Royal Cornwall Hospitals
NHS Trust

Oral and Subcutaneous Methotrexate Shared Care Guideline

V5.0

December 2025

1. Aim/Purpose of this Guideline

1.1. This Shared Care Guideline has been approved whilst the system-wide approach with the Local Medical Committee to shared care is under review. Hence this guideline may be altered sooner than its review date.

1.2. This guideline applies to medical, nursing and pharmacy staff in the safe and appropriate prescription and administration of methotrexate in adult patients with inflammatory joint disease and psoriasis. This guideline provides additional limited information necessary to aid in the treatment of rheumatology and dermatology patients. As with all shared care guidelines they highlight significant prescribing issues but should be used in conjunction with the BNF, ABPI summary of product characteristics and do not replace them.

1.3. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. The National Patient Safety Authority (NPSA) has highlighted the risks when prescribing methotrexate including failings from poor monitoring of therapy, which have led to fatalities. The 10mg strength of methotrexate tablets should not be prescribed or dispensed for these indications. This Shared Care Guideline reflects these recommendations.

2.2. **Methotrexate must only be administered as a WEEKLY dose**. Serious errors have occurred as a result of ambiguous instructions.

2.3. Methotrexate requires careful monitoring to avoid toxicity. It is recommended that it is initiated in primary care only after consultant diagnosis and under consultant supervision. Patients may be switched from oral to subcutaneous methotrexate due to poor tolerance, particularly gastrointestinal side effects, or to improve efficacy.

2.4. This Shared Care Guideline (SCG) covers the treatment of adults with inflammatory joint disease or connective tissue disease, and treatment of adults with psoriasis and other rare skin diseases.

2.5. The Methotrexate Liver Pathway Initiating and Monitoring Clinical Guideline (a separate document on RCHT document library) aims to support hepatic risk stratification and monitoring of potential hepatic complications in patients who are being considered for, or being treated with, methotrexate. This revision of this shared care guideline reflects these recommendations.

2.6. **Preparations and Dosage**

- Methotrexate 2.5mg tablets.

- Methotrexate Pre-Filled Pen – the Metoject brand is the preferred product that patients are trained to administer; there are differences in the preparation and administration technique between brands. Please prescribe by brand name.

- If Metoject is prescribed generically, the concentration will be 50mg/mL with different volumes used depending on the dose required:

- Parallel-Imported Metoject Pre-Filled Syringes are available and can be supplied against prescriptions that do not specify pens - this may cause difficulties for patients who have only been trained to administer from the pen.

2.6.1. Usual oral dose range 2.5mg – 25mg **once weekly**. **Methotrexate should be prescribed as multiples of 2.5mg tablets.**

2.6.2. The label on prescribed/dispensed methotrexate should state the instructions clearly, for example: **'methotrexate 2.5mg tablets:** (number of tablets) **to be taken as a single dose ONCE A WEEK on XXXDAY**'.

2.6.3. Usual subcutaneous dose 7.5mg – 25mg **once weekly. Methotrexate should be prescribed as complete pre-filled pens by brand name. The majority of patients will use Metoject but a small number may be on alternative brands if they are unable to operate the device.** Patients will be trained on the use of injectable methotrexate by their specialist nurse. RCHT will train patients to use the Metoject device. If General Practitioner (GP) practices opt to use a different device, then it is the responsibility of the GP practice to ensure patients can use it safely and appropriately.

2.6.4. The label on prescribed/dispensed methotrexate should state the instructions clearly, for example: 'methotrexate ……. injection: (dose) to be injected subcutaneously ONCE A WEEK on XXXDAY'.

2.6.5. To limit the side effects of methotrexate, all patients should receive folic acid 10mg once a week on the day after they take/administer methotrexate. Higher doses (e.g. 5mg daily omitted on the day of methotrexate) may sometimes be used on the advice of the specialist team.

