Grŵp Strategaeth Meddyginiaethau Cymru Gyfan
All Wales Medicines Strategy Group

All Wales Shared Care Framework

August 2025

This document has been prepared by the Shared Care Short Life Working Group, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

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All Wales Medicines Strategy Group, All Wales Shared Care Framework. August 2025.

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Glossary of useful terms

Directed Supplementary Service (DSS)
Services that all health boards are required to commission or provide.

Local Supplementary Service (LSS)
Services that are commissioned on an optional basis depending on local needs.

National Supplementary Service (NSS)
Services that all health boards are advised to commission or provide but are not mandatory.

Non-medical prescriber (NMP)
Healthcare professionals (excluding doctors and dentists) working within their clinical competence as an independent and/or supplementary prescriber[1].

Off-label use
Using a licensed medicinal product outside the terms of its marketing authorisation (licenced use)[1].

Primary care prescriber
A GP or non-medical prescriber.

Specialist
A consultant, registrar working under consultant supervision, Specialty, Associate Specialist, and Specialist doctors (SAS doctors), suitably trained specialist non-medical prescriber, or GP with extended role (GPwER).

Unlicensed medicine
A medicinal product without a valid UK marketing authorisation. These may be medicinal products that are imported, procured or manufactured under a UK specials manufacturing licence[1].

1.0 Introduction

This document outlines the principles of shared care and aims to provide a framework for the seamless sharing of care between the patient, specialist services, and primary care in situations where it is appropriate, beneficial to the patient, and supported by them. Within NHS Wales, there are now a considerable number of non-medical prescribers who should be considered in the context of shared care. This guidance applies to these professional groups in both primary and secondary care settings.

A definition of shared care was developed by the All Wales Medicines Strategy Group (AWMSG) in 2006[2]: "*A simple definition of shared-care would be where a GP supports and prescribes treatment for a patient which was initiated by a specialist. Implicit in a shared care arrangement is that the patient continues to be followed up in reviews by the specialist. There should be a clear plan of care and defined protocol, with a statement of monitoring arrangements, and responsibilities of the specialist, GP and patient. In order for this to be workable GPs should be able to decide not to share-care because they do not feel they can accept responsibility, or they feel insufficiently competent, on an individual case basis (i.e. in complex cases*)."

In 2018, the NHS England Primary Care Delivery: Policy & Strategy, Operations & Information Directorate in partnership with BMA, RCGP, RCN and NAPP issued guidance entitled Responsibility for prescribing between Primary & Secondary/Tertiary Care[3]. This defined shared care as: "*Shared care agreements are a specific approach to the seamless prescribing and monitoring of medicines which enables patients to receive care in an integrated and convenient manner. Shared care is a particular form of the transfer of clinical responsibility from a hospital or specialist service to general practice in which prescribing by the GP, or other primary care prescriber, is supported by a shared care agreement*."

In practice within NHS Wales, for medicines, the term shared care has come to represent circumstances where primary care accepts the transfer of prescribing responsibility from specialist care, for medicines that have long-term regular monitoring requirements particularly in relation to potential adverse effects. The monitoring arrangements and responsibilities are set out within a shared care protocol for the specific treatment, and the patient continues to have follow-up reviews with the specialist.

1.1 Scope

This framework applies to shared care agreements between specialist services (including secondary or tertiary care) and primary care, where responsibilities for prescribing and monitoring medicines are formally shared under a defined protocol.

Some medicines are supported by supplementary services, such as Directed Supplementary Services (DSS), Local Supplementary Services (LSS), or National Supplementary Services (NSS), which provide a mechanism for the remuneration of proposed monitoring activities in primary care. Whilst these commissioned service arrangements can include medicines prescribed using shared care protocols they are not exclusive to shared care arrangements and are therefore outside the scope of this document.

Near patient testing refers to the monitoring of medicines conducted in a setting closer to the patient, typically within primary care. While this approach can form part of a shared care arrangement, it is also used in other contexts, such as when monitoring is carried out under a supplementary service or where a specialist initiates treatment or recommends initiation of a treatment but may not be involved in subsequent follow-up. The responsibility for monitoring treatment then lies with the GP practice, and in most cases, the primary care prescriber accepts responsibility for continuing drug therapy, and legal responsibility for prescribing[2]. Whilst near patient testing arrangements can operate alongside shared care arrangements, these are not exclusive to shared care and therefore outside the scope of this guidance.

When patients consult non-NHS providers, those providers may make requests of the NHS GP surgery. If a private clinician requests that treatment be continued by the NHS under a shared care agreement with an NHS prescriber, and the NHS prescriber is considering this approach, clinicians should refer to the AWMSG Prescribing Dilemmas: A Guide for Prescribers[4] for guidance on whether to proceed.

Increasingly, health boards have provided additional written support documents to facilitate safe and effective transfer of prescribing responsibility between specialist care and primary care. Medicines included in these documents do not entail significant ongoing monitoring requirements and do not involve separate remuneration for ongoing prescribing by primary care. It is important to recognise that this does not constitute shared care and is outside the scope of this document. Care is only shared between specialist and primary care prescriber when a formal agreed shared protocol has been approved via local governance processes.

In some cases, care arrangements exist between tertiary and secondary care providers. For example, Disease Modifying Therapies (DMTs) for Multiple Sclerosis may be prescribed and administered by secondary care teams under the direction of a tertiary care specialist. These arrangements do not involve primary care and therefore fall outside the scope of this document.

The document outlines the purpose of shared care, which is to support patient-centred care across healthcare settings by clearly defining the roles and responsibilities of the clinicians involved. Robust shared care arrangements are safer for the patient, supports prescribers in both primary and secondary care, and reduces the risk of unintended adverse drug interactions. It is essential that shared care is only undertaken where the medicine is suitable for such an arrangement, and that prescribing and monitoring responsibilities are not separated.

2.0 General principles for shared care

2.1 Patient-centred

The best interest of the patient should be at the centre of any shared care agreement. 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. From the perspective of patient experience, those on long-term medication or are less well may prefer to avoid unnecessary hospital visits by receiving both their prescriptions and ongoing monitoring closer to home. Patient preferences, the safety and suitability of treatment in each setting, and access to services should all be carefully considered when determining the most suitable care setting.

2.2 Collaboration

Shared care for a medicine should involve a collaborative approach where healthcare professionals from both secondary and primary care work together to optimise patient care. This includes sharing clinical information, updates on the patient's condition, and any necessary adjustments to the care agreement. Primary care prescribers may refer patients to secondary care when needed, and the specialist team must provide advice and guidance, particularly for complex treatments such as those with narrow therapeutic windows, significant monitoring requirements, or higher risks of adverse events to ensure safe and effective management. Early consultation with primary care prescribers should be sought when developing or reviewing shared care protocols. It is essential for primary care to be involved in these processes to ensure feasibility and shared responsibility. Shared care protocols should be agreed through health board medicines governance and approval processes following engagement with stakeholders and consideration of their views.

2.3 Informed consent of all parties

This applies to patients, carers, and prescribers. All consenting individuals must receive clear, accurate, and timely information in an understandable format. Consent should be appropriately documented in the patient's clinical record. Where feasible, the use of a standardised consent form is encouraged to support consistency and clarity. This may be completed by a Clinical Nurse Specialist or another suitably trained member of the specialist team, in line with local protocols and best practice guidance.

