basis and/or assessment for effectiveness/toxicity?

YES → **Consider shared care**

NO → **Consider transfer of care**

NO → **Shared care not required** GP Information sheet could be considered on case by case basis

YES → **Consider transfer of care**

*In some situations transfer of care will be necessary to ensure that use of a drug remains within locally agreed criteria and pathways to enable fair and equitable use of limited NHS resources (e.g. NOACs).

BOX 1: Additional points to consider when deciding if shared care is required:

Shared care is NOT appropriate if:

- The majority of the patient's on-going care is being delivered by the hospital e.g. regular hospital outpatient attendances, prescribing responsibility should remain with the hospital in these circumstances.
- The drug is included as part of the tariff paid to the provider trust for a service.
- The drug is designated **red** on the RAG list (specialist/hospital only). Only drugs designated **amber** are suitable for shared care or Transfer of Care
- The drug is only available via hospitals
- The drug is undergoing or included in a hospital based clinical trial
- The specialist considers that only they are able to monitor the patients response to medication because, for example, of the need for specialised investigations
- The drug is subject to high-tech hospital at home guidance, EL(95)5
- Unlicensed drugs except where a substantial body of evidence exists to support the use of an unlicensed medicines or a licensed medicine outside its licensed indications e.g. paediatrics. The GP may be asked to prescribe in these circumstances

BOX 2: Other points to consider

- Are other similar drugs already prescribed in primary care without shared care?
- Are GPs who are being requested to assume prescribing responsibility likely to be familiar with the drug? Is prescribing within their expertise?
- Is the treatment going to be used on a long-term basis i.e. >6months?
- Could the drug be supplied directly to the patient through home healthcare options?
- Has NICE or the Department of Health indicated that the treatment is suitable for shared care?

South East London Area Prescribing Committee FINAL approved January 2014