2.7. **Contraindications – Methotrexate Should not be Used in Patients:**

- With severe / significant hepatic or renal impairment (e.g. eGFR < 30mL/min/m²).
- Active acute infectious disease, evidence of immunodeficiency syndrome.
- With serious cases of anaemia, leucopenia, thrombocytopenia.
- Receiving drugs with antifolate properties e.g. co-trimoxazole, trimethoprim, sulphonamides.
- Who are breastfeeding.
- Pregnancy – Methotrexate can reversibly affect female fertility. It can also affect the development of the unborn child so women of childbearing potential should use a reliable method of contraception to avoid the risk of an unplanned pregnancy during treatment and for at least three months after discontinuing methotrexate. When planning a pregnancy, it is important that women on this drug discuss their medication with the relevant clinical team. They will need to stop treatment with methotrexate for at least three months before attempting to conceive.

2.8. **Precautions - Caution is Advised in Patients:**

- Who are elderly (consider reduction in dose).
- With haematological depression.
- Renal impairment – use a maximum dose of 12.5mg week in patients with an eGFR 30 -60mL/min.
- Diarrhoea, ulcerative disorders of Gastro Intestinal tract.
- Psychiatric disorders.
- Radiotherapy.
- Alcohol consumption increases the risk of liver fibrosis, so it is advisable not to drink. However, an occasional drink will not usually cause significant side effects.

2.9. **Monitoring**

2.8.1. **Prior to Starting Therapy and ongoing monitoring - The Rheumatology / Dermatology Team to Undertake and Communicate to GP, Results of:**

- Screening for lung disease, including interstitial lung disease and tuberculosis, should be undertaken at clinician discretion on a case-by-case basis.
- Pulmonary function tests in selected patients.
- Hepatitis B and C screen and HIV screen.

- Baseline assessment of renal function, FBC, and liver function – including FIB4 score.
- The patient's FIB4 score should be checked annually if they are aged 35 years or older.
- Change in FIB4 score as follows (and see comments on pathology report):
  - Aged 35 – 64 years, FIB4 exceeds 1.3 – refer for Fibroscan, continue methotrexate.
  - Aged over 65 years, FIB4 exceeds 2.0 – refer for Fibroscan, continue methotrexate.
  - Any age, FIB4 exceeds 2.67 – refer for Fibroscan and hold methotrexate.
  - Fibroscan is only needed on the first occasion that a patient's FIB4 exceeds each of these thresholds.

2.8.2. **Ongoing Monitoring - General Practice:**

It is recommended that all blood counts are monitored and recorded in the patient record and patient booklet to comply with NPSA and GMS. The patient may be asked to show their methotrexate booklet when collecting prescriptions from a community pharmacy; this is an additional check to ensure that appropriate monitoring is being undertaken.
DO NOT issue further prescriptions unless the patient is attending for the required blood monitoring.

- Then FBC, Electrolytes and LFTs every 2 weekly until on stable dose for 6 weeks, then monthly thereafter for 3 months, then at least every 12 weeks unless advised otherwise. Some patients at increased risk of toxicity may be advised to have monthly blood tests for longer by their specialist team.
- CRP should be measured at the same intervals, to assist specialist teams in monitoring response to treatment (as trends are more helpful than isolated results).
- Always look at the mean corpuscular volume (MCV). A rising value may precede marrow dysplasia BUT check for other causes before stopping treatment (e.g. B12, TFT, Folate and alcohol consumption).

2.8.3. **If Any of The Following Occur, Repeat the Test, Consider Interrupting Treatment and if Required Contact the Specialist Team for Advice:**

- WCC < 3.5 x 10^9/L – particularly if falling trend.
- Neutrophils < 1.6 x 10^9/L – particularly if falling trend.
- Mean Cell Volume > 105 – particularly if rising trend.