2.4 Clear communication and emergency support

Effective, timely and open communication between primary and secondary care, as well as the patient is essential, to ensure seamless care transitions and avoid information gaps. Good organisation of care across the interface between primary and secondary care is crucial in ensuring that patients receive high quality care and in making the best use of clinical time and NHS resources. Communication between primary and secondary care should take into account the advice contained in the All Wales Communication Standards between Primary and Secondary Care[5]. Agreed communication methods should include the exchange and documentation of up-to-date telephone contact details and email addresses between the specialist and the primary care prescriber. As shared care agreements may be in place over extended periods, contact information should be reviewed regularly and updated as needed to reflect changes in personnel or roles. This enables the primary care team to access timely advice, guidance, and information if problems arise, and allows secondary care clinicians to contact the primary care prescriber as needed. Out-of-hours contact details, such as how to access on-call duty doctors or alternative support routes determined locally, should also be included. Additionally, patients and their carers should be provided with contact details for support both during and outside regular hours.

2.5 Continuity of care

Patients should experience smooth transitions between different stages of care to avoid fragmentation and ensure ongoing care without interruptions. The transfer of prescribing and monitoring responsibilities from the specialist to the patient's primary care prescriber should occur when the patient's condition is stable or predictable, and only after the primary care prescriber has agreed to take on this responsibility. Patients on shared care treatment cannot be discharged from specialist care; their care remains a joint responsibility between the primary care prescriber and specialist.

2.6 Clear documentation

All decisions, treatment plans, monitoring results, and any changes to the patient's care should be thoroughly documented, ensuring that all prescribers involved have access to accurate and up-to-date information. To support this, an electronic communication and monitoring system should be in place, with the Welsh Clinical Communications Gateway (WCCG) used as the electronic communication system[6].

2.7 Clinical governance and safety

Shared care protocols should adhere to clinical governance standards, ensuring that treatments are evidence-based. The risks associated with prescribing certain medicines in high-risk clinical situations must be minimised through appropriate monitoring, collaboration, communication, and adequate resourcing. Operational and resource considerations including capacity should be considered by local health boards before implementing any shared care protocol.

2.8 Responsibility & accountability

Patient safety is paramount, the shared care protocol should clearly define the responsibilities of prescribers sharing the care of the patient and the required monitoring. Prescribers take legal responsibility for the prescriptions they sign, and they must be prepared to explain and justify their decisions and actions. Clinical responsibility for prescribing is held by the person signing the prescription, who is also responsible for ensuring adequate ongoing monitoring is taking place. When clinical responsibility for prescribing is transferred to a primary care prescriber it is important that they are confident in prescribing the necessary medicines and that they do so within their own level of competence. Specialists should provide any necessary training, advice, and guidance to support the primary care prescriber.

2.9 Training

Any training required by primary care prescribers should be identified and provided to a satisfactory standard by the specialist department requesting the shared care arrangement. If the primary care prescriber, including non-medical prescribers (NMPs), feels a shared care request falls outside their competence, they should seek further information from the clinician sharing care responsibilities or obtain advice from another experienced colleague, such as a GP partner, in line with General Medical Council (GMC) guidance[7]. Prescribers are responsible for developing their knowledge and skills to be able to prescribe safely and where appropriate undertake any additional training necessary for prescribing and monitoring. Where uncertainty remains despite consultation with (more senior) colleagues, the primary care prescriber may seek further advice from the health board's primary care medical leadership team or medicines management team. 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.

2.10 Standardised protocols

All shared care protocols should be based on the current AWMSG template to ensure consistency in layout and promote familiarity. Similarly, the AWMSG standard shared care request letter should be used to ensure that core essential information is effectively communicated. (See Appendix 1: Template - Shared care protocol and Appendix 2: Template letter - Request for shared care agreement (specialist to primary care prescriber))

2.11 Continuous evaluation

The shared care protocol should be reviewed every three years to ensure it remains appropriate. However, it should be reviewed sooner if there are changes to clinical guidelines, any patient safety incidents, or other significant changes affecting the patient's condition.

3.0 Medicine factors where shared care is appropriate for consideration

The following outlines situations where a shared care agreement may be considered:

3.1 Where a patient is prescribed a medicine for a chronic condition (that may be complex) requiring frequent monitoring which can be undertaken in the primary care setting, but where the overarching specialist involvement is retained for review and support.

3.2 Where a patient is prescribed a medicine that requires regular ongoing monitoring (blood tests or other measurements) at least once every 6 months, for efficacy and adverse drug reactions, and where this monitoring can be provided within primary care. Ongoing specialist support and review are also required to assess the medicine's effectiveness, determine whether it should be continued, and/or to reduce the risk of toxicity.

3.3 Where a patient is prescribed a medicine which has a significant pharmacological complexity of use, making the prescribing of the medicine relatively uncommon in primary care, and where monitoring can be undertaken in primary care.

3.4 Where a patient is prescribed an off-label medicine (i.e. where the medicine has a marketing authorisation but is used outside of the terms of the licence), shared care may be considered if there is recognised evidence base. This may include recommendations from bodies such as Royal Colleges or professional societies or if the treatment is considered standard practice. For medicines prescribed off-label, use of a shared care protocol should be in accordance with GMC guidance on 'Prescribing unlicensed medicines'[8] and the AWMSG Understanding unlicensed medicines guidance[9].

3.5 Where a patient is prescribed medicines that are specifically suggested as suitable for shared care by NICE or AWMSG.

Please see Appendix 3: Decision support flow diagram to determine if a medicine is appropriate for shared care.

4.0 Medicine factors where shared care is inappropriate

The following are examples where the responsibility for prescribing may be considered within primary care:

4.1 Medicines initiated in the specialist setting or recommended by a specialist for initiation and continued prescribing in primary care, which do not require ongoing oversight by a specialist but may require some monitoring within primary care. These are often given a formulary status of “Green” or “Green/Amber Specialist initiated”.

4.2 Medicines that require short-to-medium term specialist prescribing to monitor the patient’s response, adjust dose and treat side-effects, but which do not require ongoing oversight by a specialist. A primary care prescriber should then be asked to take over prescribing responsibility once the patient is on a maintenance dose defined as ‘annual monitoring’ or no monitoring is required.

4.3 Medicines that have no monitoring requirements, are in routine use and can be prescribed within primary care with no special restrictions, specialist knowledge or experience.

Please see Appendix 3: Decision support flow diagram to determine if a medicine is appropriate for shared care.

The following are examples where the specialist should retain responsibility for prescribing:

4.4 Medicines requiring ongoing specialist intervention and specialist monitoring.

4.5 Patients receiving the majority of ongoing care, including monitoring, from the specialist service and the only benefit of transferring care would be a transfer of costs away from the specialist setting.

4.6 Medicines that do not have a marketing authorisation within the UK should not be considered for shared care.

4.7 Medicines which are only available through specialist routes, i.e. are not available on WP10, including any ‘borderline’ products when used outside approved indications.

4.8 The medicine requires specialist knowledge to safely use or requires long-term on-going specialist monitoring of efficacy or toxicity (either because of difficulty in recognising side effects or high cost/availability of investigations to identify toxicity).

4.9 The medicine is specifically designated as hospital only by nature of the product.

4.10 Medicines prescribed as part of an ongoing hospital based clinical trial, or requiring administration and monitoring using specialist skills or equipment.

