

Shared Care in Oxfordshire

Update and Additional Information to Report on Shared Care for Meeting on 22nd March.

Following meetings with all five PCTs, the DAAT considers that the way forward is to support shared care to continue to operate in different ways in the 3 localities, thus meeting the different needs of those localities. A brief summary of the different ways shared care operates in the 3 localities is as follows:

- The **City** has the most demand on its services and has the highest number of RCGP qualified GPs. It operates exclusively from Practices with most GPs seeing more than 10 patients. A resource centre model is not appropriate in this locality. The City GPs may be willing to sign up to an LES but would require funding of £150 per patient (additional to the proposed retainers) to be paid to both bands. Services would be provided by 12 GP Practices, none seeing less than 10 patients. The Luther Street Practice would have a separately negotiated contract to continue providing shared care in addition to this.
- The **South** has 2 Practices with an RCGP qualified GP each seeing more than 10 patients. Of the other 13 practices involved in the scheme, only 1 sees more than 10 patients. The model in the south is that the provision of 3 resource centres (that will see in the region of 20 patients) meets additional need. Sessions within a resource centre should only be offered by a RCGP qualified GP who should be paid at the rate of £150 per session (total cost of 3 resource centres is £24,000. Other costs relating to the resource centres are paid for separately).
- The **North** has 16 practices currently involved in shared care. Two practices have an RCGP trained GP, one further practice having 2 GPs completing the qualification, and 1 practice having 1 GP completing the qualification. A clinic also operates in the north east. There is a fairly even split between practices seeing more than 10 patients and those seeing less.

The DAAT recommends that all 3 localities are represented on the SCMG in order that the local development/monitoring structures are fully integrated.

The DAAT recommends that the PCTs consider issues of clinical governance in their LES agreements. Currently not all RCGP qualified GPs attend the ongoing (voluntary) training and mentoring provided by Dr Frances Davies (although most do).

The DAAT also recommends that within the LES the balance of responsibility is clear between the GP and supporting SCAS worker, so that shared care is indeed partnership working. RCGP trained GPs may also have a wider role for the benefit of PCTs by disseminating knowledge regarding shared care.

Shared Care Funding

The total investment in the scheme by Oxfordshire DAAT in 2004/5 will be £1,160,000. This will fund the SCAS locality teams to support shared care; the Development Pharmacist and Pharmacist remuneration scheme; GP remuneration; DAAT Specialist GP; a clinic in North East Oxfordshire; 3 Resource Centres in South Oxfordshire; North, City, South and West Oxfordshire Shared Care Training Lunches. In addition, continued funding for SCAS Specialist Services (circa £500,000) is provided by the PCTs, which is pooled with DAAT funding. The PCTs have also undertaken to have systems to take on prescribing by 2005.

DAAT funding that will be utilised to specifically pay for GP remuneration under an LES is:

£210,000 - GP Remuneration budget (additional DAAT investment of £60,000)*

£30,000 - GP remuneration for providing services in 3 Resource Centres

*This budget includes the funding for Luther Street, which is assumed to be in the region of £20,000.

Option 1

Band 1 Practice (less than 10 patients) = £1,000 retainer
Band 1 Practice (more than 10 patients) = £2,000 retainer plus £100 per patient
Band 2 Practice (more than 10 patients) = £4,000 retainer plus £150 per patient

There is some capacity for growth within this scheme. However, there is continuing concern that this system is extremely unfair to busy GPs (as potentially a Practice seeing one patient may receive £1,000). It would also be difficult to administrate.

Option 2

Band 1 Practice (less than 10 patients) = £1,000 retainer
Band 1 Practice (more than 10 patients) = £2,000 retainer plus £150 per patient
Band 2 Practice (more than 10 patients) = £4,000 retainer plus £150 per patient

Each patient within this scheme attracts an equal payment of £150. However, the cost of treating 650 patients under this scheme and paying Band 1 Practices seeing under 10 patients a £1,000 retainer means that the first year cost (assuming 650 patients) would be in the region of £188,000. There is no room for growth.

Option 3

<p>Band 1 Practice (less than 10 patients) = £150 per patient Band 1 Practice (more than 10 patients) = £2,000 retainer plus £150 per patient Band 2 Practice (more than 10 patients) = £4,000 retainer plus £150 per patient</p>
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In this scheme each patient attracts an equal payment of £150 but Band One Practices seeing less than 10 patients do not receive a retainer payment. This means that there is some capacity for growth (up to 800/850 patients).

Option 3 seems to be a fair system of payment that can operate with some growth within the DAAT budget. However, PCTs must consider the impact this scheme may have on Practices that provide treatment for small numbers of patients, and on the overall Shared Care Scheme.

In addition, there are a number of other issues regarding funding that the DAAT and the PCTs need to agree upon if a county wide payment structure is agreed. For example, should a practice that has more than one RCGP qualified GP receive more than one retainer payment in recognition?

Also, how should the budget be administered? The DAAT recommends that the budget continues to be held centrally. If the budget is paid to PCTs on an agreed formula, then some PCTs may be left with an overspend whilst others have underspends (PCTs are reminded that PTB is not part of the PCT mainstream budget and cannot be diverted).

Finally, the DAAT wishes to retain involvement in the decision regarding GPs joining the scheme and undertaking RCGP training, as this has impact on the budget and on all the PCTs.

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