- Unexplained eosinophilia > 0.5 x 10^9/L. Though for Dermatology patients, only alert secondary care if there is an increase from baseline.
- Platelet count < 140 x 10^9/L.
- ALT and/or AST > 100.
- Unexplained reduction in albumin (below 30 g/L).
- Creatinine increased > 30% over 12 months.
- eGFR decreases < 60mL/min/1.73m² and there is a significant falling trend. If eGFR decreases to between 30 and 60mL/min/1,73m² but is stable, reduce the dose to a maximum of 12.5mg weekly.
- eGFR decreases < 30mL/min/1.73m², discontinue methotrexate and repeat the test 10-14 days later. If eGFR improves to > 30mL/min/1.73m², is stable, and the drop is due to a reversible cause (e.g. AKI), methotrexate can be restarted with fortnightly bloods for a month, then monthly. If eGFR does not improve, contact the specialist team for advice.
- Severe nausea or diarrhoea.
- Severe mouth or genital ulceration.

NB: Do not routinely stop treatment prior to surgery or if the patient has an infection, unless hospital admission or parenteral antibiotics are required.

2.10. **Side Effects**

2.9.1. Patients must report mouth ulcers, sore throat, fever, epistaxis, unexpected bruising or bleeding, and any unexplained illness/infection and should be seen urgently for full blood count and liver function tests.

2.9.2. **If pulmonary symptoms are reported, these should be investigated urgently with a chest x-ray to exclude pneumonitis.**

2.9.3. **Beware of patients attending GP surgeries or pharmacies presenting with other symptoms; signs of methotrexate toxicity may present as, for example, breathlessness, dry persistent cough, vomiting and diarrhoea.**

2.9.4. Photosensitivity reactions can be severe. Patients should be advised to take precautions to protect their skin in the sun.

2.9.5. Very common/Common:

- Mouth ulcers, nausea and diarrhoea, hair loss.

2.9.6. Uncommon:

- Headaches, bone marrow suppression, lung inflammation, liver inflammation, clinically significant renal failure.

2.9.7. Very rare:

- Drowsiness.

2.10. Common / Significant Drug Interactions

- Folate antagonists should be avoided – nitrous oxide, co-trimoxazole, **trimethoprim**, sulphonamides, phenytoin and some antimalarials.
- NSAIDs – This is not considered to be a problem in patients with inflammatory arthritides as the doses used take this interaction into account. However, it may be an issue with Dermatology patients and advice should be sought from the Dermatology Team.
- Ciclosporin.
- Acitretin.
- Clozapine: increased risk of agranulocytosis.
- Leflunomide: increased risk of liver toxicity.
- Drugs affecting transport function of renal tubules – ciprofloxacin, penicillins, probenecid, aspirin (though low-dose aspirin can be used safely).
- Caution is needed when co-prescribing hepatic or nephrotoxic drugs.

2.11. Vaccinations

2.11.1. **The Green Book should be regarded as the definitive source of information regarding vaccination; chapter 7 deals specifically with immunosuppressed patients.**

Recommended vaccines for all patients include influenza (annually) and pneumococcal pneumonia, as a single dose of Pneumovax. Ideally this should be administered before starting treatment, but if this is not possible it should be administered as soon as practicable.

2.11.2. **Low levels of immunosuppression are not considered an absolute contraindication to the shingles vaccine (Zostavax) and the Green Book recommends that low-dose (≤ 25mg/week) methotrexate is not a contraindication in most patients, though clinician discretion is advised. Passive immunisation should be carried out using Varicella Zoster Immunoglobulin (VZIG) in non-immune patients if exposed to chickenpox or shingles; this will need to be discussed with the on-call Consultant Medical Microbiologist.**

2.11.3. Other live vaccinations may be permitted; Refer to the Green Book for advice re: other vaccinations/infections.

2.11.4. Treatment with methotrexate does not contraindicate the use of any currently available Covid-19 vaccine. Patients should be vaccinated in accordance with JCVI recommendations. They do not need to stop methotrexate prior to vaccination.

2.12. Handling and Disposal

2.12.1. The patient will be trained in safe self-administration of subcutaneous methotrexate by one of the lead nurses in an outpatient setting using Metoject. When the patient feels confident, and the nurse is satisfied that the patient is able to self-administer, they can start to self-administer at home. The hospital will supply the first cytotoxic sharps bin.

2.12.2. If the GP surgery decide to prescribe a different brand of methotrexate injections, they are responsible for patient training as above.