4.11 The medicine is not listed in the current British National Formulary (BNF) or BNF for Children (BNFC).

4.12 There is an AWMSG/NICE recommendation that the medicine should not be prescribed on the NHS for the condition specified.

4.13 The medicine cannot be safely administered in primary care.

4.14 The medicine is included in a package of care (e.g. in vitro fertilisation [IVF]), or requires only a limited course of treatment.

4.15 Where no national or locally approved protocol exists, or where the medicine falls outside the criteria defined as being suitable for inclusion in a shared care agreement.

Please see Appendix 3: Decision support flow diagram to determine if a medicine is appropriate for shared care.

5.0 Patient-centred factors

The best interests and needs of the patient should be central to the decision to enter into a shared care agreement. Clinicians should clearly explain what a shared care arrangement entails and why it may be a suitable option for that patient. (See Appendix 4: Shared care – Patient information leaflet)

Example of situations appropriate for shared care:

5.1 Before commencing shared care, patients should be given the opportunity to ask questions and receive clear, accurate, and timely information presented in an easily understandable format. They should be fully involved in the decision-making process and in agreement with moving to a shared care model for their ongoing care.

5.2 Involvement of carers or a person with lasting power of attorney may be critical, especially in circumstances when it is not possible for the patient to make a decision (e.g. due to mental capacity). Where appropriate, carers should be included in discussions about shared care.

5.3 Informed consent should be given voluntarily, either verbally or written, and must be documented in the patient's notes. The use of a patient consent form is recommended where written consent is obtained (See Appendix 5: Template – Shared care patient consent form).

5.4 Patients should be fully informed about and agree to attending appointments and adhering to monitoring requirements.

5.5 Patients should be made aware that their primary care prescriber must agree to the shared care request before the responsibility for prescribing and monitoring is transferred.

5.6 The shared care approach should remain flexible, accommodating the evolving needs of the patient as their condition or preferences change.

Example of situations inappropriate for shared care:

5.7 Cases where patients have declined the shared care option following informed discussions with the specialist prescriber.

5.8 Cases where the patient must attend the specialist on a regular basis (for reasons other than obtaining a prescription) and/or receives most of their on-going care through secondary care, it may be safer and more appropriate for prescribing to remain within the specialist care setting.

5.9 Cases where care is being transferred solely on the basis of cost or practical considerations of supply which do not directly benefit the patient.

5.10 Cases where the patient lacks capacity to comply with the shared care guideline and agreement, and there is inadequate supportive care available from a carer.

6.0 Best practice for shared care

6.1 Robust shared care arrangements facilitate the safe transfer of prescribing and monitoring responsibilities for specific medicines between specialist and primary care prescribers.

6.2 AWMSG national shared care protocols should be considered for local adoption where available. If a national shared care protocol is not available, it is recommended that when developing a local protocol, consideration is given to whether the medicine and condition are suitable for shared care. The most appropriate prescribing setting should also be considered, supported by the use of the decision support flow diagram (Appendix 3) for both new medicine applications and existing treatments. Proposals for new shared care arrangements should take into account any operational and resource implications for both hospital and general practice settings to ensure that patient care remains safe and effective. Engaging with primary care prescribers early in the protocol development process is essential; this engagement should include the Local Medical Committee (LMC), local prescribing leads, and other relevant stakeholders. Engagement is necessary to determine feasibility, ensure shared responsibility, assess resourcing requirements, and facilitate adoption of shared care protocol to support patient care.

6.3 If a medicine is considered suitable for shared care, shared care arrangements should be developed using the AWMSG template (Appendix 1) following local consultation and agreement among prescribing leads and relevant stakeholders. The protocol should outline the respective clinical responsibilities of all parties and include any other medicine-specific responsibilities. Supporting information should be provided to patients and carers to support them in understanding and agreeing to their responsibilities

6.4 Shared care protocols should only be endorsed where the safety profile of the medicine is such that regular ongoing monitoring is required. This may include biochemical or haematological monitoring to ensure safe and effective use of the medicine.

6.5 Where possible, each health board will maintain a list of shared care protocols which are available within their local formularies along with details of any associated supplementary services.

6.6 Shared care must be initiated by a specialist and sharing clinical responsibility with primary care should only be considered when the patient requires long-term treatment (i.e., more than one year), their condition is stable and predictable, and their treatment has been initiated and stabilised in, or by, the specialist setting for a minimum of 4–6 weeks. At this point, the specialist may seek the agreement of the primary care prescriber concerned (and the patient) to participate in a shared care agreement. As part of the consent process, patients must be made fully aware of all monitoring requirements.

6.7 In proposing a shared care agreement to the primary care prescriber, the specialist should provide the following information:

- an overview of the condition and detailed information on the medicine
- advise which medicine to prescribe and monitoring arrangements
- clearly define the areas of care for which the specialist and the primary care prescriber are responsible for
- 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).

This must be captured in a shared care protocol (See Appendix 1 and Appendix 2)

6.8 The decision to accept transfer of prescribing responsibility should be taken on an individual patient basis by the individual practitioner. The primary care prescriber should respond to the proposed shared care request (which may be electronic) within a locally agreed timeframe (See Appendix 6: Template letter – Primary care response). In certain circumstances, primary care prescribers may decline a shared care agreement if they consider it is in the best interests of the patient.

6.9 In cases where a primary care prescriber declines to participate in a particular shared care agreement, the reason for declining participation in shared care for a specific patient should be communicated to the initiating specialist (See Appendix 6: Template letter – Primary care response). It is the joint responsibility of both primary and secondary care clinicians to engage in timely dialogue to ensure that safe and appropriate arrangements for the patient's ongoing care are established. The initiating specialist should follow up with the primary care prescriber to understand the concerns raised and to collaboratively explore potential solutions.

6.10 Sharing of prescribing and monitoring with the primary care prescriber should only take place once the primary care prescriber has agreed to this in each individual case. The specialist provider must supply an adequate amount of the medicine to cover the transition period. Where there is no agreement in respect of arrangements for prescribing, responsibility for prescribing remains with the specialist until resolved. Transfer of prescribing responsibility to a primary care prescriber without prior agreement is not appropriate.

6.11 Prescribers are responsible for developing their knowledge and skills to be able to safely prescribe. Adequate training and educational support should be 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 agreement. This should also be the case for the patient and/or carer if expected to self-administer under this arrangement.

6.12 In cases where transfer of prescribing responsibility is declined by the patient's primary care prescriber, health boards should have systems in place to maintain the safe and effective long-term provision of medication within secondary/specialist care or, where appropriate, through other primary care prescribers (e.g. those working in community clinics, local healthcare services outside hospital settings). This is an essential component of any shared care arrangement.

6.13 As for any transfer of prescribing responsibility, transfer involving a shared care agreement should be seamless to ensure the patient receives care in an integrated and convenient manner. Patients should never be placed in a position where they are unable to obtain their medicines because of a lack of communication between primary and specialist care.

