

North Nottinghamshire Prescribing Strategy Group

Rheumatology Shared Care Guidelines**Background Information**

Inflammatory arthritis is a chronic inflammatory condition affecting approximately 2% of the population. The ratio of females to males is 6:4. The disease can start at any time from childhood onwards, the peak for females is in the 40's and a little latter for males. Nearly 90% of patients with aggressive disease will become clinically disabled within 20 years.

The pyramid approach to therapy, starting with non-steroid anti-inflammatory drugs and progressing to disease modifying antirheumatic drugs (DMARDs) has had limited success at preventing joint destruction or improving long term outcome. The use of DMARDs in earlier stages of the disease is now increasing. General practitioners are becoming more involved in active management of the condition with the recognition that patients should be referred early for specialist advice and the initiation of disease modifying drugs.

Some of the new therapies for rheumatoid arthritis are experimental, while others represent a combination of existing drugs. It would be clearly inappropriate for patients on experimental drugs to be monitored in primary care, but there is a place for the monitoring of patients on *widely used and accepted drugs* within a general practice setting. Patients on these drugs need regular but infrequent consultant follow up, but frequent monitoring of side effects, which may be more appropriately carried out in Primary Care.

Patient selection

- Patients with inflammatory arthritis who have been referred to secondary care for initiation of a treatment regime.
- Patients receiving *conventional* disease modifying therapy, as in the attached information sheets.
- DMARDs initiated by the consultant in secondary care, and a treatment plan defined for that particular patient, who is established on the appropriate drugs in secondary care.
- The patient's initial reaction to and progress on the drugs is satisfactory.
- The patient's general physical, mental and social condition is such that he/she would benefit most from shared care arrangements.

Drug Treatment, Indications and Management Plan

Please see the attached GP information sheets for each drug.

Procedure for Initiating Shared Care Arrangements

For suitable drugs and medical conditions, hospital consultants and general practitioners may come to an agreement that they will share the clinical responsibility for a patient who is being seen by both of them.

In the case of rheumatology, when an agreement to manage a patient under a shared care guideline is in place, the general practitioner will be responsible for ensuring the continued monitoring of the patients with inflammatory arthritis is undertaken, and the prescribing of recommended drugs.

Shared care must be agreed before the patient is directed to primary care for continuation of their treatment.

- All general practitioners will be circulated with copies of the North Nottinghamshire Rheumatology Shared Care Guidelines.
- The hospital consultant must contact the patient's general practitioner regarding the suitability of a particular patient for shared care.

The Trust will be responsible for the following:

1. The consultant will confirm the working diagnosis.
2. The consultant will recommend and initiate the treatment.
3. The consultant will suggest that shared care may be appropriate for the patient's condition. Patients who need frequent drug or dosage changes due to their fluctuating clinical condition should remain within secondary care.
4. The consultant will ensure that the patient has an adequate supply of medication (usually 28 days) until shared care arrangements are in place. Further prescriptions will be issued if, for unseen reasons, arrangements for shared care are not in place at the end of 28 days. Patients should not be put in a position where they are unsure where to obtain supplies of their medication.
5. If shared care is considered appropriate for the patient, the consultant will contact the general practitioner.

The consultant will provide the patient's general practitioner with the following information:

- Diagnosis of the patient's condition with the relevant clinical details.
- Details of the patient's treatment to date.

- Details of treatments to be undertaken by GP
- Details of monitoring arrangements

Including reasons for choice of treatment, drug or drug combination, frequency of treatment, number of months of treatment to be given before review by the consultant.

The Trust recognises that under certain circumstances the general practitioner may decline to take on the shared care, and in such an event the total responsibility for the patient for the diagnosed condition will remain with the consultant.

6. If the General Practitioner agrees to shared care for the patient then he/she will inform the Consultant of his acceptance in writing within 14 days.
7. The hospital will issue the patient with a patient held record prior to initiation of shared care.
8. Whenever the consultant sees the patient, he/she will send a written summary within 14 days to the patient's General Practitioner.
9. The consultant or his representative will be available for information or advice to the General Practitioner.

Role and responsibility of the General Practitioner

The GP will be responsible for:

1. Ensuring that he/she has the information and knowledge to understand the therapeutic issues relating to the patients clinical condition.
2. Undergoing any additional training necessary in order to carry out a practice based rheumatology service.
3. Agreeing that in his / her opinion the patient should receive shared care for the diagnosed condition unless good reasons exist for the management to remain within secondary care.
4. Writing all prescriptions in an accurate, legible form, according to the guidance in the current BNF.
It is important that whoever prescribes the medication will be considered clinically responsible.
5. Giving the maintenance therapy in accordance with the written instructions contained within the GP information sheets.
6. Keeping the patient held record up to date with the results of investigations changes in dose and alterations in management.
7. Reporting any adverse effect in the treatment of the patient to the consultant.

8. The general practitioner will ensure that the patient is monitored according to the North Nottinghamshire shared care agreement for DMARDs and will take the advice of the referring consultant if there are any amendments to the suggested monitoring schedule.
9. The general practitioner will ensure that the patient is given the appropriate appointments for follow up and monitoring, and that defaulters from follow up are contacted to arrange alternative appointments. It is the general practitioners responsibility to decide whether to continue treatment in a patient who does not attend appointments required for follow up and monitoring

Support, Education and Information.

Clinical staff should be made available from the Trust, both from consultant and more junior medical staff, and from nurse practitioners where appropriate.

Queries regarding specific drugs may be directed where appropriate to the Trust's Medicines Information department.

The Trust may lead or participate in educational sessions for general practitioners and practice nurses where appropriate.

Queries from a general practitioner should be directed to the most appropriate member of the secondary care team.

Safety net

In cases where shared care arrangements are not in place, or where problems have arisen with the agreement, and patient care may suffer, the responsibility for the prescribing and management of the patient will revert to the Trust.

Authors: Dr K Lim, Consultant Rheumatologist, Sherwood Forest Hospitals NHS Trust
 Dr D A Walsh, Honorary Consultant/Senior Lecturer, Dept. of Rheumatology, Sherwood Forest Hospitals NHS Trust,
 Dr Al-Khoffash, Consultant Rheumatologist, Doncaster & Bassetlaw Hospitals NHS Trust
 Miss Louise Goodman, Prescribing Advisor, North Nottinghamshire Health Authority

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