2.12.3. Should a nurse administer subcutaneous methotrexate, then it is advised they follow accepted good practice as described in the RCN guidance (see reference). Gloves and apron should be worn, and methotrexate should not be administered by anyone who is, or suspects they may be, pregnant.

2.12.4. All waste contaminated with methotrexate is classed as a cytotoxic waste and therefore should be disposed in accordance with local policy for the disposal of hazardous waste. Disposal of full sharps bins is via Cornwall Council (see https://www.cornwall.gov.uk/rubbish-recycling-and-waste/recycling-and-rubbish-collections/clinical-waste-bags-and-sharps-bins/ or call 0300 1234 141 for details).

2.12.5. For home use, purple lidded cytotoxic sharps bins can be prescribed on an FP10 as: Sharpsguard (Daniels) or Sharpsafe (Frontier) Cyto/Purple, 1 Litre. NB. Not all practice computer systems list the colour of the container and so prescribers may need to manually add the word ‘purple’ to the prescription to ensure a cytotoxic one is supplied.

2.13. Areas of Responsibility for the Sharing of Care

2.13.1. These are suggested ways in which the responsibilities for the management of patients with rheumatoid arthritis or psoriasis and other rare skin disorders who are prescribed oral or subcutaneous methotrexate can be shared between the specialist and the general practitioners. GPs are invited to participate. The expectation is that these guidelines should provide sufficient information to enable GPs to be confident to take clinical and legal responsibility for prescribing these drugs. If a specialist asks the GP to prescribe this drug the GP should reply to this request as soon as practical. Sharing of care assumes communication between the specialist, GP and patient. The intention to share care should be explained to the patient and be accepted by them.

In the NHSE guidelines on responsibility for prescribing (January 2018) between hospitals and GPs, it is advised that legal responsibility for prescribing lies with the doctor who signs the prescription.

2.13.2. **Specialist:**

- Decision to prescribe methotrexate.
- Discussion with the patient regarding the benefits and side effects of treatment and gain consent to treatment. Refer patient to specialist nurse service where appropriate (e.g. new patient) for advice on taking/administering the drug, its cautions, side effects associated with treatment, monitoring requirements and the timing of re-assessment and by whom.
- Baseline tests and annual FIB4 score.
- A patient information leaflet and booklet for recording test results must be issued.
- To remind patients to bring their monitoring booklet with them each time they see a healthcare professional (so results can be recorded appropriately) and each time they collect a prescription from the community pharmacy.
- Either start oral methotrexate treatment by providing the first prescription and ensuring the patient's condition is stabilized (usually requires two to three month's treatment prescribed by the specialist) and ask the GP whether they are willing to participate in shared care using the suggested wording template (Appendix 3), OR ask the GP whether they are willing to participate in shared care and initiate treatment. In general, Rheumatology ask primary care to initiate oral treatment, whereas Dermatology ask primary care to take over after about one to two months.
- Subcutaneous treatment should always be initially prescribed by the specialist and will require using the suggested wording template (Appendix 3).
- Prompt communication with GP of any changes in treatment, results of monitoring undertaken and assessment of adverse events.
- Specify review dates at clinically relevant time intervals for both the GP and the consultant.
- Advice to GPs on when to stop treatment.
- Ensure clear arrangements for back-up advice and support.
- Reporting adverse events to the Medicines and Healthcare products Regulatory Agency (MHRA).

2.13.3. **General Practitioner:**

- To respond to the shared care request from the consultant in writing without undue delay.
- Prescribing of oral or subcutaneous methotrexate after communication with specialists regarding the need for treatment.
- If relevant, taking note of National Patient Safety Advice on methotrexate and on injectable medicines.
- Monitoring as outlined in the shared care guideline, and stopping treatment if patients are non-compliant with monitoring requirements.
- Recording of the results of monitoring in GP system and encouraging the recording of results in the patient booklet.
- Ensure that the GP computer system has an alert flag in accordance with NPSA guidance.
- Prompt referral to a specialist if there is a change in the patient's status.
- Reporting to and seeking advice from a specialist on any aspect of patient care which is of concern to the GP and may affect treatment.
- Reporting adverse events to specialist and MHRA.
- Stopping treatment in the case of a severe adverse event or as per shared care guideline.
- Provision of replacement monitoring booklets when full or lost/damaged.