6.14 When a patient under a shared care agreement is transferred from one specialist service or GP practice to another, it is essential to ensure that care is not interrupted while new arrangements are put in place. The following should be considered in these situations:

- Where a patient joins a new GP practice within the same health board, the original shared care documentation may be used temporarily, provided the new primary care prescriber agrees to continue the arrangement. However, to ensure clear accountability, support governance standards, and minimise any medico-legal liabilities, a new shared care agreement should be completed as soon as possible following the transfer. The new primary care prescriber should obtain the latest correspondence from the initiating specialist and the most recent blood results, including accessing these through Electronic Transfer of Notes or the Welsh Clinical Portal (WCP), where applicable. Changes to the patient's GP practice or contact details should be communicated promptly to the initiating specialist.
- Where a patient joins a GP practice from outside the health board but remains under the care of their existing specialist team based in another health board (e.g. a tertiary centre), a new shared care agreement should be completed. In these situations, the existing shared care protocol may differ from the protocol used within the local health board. If the primary care prescriber reviews the current shared care protocol and considers it safe and clinically appropriate, they may continue prescribing for a defined period while arrangements are made to transition to the local protocol. If the prescriber does not agree to continue during this period, prescribing responsibility remains with the specialist service. The local prescribing team should be consulted for further guidance.
- Where an out of area patient joins a GP practice while on a shared care drug classified as 'Hospital Only' within the receiving health

board, an urgent referral to secondary care is required. The local prescribing team should be consulted for further guidance as specific local arrangements may be in place to facilitate this transition.

- Where a patient's care is transferred from one specialist service to another, a new shared care agreement must be completed by the receiving specialist team. It is the responsibility of the transferring specialist to ensure that all relevant clinical information including test results, treatment plans, and patient history is promptly shared with the new specialist team to ensure continuity of care. The primary care prescriber should also be informed of the change, so they are aware of who the new specialist is moving forward. During the transfer of care between specialist teams, the primary care prescriber may continue prescribing under the existing shared care agreement, where clinically appropriate, to avoid any interruptions in care. However, if the existing agreement is no longer valid or if the primary care prescriber does not agree to continue prescribing during this period, prescribing responsibility remains with the specialist service. A new shared care agreement should be completed as soon as possible.

6.15 When a primary care prescriber accepts responsibility for prescribing medicines which are not usually dispensed in the community, and where the patient is stabilised on a particular medication, there should be liaison with the transferring hospital and, if appropriate, the relevant community pharmacist to ensure continuity of treatment. However, shared care is not appropriate if the prescribed medication cannot be obtained through a community pharmacy, as this could lead to interruptions in patient care.

6.16 All appropriate monitoring requirements specified within the shared care protocol must be fulfilled. The person delivering that aspect of the shared care agreement should ensure that the resources to do this are in place in the clinical setting in which they are delivered.

6.17 Where community nurse involvement is required in the administration of medicines under a shared care agreement, they should be provided with adequate information and guidance by the prescriber or specialist, and arrangements should be made in good time to resolve any potential issues before patient care is compromised. The responsibility for writing or transcribing Medication Administration Records (MARs) for the administration of medicines by community nurses should be outlined in the additional responsibilities section of the shared care protocol.

6.18 Telephone details and secure email addresses of both the specialist and the primary care prescriber should be exchanged and appropriately recorded. This will enable primary care to access timely advice, guidance and information if problems arise, and enable secondary care clinicians to easily contact the relevant prescriber in primary care if necessary. This should include out-of-hours contact numbers (e.g. how to access the on-call duty doctor). While the *Consultant Connect* app is primarily used for urgent, unscheduled care queries and can support prescribers in accessing rapid clinical advice, other platforms, such as WCCG, are increasingly used for planned care, routine advice and guidance. Patients and their carers should also be provided with contact details

for support and help if required; both in and out of hours. These details should also be shared with the patient's community pharmacist.

6.19 Specialists and primary care prescribers should ensure that records of shared care agreements are maintained for each patient for audit purposes, and to enable patient identification and recall. Use of appropriate SNOMED codes, or Read Codes where SNOMED is not yet in use, may facilitate this.

6.20 The implementation of shared care protocols should be audited regularly to ensure that all parties (specialists, primary care prescribers, and patients) are following the agreed processes and responsibilities outlined in the protocol. See Appendix 7: Template – Shared care protocol audit which provides a standardised tool that can be adapted for local use.

7.0 Roles and responsibilities

7.1 Roles and responsibilities of the specialist:

7.1.1 Assess the patient and provide diagnosis.

7.1.2 Use a shared decision-making approach; discuss the benefits and risks of treatment and provide the patient with any relevant information and advice, including patient information leaflets on individual medicines. Obtain informed consent and document in patient notes.

7.1.3 In cases involving off-label use of medicines, the initiating specialist should clearly explain the rationale for use, provide supporting information to the patient (and/or carer), and ensure that consent is fully informed and documented. This process should align with GMC guidance on Prescribing unlicensed medicines and the AWMSG Understanding Unlicensed Medicines guidance. Confirmation that the relevant professional standards for prescribing off-label medicines have been met should be included in communications to the primary care prescriber to support transparency and informed decision-making in shared care.

7.1.4 Initiate treatment, conduct baseline monitoring, and optimise treatment to the point at which the patient's condition is stable or predictable.

7.1.5 Ensure that patients (and their carers where appropriate) are aware of and understand their responsibilities to attend appointments and the need for continued monitoring arrangements.

7.1.6 If shared care is considered appropriate for the patient, complete the shared care request letter (which may be electronic) and send it to the patient's GP practice (Appendix 2). Transfer of monitoring and prescribing to primary care is normally requested after the patient's dose has been optimised and with satisfactory investigation results for at least 4 weeks.

7.1.7 Patients should be made aware that shared care is a tripartite agreement involving the specialist, the primary care prescriber, and the patient. All three parties must agree that shared care is the most appropriate option for the individual. Patients should also be informed that their primary care prescriber

must accept the shared care request before prescribing is transferred. Importantly, patients should never be used as a conduit for communicating the transfer of prescribing responsibility to the primary care prescriber.

7.1.8 In proposing a shared care agreement, the specialist should provide:

- diagnosis, relevant clinical information and baseline results, treatment to date and treatment plan
- which medicine to prescribe, what monitoring will need to take place in primary care, and the date from which the primary care prescriber should begin prescribing the treatment
- how often the medicine must be reviewed and what action to take in the event of difficulties
- contact details for both working and non-working hours

This must be captured in a written shared care protocol (which may be electronic) and should include a route of return to specialist care if the condition changes and requires specialist clinical review. (See Appendix 1)

7.1.9 The specialist should work directly and collaboratively with primary care prescribers to understand any concerns, address barriers to shared care, and actively seek resolutions to prevent any interruption to patient care. Where agreement is reached or not reached, the initiating specialist is responsible for communicating with the patient and ensuring that the management plan is clearly set out and updated accordingly. If agreement with the primary care prescriber cannot be reached despite reasonable efforts, prescribing should remain the responsibility of secondary care.

7.1.10 If the primary care prescriber accepts the shared care agreement; ensure that the patient has an adequate supply of medication (usually 28 days) until shared care arrangements are in place, including in cases of unforeseen delays in the transfer of care.

7.1.11 Review the patient according to details set out in the shared care protocol based on clinical response and tolerability. This review should be at least annually to determine ongoing suitability of the medication. Following each review, a written summary (which may be electronic) should be sent to the patient's primary care prescriber within 14 days, confirming

- whether continued treatment with the monitored medicine remains appropriate.
- Any relevant test results which should also be recorded in the patient-held monitoring booklet, where applicable.
- The current dosage and any changes made should be clearly communicated both to the patient and in writing to the primary care prescriber (which may be electronic), who will then take the necessary action as required.

7.1.12 Any Did Not Attends (DNAs) by patients for secondary care appointments should be followed up by the specialist service, who should liaise with the patient to offer a further appointment if appropriate and inform primary care of any clinical concerns or actions required promptly.

7.1.13 All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care prescriber. Where a shared care protocol does not include provision for the primary care prescriber to amend the dose or formulation, responsibility for any changes remains with the initiating specialist. In such cases, it is the responsibility of the specialist to ensure that any dose or formulation adjustments are clearly communicated to the patient. It is the responsibility of the prescriber making the dose change to ensure the patient is informed. Where the shared care protocol does allow the primary care prescriber to make dose or formulation adjustments on the advice of the specialist, the specialist is responsible for discussing and agreeing upon the proposed changes with the primary care prescriber.

7.1.14 Report any adverse effects experienced during the patient's treatment to the primary care prescriber, and via the MHRA Yellow Card Scheme.

7.1.15 Discuss any concerns with the primary care prescriber regarding the patient's therapy.

7.1.16 Offer training, advice, and guidance as needed for primary care prescribers to support the shared care agreement including information on how to fast-track referral back to secondary/specialist care.

7.1.17 Patients will remain under the care of the specialist, i.e. they should not be discharged.

7.1.18 Termination of treatment will be the responsibility of the specialist, including responsibility for communicating this to the patient.

7.2 Roles and responsibilities of the primary care prescriber:

7.2.1 Respond in writing (which may be electronic) to the specialist request for shared care within the locally agreed timeframe, before prescribing responsibilities are shared (See Appendix 6). The response should confirm that the primary care prescriber agrees the patient should receive shared care for the diagnosed condition, unless there are clear and justifiable reasons for management to remain within secondary or specialist care.

7.2.2 If the shared care agreement is accepted, confirm agreement and prescribe ongoing treatment as detailed in the shared care protocol.

7.2.3 If there are any concerns about entering into a shared care arrangement, the primary care prescriber should contact the requesting specialist and work directly and collaboratively with the specialist team to address them. A resolution should be sought to ensure there is no interruption to patient care.

7.2.4 If the primary care prescriber is uncertain about their competence to take on responsibility for the patient's ongoing care, they should seek further information or guidance from the clinician sharing care responsibilities and/or consult with another experienced colleague in the GP practice. Where uncertainty remains despite consultation with (more senior) colleagues, the primary care prescriber may seek further advice from the health board's primary care medical leadership team or medicines management team. The

primary care prescriber should complete any additional training required to manage the prescribing and monitoring effectively. If the prescriber remains uncertain, they should make suitable arrangements for the patient's continued care.

7.2.5 Keep up-to-date with relevant guidance on the use of the medicines and on the management of the patient's condition.

7.2.6 Prescribe the maintenance therapy in accordance with the written instructions contained within the shared care protocol or other provided documentation. Where the shared care protocol allows the primary care prescriber to make dose or formulation adjustments based on specialist advice, the specialist is responsible for discussing and obtaining agreement on the proposed changes with the primary care prescriber. In such cases, any dose changes made by the primary care prescriber must be communicated to the patient. It is the responsibility of the prescriber making the dose change to ensure the patient is informed.

7.2.7 Report any adverse effects experienced during the patient's treatment to the specialist team, and via the MHRA Yellow Card Scheme.

7.2.8 Where applicable, keep the patient-held monitoring record up-to-date with the results of investigations, changes in dose, alterations in management, and ensure that any dose changes are communicated to the patient. Take any actions necessary to support ongoing care.

7.2.9 Ensure that the patient is monitored as outlined in the shared care protocol and take the advice of the referring specialist if there are any amendments to the suggested monitoring schedule. The primary care prescriber will also ensure that a robust monitoring system is in place to support the patient's attendance at the appropriate appointments for follow-up and monitoring. Any DNAs (Did Not Attends) relating to primary care appointments should be followed up to re-arrange the appointment. The primary care prescriber in discussion with the specialist is responsible for deciding whether to continue treatment if the patient fails to attend required monitoring appointments. The primary care prescriber should inform the specialist of any actions taken.

7.2.10 In the event of medicine shortages or supply issues, primary care prescribers should communicate promptly with community pharmacists and the specialist team to discuss and agree on suitable alternative treatment options where applicable, ensuring continuity of care and patient safety. Additionally, primary care prescribers should consider providing the patient with the AWMSG-endorsed patient information leaflet on managing medicine shortages in Wales. If the medicine is changed to one that can only be prescribed in hospital, and the shared care agreement is no longer applicable, prescribing responsibility will remain with the specialist team.

7.2.11 Refer to the specialist in the event of a deteriorating clinical condition or any aspect of patient care that is of concern and may affect treatment.

7.2.12 Stop treatment as advised by the specialist.

7.3 Roles and responsibilities of the patient/carer:

7.3.1 To be fully involved in and in agreement with the decision to move to shared care.

7.3.2 Take medication as prescribed and avoid abrupt withdrawal unless advised by primary care prescriber or specialist.

7.3.3 To attend hospital and primary care clinic appointments and to bring monitoring information (e.g. booklet if required). Failure to attend will potentially result in the medication being stopped.

7.3.4 Report any suspected adverse effects to their specialist or primary care prescriber.

7.3.5 Inform the specialist, primary care prescriber or community pharmacist dispensing their prescriptions of any other medication being taken, including over the counter medication and/or herbal remedies.

7.3.6 Inform the specialist if they are moving out of the area or moving to a different GP practice within the same area, so that appropriate arrangements for ongoing care can be made.

7.4 Roles and responsibilities of the community pharmacist (when not the primary care prescriber):

7.4.1 Be aware of where to access national and locally agreed shared care protocols to support patient care, particularly in responding to patient queries about their prescribed medicines. To facilitate this, the health board is responsible for publishing these protocols, ensuring community pharmacy teams have timely and appropriate access to support safe and effective dispensing and patient care.

7.4.2 Clinically check prescriptions to ensure they are safe for the patient and contact the primary care prescriber if clarification of their intentions is needed.

7.4.3 Where applicable, it is good practice to check the patient's monitoring record book to ensure the correct dose is dispensed.

7.4.4 Fulfil legal prescriptions for medication unless the medication is considered unsafe for the patient.

7.4.5 Counsel the patient on the proper use of their medication to ensure they understand how to manage their treatment and any potential side effects. Advise patients who are suspected of experiencing an adverse reaction to their medicines to contact their primary care prescriber or specialist/specialist nurse team.

7.4.6 In cases where the community pharmacy is experiencing difficulty, or is unable to source a prescribed medicine, pharmacy professionals must act in the best interests of the patient by following professional guidance on medicine shortages. This includes promptly communicating with the primary care prescriber to explore alternative supply options to maintain an adequate and timely supply of medicines. Additionally, pharmacy teams should consider

providing the patient with the AWMSG-endorsed patient information leaflet on managing medicine shortages in Wales.