2.13.4. **Patient: and parent / carer responsibilities**

- Report any adverse effects to their GP and/or specialist whilst being treated with methotrexate.
- Ensure that they have a clear understanding of their treatment. The patient may need support from an appropriate health professional on how to complete the patient held record.
- Ensure they organise and attend for monitoring blood tests as per shared care guideline.
- Aware that treatment will be stopped if patient does not attend for monitoring.
- Aware that a record of monitoring results should be entered in their booklet, and that they may be asked to show this record when collecting prescriptions from their pharmacy.
- Disposes of used syringes and full sharps bins appropriately and safely.

2.13.5. **BACK-UP ADVICE AND SUPPORT IS AVAILABLE FROM THE RELEVANT CLINICAL TEAM.**

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance with prescribing and administration in accordance with this guideline (or other safe practice).
Lead	Head of Prescribing Support Unit.
Tool	Audit and review tool using patient documentation.
Frequency	As required according to clinical incident reports.
Reporting arrangements	Via Cornwall Area Prescribing Committee / Medication Practice Committee.
Acting on recommendations and Lead(s)	Relevant Clinical Staff.
Change in practice and lessons to be shared	Lessons and changes in practice will be communicated through various channels to relevant staff.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Oral and Subcutaneous Methotrexate Shared Care Guideline V5.0
This document replaces (exact title of previous version):	Shared care guideline for oral and subcutaneous methotrexate V4.4
Date Issued/Approved:	November 2025
Date Valid From:	December 2025
Date Valid To:	December 2028
Directorate / Department responsible (author/owner):	Rheumatology and Dermatology Team / Pharmacy - Head of Prescribing Support Unit
Contact details:	01872 253548
Brief summary of contents:	Some clinical issues and details of prescribing responsibilities for GP and specialists.
Suggested Keywords:	Methotrexate, Shared Care.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** Yes
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Cornwall Area Prescribing Committee
General Manager confirming approval processes:	Richard Andrzejuk
Name of Governance Lead confirming approval by specialty and care group management meetings:	Kevin Wright
Links to key external standards:	None
Related Documents:	Summary of Product Characteristics. Russell MD, et al. British Society for Rheumatology guideline on prescribing drugs in pregnancy and breastfeeding: immunomodulatory anti-rheumatic drugs and corticosteroids. Rheumatology 2023;62:e48-e88.

Information Category	Detailed Information
	Joint Committee on Vaccination and Immunisation. Immunisation against infectious diseases. London: Public Health England; 2025. Available from: immunisation-against-infectious-disease-the-green-book Bechman K, et al. The 2025 British Society for Rheumatology guideline for the prescription and monitoring of conventional synthetic disease-modifying anti-rheumatic drugs. Rheumatology. https://doi.org/10.1093/rheumatology/keaf522 Royal College of Nursing. Administering subcutaneous methotrexate for inflammatory arthritis. 3rd ed. London: Royal College of Nursing; 2016. /http://www.nrls.npsa.nhs.uk/resources/
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Pharmacy

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
Sept 12	V1.0	Initial issue.	M Wilcock, Head of Prescribing Support Unit
Nov 2015	V2.0	Minor revision.	M Wilcock, Head of Prescribing Support Unit
Jan 2018	V2.1	Minor revision.	M Wilcock, Head of Prescribing Support Unit
Jan 2019	V3.0	Minor revision with dosing in renal impairment.	M Wilcock, Head of Prescribing Support Unit
March 2020	V3.1	Appendix 3 added following FRG approval - CHA4215 Shared Care Agreement Letter Consultant Request.	Demi Louise Kent, Corporate records Manager