8.0 Review of shared care protocols

A shared care protocol is usually approved for a period of three years, after which it should be reviewed, with any necessary amendments incorporated. However, any updates to national guidance, changes in practice, prescribing advice, the evidence base or emerging safety concerns should prompt an earlier review of the protocol. When reviewing the protocol, consider whether the medicine remains suitable for shared care. If guidance has changed and monitoring is no longer required, the formulary status of the medicine should be reassessed. If changes are made to a shared care protocol as a result of a review, patients and their prescribers should be informed of any changes to their treatment in a timely manner. The health board is responsible for supporting clinicians to ensure that appropriate communication processes are in place when changes to a shared care protocol such as withdrawal or amendment of clinical parameters may impact how a patient receives their medication.

9.0 References

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2. All Wales Prescribing Advisory Group. Appendix 1. Defining shared care. 2006. Available at: https://awttc.nhs.wales/files/guidelines-and-pils/shared-care-defining-shared-care-pdf/. Accessed February 2025.
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Appendix 1: Template – Shared care protocol

PROTOCOL: [DRUG NAME] *This document should be read in conjunction with the current SPC*: www.medicines.org.uk/	
1. Licensed indications State if drug is being used off-label.	
2. Therapeutic use and background	
3. Contraindications	
4. Typical dosage regimen (adults)	**All dose adjustments will be done by secondary care. The following is for information only:** 1. Route 2. Formulation 3. Recommended starting dose___as a single daily /weekly dose or as divided daily dose 4. Titrate dosage up by ___ (dose)/____ (week or day) according to response. 5. Maintenance dosage up to a maximum ____. 6. Adjunctive treatment regime 7. Conditions requiring dose reduction e.g. impaired renal/ liver function. 8. Usual response time 9. Duration of treatment_____ *or as* long as indicated by clinical effectiveness
5. Drug interactions For a comprehensive list, consult the BNF or SPC	

<table>
<tr><td rowspan="9">6. Adverse drug reactions
For a comprehensive list (including rare and very rare adverse effects), or if significance of possible adverse event uncertain, consult the SPC or BNF</td><td colspan="5">Most serious toxicity is seen with long-term use and may therefore present first to primary care. The frequency of adverse reactions is classified using the following convention:
Very common (≥ 10%); common (≥ 1% and < 10%); uncommon (≥ 0.1% and < 1%); not known (cannot be estimated from the available data).</td></tr>
<tr><td colspan="2">Clinical condition (Where possible indicate if common, rare or serious)</td><td colspan="3">Management (Including threshold at which to contact specialist)</td></tr>
<tr><td colspan="2">System – symptom/sign</td><td colspan="3"></td></tr>
<tr><td colspan="2"></td><td colspan="3"></td></tr>
<tr><td colspan="2"></td><td colspan="3"></td></tr>
<tr><td colspan="2"></td><td colspan="3"></td></tr>
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<tr><td colspan="2"></td><td colspan="3"></td></tr>
<tr><td colspan="2"></td><td colspan="3"></td></tr>
<tr><td colspan="5">IF YOU SUSPECT AN ADVERSE REACTION HAS OCCURRED, PLEASE STOP THE DRUG/CONTACT THE SPECIALIST DEPARTMENT.

The patient should be advised to report any of the following signs or symptoms without delay:
Other important comorbidities (e.g. Chickenpox exposure)

Any adverse reaction to a black triangle drug, or serious reaction to an established drug, should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) via the “Yellow Card” scheme.
https://yellowcard.mhra.gov.uk/</td></tr>
<tr><td>7. Baseline investigations</td><td colspan="5">To be undertaken by secondary care</td></tr>
<tr><td rowspan="3">8. Monitoring</td><td>Monitoring</td><td>Frequency</td><td>Results</td><td>Action</td><td>By</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>9. Pharmaceutical aspects</td><td colspan="5">E.g. special storage requirements, washout
Or
No special considerations</td></tr>
</table>

10. Advice to patients and carers The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.	
11. Pregnancy (men and women) and breast feeding It is the responsibility of the specialist to provide advice on the need for contraception to male and female patients on initiation and at each review but the ongoing responsibility for providing this advice rests with both the primary care prescriber and the specialist.	
12. Specialist contact information	**If stopping medication or needing advice please contact:** **Specialist:** **……** **Contact number:** **……** **Hospital:** **……** **Email:** **……** **For Out of Hours advice, please telephone:** **……**

13. Access to support, advice and training Information on how primary care prescribers can access advice, support, and clinical guidance from the specialist team should be clearly outlined here.	
14. Criteria for shared care	Prescribing responsibility will only be transferred when: • Treatment is for a specified indication and duration. • Treatment has been initiated and established by the secondary care specialist. • The patient's initial reaction to and progress on the drug is satisfactory. • The primary care prescriber has agreed in writing (which may be electronic) in each individual case that shared care is appropriate. • The patient's general physical, mental and social circumstances are such that he/she would benefit from shared care arrangements.
15. Responsibilities of initiating specialist	• Initiate treatment. • Undertake baseline monitoring. • Dose adjustments. • Monitor patient's initial reaction to and progress on the drug. • Ensure that the patient is taking their medication and has an adequate supply of medication until primary care supply can be arranged. • Continue to monitor and supervise the patient according to this protocol, while the patient remains on this drug. Reviews should occur at least annually. • Follow up if the patient misses any secondary care appointments and inform the primary care prescriber. • Provide training, advice, and guidance to primary care prescribers as needed to support the shared care agreement. • Patients will remain under the care of the specialist and should not be discharged. Provide primary care prescriber with: • Diagnosis, relevant clinical information and baseline results, treatment to date and treatment plan, duration of treatment before consultant review. • Provide primary care prescriber with details of outpatient consultations, ideally within 14 days of

	seeing the patient, *or* inform primary care prescriber if the patient does not attend appointment. • Advice on when to stop this drug. Provide patient with relevant drug information to enable: • Informed consent to therapy. • Understanding of potential side effects and appropriate action. • Understanding of the role of monitoring. • Monitoring booklet where appropriate. • Any dose or formulation changes made in secondary care
16. Responsibilities of primary care	• To monitor and prescribe in collaboration with the specialist, according to this protocol. • To ensure that the monitoring and dosage record is kept up-to-date. • Symptoms or results are appropriately actioned, recorded and communicated to secondary care when necessary. • Communicate any dose or formulation changes, agreed with the specialist and undertaken in primary care to the patient • Follow up if the patient misses any primary care appointments and inform the specialist • Refer the patient to the specialist if there is a deterioration in their clinical condition • Discontinue treatment as advised by the specialist. • In case of medicine shortages, promptly inform the community pharmacist and specialist. *Delete as appropriate:* Provision of shared care is in accordance with Local Supplementary Scheme, where available. Near-patient testing is in accordance with the service outline of the GMS contract.
17. Responsibilities of patients	• To attend hospital and primary care appointments, including those for monitoring. • Ensure monitoring booklet (if issued) is taken to appointments. • Failure to attend will result in medication being stopped (on specialist advice). • To report adverse effects to their specialist or primary care prescriber. • Inform the specialist if they are moving out of the area or registering with a different GP practice
18. Additional responsibilities	List any special considerations. Responsibilities of all prescribers: Any serious reaction to an established drug should be reported to MHRA.
19. Supporting documentation	• Include hyperlinks to the original sources and access dates

	• All Wales AWMSG Shared Care Framework • General Medical Council. Good practice in prescribing and managing medicines and devices. Shared care. Available from https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care
20. Patient monitoring booklet	Include patient information leaflet if available
21. Primary care letter	Attached below
22. Protocol date	
23. Protocol review date	

Appendix 2: Template letter – Request for shared care agreement (specialist to primary care prescriber)

Specialist request

Dear **IMPORTANT: ACTION NEEDED**

Patient name:
Date of birth:
NHS number:
Diagnosis:

This patient is suitable for treatment with (*insert drug name*) for the treatment of *(insert indication).*

The patient is fully aware of and agrees to attend all required monitoring appointments (tick):
☐
A patient information leaflet (PIL) has been provided and discussed with the patient (tick):
☐
This drug has been accepted for Shared Care according to the enclosed protocol (as agreed by Trust/Health Board/AWMSG). **I am therefore requesting your agreement to share the care of this patient, as they are now stable on the treatment**. Where baseline investigations are set out in the shared care protocol, I have carried these out.

Treatment was started on (*insert date started*) (*insert dose*). I have provided the patient with sufficient medication to last until (*insert date*).

If you are in agreement, please undertake monitoring and treatment from *(insert date*). (NB: date should be no earlier than 4–6 weeks after initiation of treatment, once the patient's condition has stabilised under specialist care.)

Baseline tests: *(insert information)*

Next review with this department: *(insert date)*

You will be sent a summary within (*XX)* days. The medical staff of the department are available at all times to give you advice, contact details for them are *(insert in and out of hours contact numbers)*. The patient will not be discharged from out-patient follow-up while taking *(insert drug name)*.

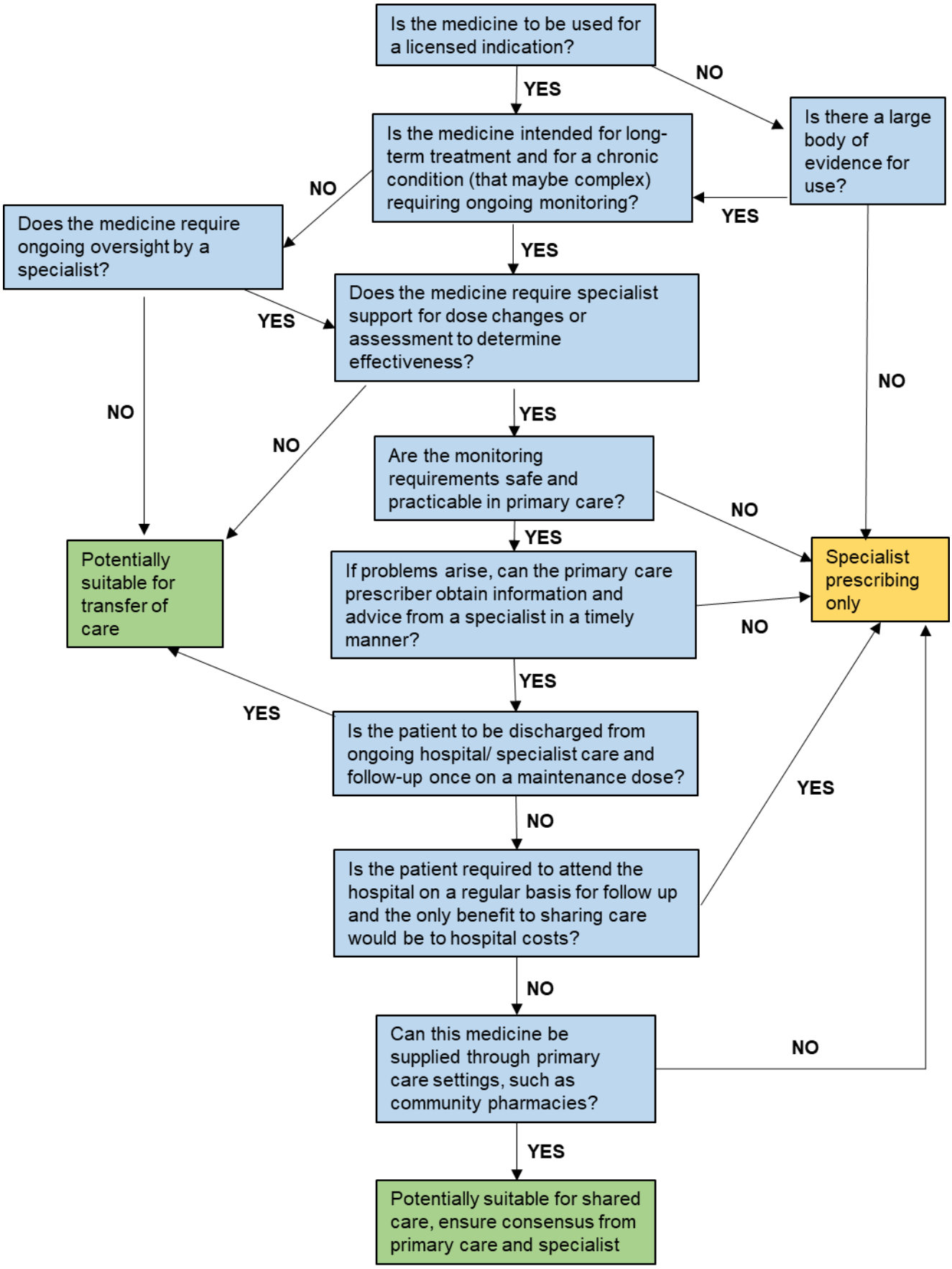
Please use the reply slip overleaf and return it as soon as possible.

Thank you.

Signature *Date*

Specialist name

Appendix 3: Decision support flow diagram to determine if a medicine is appropriate for shared care



Appendix 4: Shared care – Patient information leaflet

What is shared care?

Shared care is a formal agreement between you and two healthcare professionals who manage your treatment. Usually these are your specialist (such as: a consultant, hospital doctor or other healthcare worker who can prescribe medicines) and a healthcare worker at your GP practice (such as: a GP or other healthcare worker who can prescribe medicines).

Shared care lets your specialist transfer some of your treatment with *[insert medicine name here]* to a healthcare worker at your GP practice, when this is suitable and in your best interests. Shared care lets them continue prescribing you a medicine started by your specialist and should be more convenient for you to receive some of your treatment. Your specialist has not discharged you – your treatment is shared between your specialist and the healthcare worker at your GP practice.

Your specialist and the healthcare worker at your GP practice must both agree to shared care. If they do not agree, your specialist will continue to manage your treatment.

How does shared care work?

Before you start treatment with a medicine, your specialist will explain:

- the benefits and risks of treatment, and give you any written information you might need
- the need for monitoring the treatment and how this will be arranged
- their role, your role, and the role of the healthcare worker at your GP practice in managing your treatment.

If you agree, your specialist will begin prescribing your medicine and will arrange monitoring. Monitoring may include blood tests and other health checks, to ensure your condition is responding well to the treatment.

When your specialist thinks you are on a stable dose of medicine, and if you agree, they will ask the healthcare worker at your GP practice about shared care.

Your specialist will continue to prescribe your medicine and monitor your treatment while waiting for the healthcare worker at your GP practice to consider shared care. If the healthcare worker at your GP practice agrees, they will take over prescribing and monitoring as requested by your specialist and will start issuing prescriptions for you.