Date	Version Number	Summary of Changes	Changes Made by
June 2021	V3.2	Clarification this is for adults in 1.1 Removal of ESR monitoring 2.8.2 Addition of 2.11.4.	M Wilcock, Head of Prescribing Support Unit
August 2021	V3.3	Substitution of Shared Care Agreement Letter with suggested wording template instead (Appendix 3), and minor amendments to related text.	M Wilcock, Head of Prescribing Support Unit
May 2022	V4.0	Full Review and Transposed to latest Trust template.	M Wilcock, Head of Prescribing Support Unit
July 2023	V4.1	Removal of need for chest X ray as baseline test. Minor typo corrections.	M Wilcock, Head of Prescribing Support Unit
November 2023	V4.2	Addition of photosensitivity side effects at 2.9.4.	M Wilcock, Head of Prescribing Support Unit
May 2024	V4.3	Removal of mention of pro-collagen III (PIIINP) test under 2.8.2. Revised website link at 2.12.4.	M Wilcock, Head of Prescribing Support Unit
November 2024	V4.4	Change of wording to 2.8.3 for Dermatology indication	M Wilcock, Head of Prescribing Support Unit
November 2025	V5.0	New statement at 1.1. New wording at 2.1 and 2.5 and additional text about FIB4 score. 2.8.1 now includes baseline screening. Updated references. New wording at Appendix 3.	M Wilcock, Head of Prescribing Support Unit

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Oral and Subcutaneous Methotrexate Shared Care Guideline V5.0
Directorate and service area:	Pharmacy
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Mike Wilcock, Pharmacy RCHT
Contact details:	01872 253548

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide information on prescribing of methotrexate to enable General Practitioners to take over prescribing responsibility from secondary care.
2. Policy Objectives	To promote a consistent level of shared care between primary and secondary care (in relation to RCHT catchment area).
3. Policy Intended Outcomes	Confident and competent prescribers, enabling medicines to be access in a primary care setting.
4. How will you measure each outcome?	Six monthly review.
5. Who is intended to benefit from the policy?	General practitioners, hospital specialists and community pharmacists – from understanding local guidance around use of these medicines. Patients/carers, from being able to access medicines from their GP.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: Yes • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Cornwall Area Prescribing Committee.
6c. What was the outcome of the consultation?	Agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment:
Dan Thomas, Pharmaceutical Services Contracting Team, NHS Kernow.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Suggested wording for Specialist communication re commencement of shared care

Medication: [INSERT NAME].

Indication: [INSERT INDICATION].

Date treatment started: [DATE].

Current dose: [INSERT DOSE] mg.

Time on treatment: [INSERT NUMBER OF MONTHS] months.

Prescription provided for: [INSERT NUMBER OF WEEKS] weeks.

NB: It is expected that the specialist team will prescribe sufficient medication to provide at least 4 (four) weeks of treatment.

GP practice to monitor and prescribe from: [INSERT DATE].

Next blood monitoring due: [INSERT DATE].

Next follow up: [INSERT DATE (if known) OR TIMESCALE].

As per the agreed Cornwall Area Prescribing Committee shared care guideline, this patient is now suitable for prescribing to move to primary care.

The patient fulfils the criteria for shared care and I am therefore requesting your agreement to participate in shared care. Where baseline investigations are set out in the shared care protocol, I have carried these out.

I can confirm that the following has happened with regard to this treatment:

- The patient has been initiated on this therapy and on a stable dose for the following period of time stated above
- Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory.
- The condition being treated has a reasonably predictable course of progression and the patient can be suitably maintained by primary care.
- The risks and benefits of treatment have been explained to the patient.
- The roles of the specialist, specialist team, primary care prescriber, patient and pharmacist have been explained and agreed.
- The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments.
- A copy of the shared care document is either attached or can be found on the RCHT or CFT document library or via the Cornwall Joint Formulary website.

- I have provided the patient with sufficient medication to last for the period of time specified above. (NB: there is an expectation that the specialist will prescribe sufficient medication to provide at least 4 (four) weeks treatment.).

- I have arranged a follow up with this patient as specified above.

If you are in agreement, please undertake monitoring and treatment the date specified above (NB: date must be at least 1 month from initiation of treatment).