Your specialist will still oversee your treatment and review your progress in their clinic, according to your care management plan. If anything changes with your health, your specialist will review your treatment.

What are the benefits of shared care?

You'll continue with the same treatment, without needing to go to see your specialist so often.

Your specialist and the healthcare worker at your GP practice are both involved in your treatment. Both will monitor your progress and the healthcare worker at your GP practice will alert your specialist if they have any concerns.

What is my role in shared care?

Take your medicine as prescribed and read all information your specialist gives you.

Attend all appointments with the healthcare worker at your GP practice and with your specialist, including regular monitoring visits, such as blood tests and health check-ups. These visits help to assess how well the medicine is working for you, and if you're experiencing any unwanted effects.

If you miss appointments your specialist or healthcare worker may stop your treatment, so it's important not to miss them.

If you have a monitoring booklet, take it with you to every appointment.

If you experience any unwanted effects of treatment, tell your specialist or the healthcare worker at your GP practice.

If you're taking any other medicines, supplements or herbal remedies, tell your specialist and healthcare worker at your GP practice, and also tell other healthcare workers, such as your pharmacist or dentist.

Always check with your pharmacist before you buy over-the-counter medicines, including herbal remedies.

Never stop taking your medicine unless your specialist or the healthcare worker at your GP practice advise you to stop. If you notice any new or worsening symptoms, tell your specialist or the healthcare worker at your GP practice.

Keep your specialist and the healthcare worker at your GP practice informed of any changes in your life that could affect your treatment.

Inform your specialist if you change address as they may have to arrange a new shared care agreement with a new GP practice closer to your new address.

What happens if my treatment needs to change?

If your condition changes, or if you need to take a different medicine, your specialist and the healthcare worker at your GP practice will agree the best course of action.

What should I do if I have concerns?

If you have any concerns, or if something about your treatment is not clear, talk to your specialist or the healthcare worker at your GP practice.

You should be given contact details for support with your treatment, including any help you might need during and outside usual contact hours.

Can I leave a shared care arrangement if I change my mind?

Yes, if you change your mind, speak with your healthcare worker at your GP practice or specialist to discuss your concerns.

How is my information used?

Your GP practice and specialist team will only use your personal information for managing your care. They will follow NHS data protection policies and UK General Data Protection Regulation (UK GDPR). They will store your information securely and will always treat it as confidential. They will not share your information with other parties without your agreement.

Appendix 5: Template – Shared care patient consent form

AFFIX PATIENT ID LABEL HERE OR FILL IN PATIENT DETAILS:

Please read the following statements carefully and initial the boxes if you agree.

I provide my consent to proceed with a shared care arrangement for the management of my condition	

In doing so I confirm my understanding of the following points:

I have had the opportunity to discuss the shared care arrangement with the healthcare team	
I have read and understood the information provided in the Shared Care Patient Information Leaflet *(include leaflet version number or publication date)*, including what shared care involves and the responsibilities of myself, my specialist, and my GP practice	
I understand the importance of regular monitoring and agree to attend all appointments as part of my treatment plan	
I understand that shared care will only begin if my GP practice agrees to take on the responsibility for prescribing and monitoring	
I understand that my needs and preferences may change over time, and the shared care arrangement can be reviewed	

Patient/Carer

Signature ..... Date .....

Print name .....

Specialist team

Signature ..... Date .....

Print name .....

Appendix 6: Template letter – Primary care response

Dear

Patient: *(Insert Patient's name)*

Identifier: *(Insert Patient date of birth/address/NHS number)*

I have received your request for shared care of this patient who has been advised to start (*insert drug name):*

A I am willing to undertake shared care for this patient as set out in the protocol

B I wish to discuss this request with you

C I am unable to undertake shared care of this patient for the reason(s) below:

	Reason	Tick
1.	**A minimum duration of supply by the initiating specialist** 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.***	
2.	**Initiation and stabilisation by the initiating specialist** As the patient has not been stabilised 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 stabilised on this medication the responsibility for providing the patient with their medication remains with you.***	
3.	**Shared Care Document not received** As legal responsibility for clinical care lies with the healthcare professional 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 this information, responsibility for providing the patient with their medication remains with you.***	

4.	**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.***	
5.	**Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted)**	

Please do not hesitate to contact me if you wish to discuss any aspect of my letter in more detail.

Signature of primary care prescriber Date:

Contact details (phone number and email):

GP address/practice stamp

Appendix 7: Template – Shared care protocol audit

This template provides a standardised audit tool that can be adapted locally to assess compliance with shared care protocols.

Audit title:
Audit of compliance with shared care protocol for [Drug name]

Name of protocol:
[Full name of the shared care protocol, e.g. "Shared care protocol: Methotrexate for rheumatoid arthritis"]

Audit period:
From: _____ To: _____

Section A: Protocol governance and eligibility

Audit standard	Met	Not met	N/A	Comments/Actions
Named protocol is the current, approved version	☐	☐	☐	
Protocol is clearly referenced in patient records	☐	☐	☐	
Indication for treatment is in line with the protocol	☐	☐	☐	
Use of drug is licensed OR off-label with justification documented	☐	☐	☐	
Shared care agreement completed and documented (electronic or written)	☐	☐	☐	
Responsibilities of both primary and secondary care are clearly recorded	☐	☐	☐	

Section B: Secondary care responsibilities (Specialist)

Audit standard	Met	Not met	N/A	Comments/Actions
Drug was initiated and stabilised in secondary care	☐	☐	☐	
Baseline tests completed and results shared with primary care	☐	☐	☐	
Initial prescription issued until primary care could prescribe	☐	☐	☐	
Treatment plan, diagnosis, and review schedule shared	☐	☐	☐	
Specialist contact details (including for OOH) provided	☐	☐	☐	
Specialist is reviewing the patient in accordance with the shared care protocol	☐	☐	☐	

Section C: Primary care responsibilities

Audit standard	Met	Not met	N/A	Comments/Actions
Prescribing initiated in primary care only after formal agreement	☐	☐	☐	
Monitoring carried out at specified intervals	☐	☐	☐	
Results reviewed and actioned according to protocol	☐	☐	☐	
Specialist contacted for abnormal results or clinical concerns	☐	☐	☐	
Accurate records maintained of doses, monitoring, and communications	☐	☐	☐	

Section D: Monitoring compliance snapshot
Review a sample set of patients and monitoring data to complete this section.

Test	Required frequency	% Compliance	Notes

Section E: Adverse events and safety

Audit standard	Met	Not met	N/A	Comments/Actions
Adverse effects recorded, reviewed, and reported appropriately	☐	☐	☐	
Yellow Card reports completed where required	☐	☐	☐	
Specialist advice sought for serious/unexpected events	☐	☐	☐	

Section F: Patient education and engagement

Audit standard	Met	Not met	N/A	Comments/Actions
Patient provided with medicine information leaflet	☐	☐	☐	
Patient provided with monitoring record/booklet if required	☐	☐	☐	
Non-attendance or missed monitoring followed up appropriately	☐	☐	☐	

Section G: Patient experience

Audit standard	Met	Not met	N/A	Comments/Actions
Patient feedback on their experience of shared care has been recorded	☐	☐	☐	

Section H: Summary and action plan
Number of patients/Records reviewed: _____
Overall protocol compliance: _____%

Key areas for improvement:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____