

Systems Of Shared Care Co-Ordination And Models Of Shared Care

1. Introduction and Brief History of Shared Care

GPs have been taking on an increasing role in the treatment of substance misuse over the last 10-15 years in response to the need that they see in primary care. A growing body of experience and expertise in working has supported this, and has been underpinned by the development of the RCGP Certificate in the Management of Drug Misuse which provides training for GPs working at a generalist level (Part1) and for GPs wishing to become a GP with a specialist interest (Part 2). One of the ways of supporting GPs is through shared care, which has developed a range of local models, dependent on the history of local service development, with specialist, voluntary or PCT support. We would like to address this slightly haphazard development of shared care in the following paper, in particular looking at the ways in which support for the role of shared care co-ordinators can be given, developing a network of co-ordinators, good practice guidelines and meeting of training needs of shared care co-ordinators.

The Department of Health defines shared care as:

“The joint participation of specialists and GPs (and other agencies as appropriate) in the planned delivery of care for patients with a drug misuse problem, informed by an enhanced information exchange beyond routine discharge and referral letters. It may involve the day-to-day management by the GP of the patient’s medical needs in relation to his or her drug misuse. Such arrangements would make explicit which clinician was responsible for different aspects of the patient’s treatment and care. These may include prescribing substitute drugs in appropriate circumstances.”

Reviewed shared care arrangements for drug misusers. London: Department of Health, 1995 (Executive letter; EL(95) 114).

‘Traditional’ shared care as defined above i.e. support and advice provided from specialist services (often the local Mental Health Trust), into primary care where the patient is prescribed for by the patient’s own GP, is just one among several ways of providing primary care based drug treatment services. Increasingly the way that drug users are treated in primary care is becoming more sophisticated and innovative, with prescribing being provided by e.g. PMS+ practices which see a particular group of patients, or GPwSIs offering prescribing for more chaotic patients. While these developments are to be welcomed, they are not always shared care, but rather the provision of primary care based specialist services. So communication issues between GP and specialist, and the provision of clear pathways for patients to move through the system will be as important whether the specialist is a Mental Health Trust or a local GPwSI.

Development of primary care services has also been supported by shared care being part of the star ratings for PCTs 2004/5 which increased its’ potential importance to PCTs and led to development in this area, and the nGMS contract which from 2004 has defined the treatment of drug users in primary care as an enhanced service.

To meet the 10 year Drug Strategy targets of doubling numbers in treatment over the period 1998-2008, some of this expansion will need to take place proportionately more within primary care, with specialist services treating hard to reach groups, those who are chaotic with complex needs, and working with the criminal justice pathways, particularly prisons. With the PCTs now being star rated on total numbers in drug treatment it seems obvious that primary care is an important element in provision.

2. Emerging Patterns Of Shared Care And Some Definitions

There is an ongoing expansion of shared care schemes with GPs taking on 'stable', non-complex patients so that increasingly the bulk of drug users would be treated in primary care, with specialist services working more intensively with more difficult patients and providing a range of on-going shared care support to GPs and patients prescribed in primary care.

What makes it good shared care?

Good co-ordination of local schemes is essential in ensuring that **quality** issues do not take second place to quantity concerns and target based drivers. Shared care should be regarded as an opportunity to provide a **holistic, patient centred approach** to the treatment of drug users **in their own practice** where they are **normalised** with respect to their treatment. It should ensure shared care **that is flexible and tailored to the need of both the GP and individual patient.**

It should be noted that a lot of GPs might see themselves very much as generalists and not want to take on prescribing without guidance. Here it is important that there is a defined structure that supports and protects GP; as GPs and workers become more confident and experienced, the way of working can become more flexible and responsive to patient need.

What makes it shared care? **A good rule of thumb is if the patient is receiving their prescription and GMS from the same practice**, and other psychosocial support services are available (not necessarily within the same building) and that the GP and other workers are working together to the same care plan. The original notes for the treatment episode should be at the practice where the patient is registered and clinical responsibility for the patient resides with the prescribing GP. (Please note that under the NES conditions, GPs can be commissioned to provide treatment to patients registered at other GPs, providing communication to the patients own GP is ensured – some areas are using GPwSIs in this way).

It can be paid as an enhanced scheme, local or national, commissioned from the practice by the PCO.

What shared care is not...

A GP employed at a local drug service to prescribe – this is a GP acting as a clinical assistant, they don't see their own patients.

A GPwSI employed to see more complex patients from other practices – this is a primary care based specialist/intermediate service, again they're not seeing their own patients.

More mature schemes seem to be opting for a tiering approach with Level 1 GPs having more support from specialist services, Level 2 GPs being more confident and having a wider range of experience to take on more of the work (equivalent to NES requirements), and one or more GPwSIs providing intermediate/specialist services to more difficult to manage patients.

It may be that GPs will play an increasing role in directing services, especially as primary care becomes the dominant location of treatment, and in supervising and supporting other GPs providing prescribing services. This could lead to GPs acting as clinical directors of primary care based treatment services.

However it should be noted that the various models of shared care and spread of service provision should be related to the local milieu and not enforced in a 'one size fits all' mentality. A model that works well in one area might not work at all in another.

GPsWI – there is some confusion between this as **a role within** a primary care system – i.e. a GP who can see more complex patients, and as a self **description** of a GP who has worked in this field for a long time and gained a lot of expertise in this field – they might then undergo training e.g. RCGP2 and complete a number of hours of CPD to support their work e.g. as a sessional clinical assistant at a drug service. Some PCTs are looking to employ GPsWIs to act as chairs of shared care monitoring groups and to support the work of the shared care co-ordinator in developing shared care systems, but not to fulfil a clinical role other than prescribing for their own patients. Whilst the term GPsWI might then denote that they have skills and knowledge in this field, they are not actually employed to provide the kind of intermediate care within the local health economy. The lack of a national job description, or possible role profile allows this kind of confusion to occur, although equally local areas should be commissioning services appropriate to what is happening locally, and so should be free to develop a job description that fits the needs of the local community.

3. The role of shared care co-ordinators

As treatment systems develop, it becomes more important that there is someone based in primary care who is aware of, and co-ordinating, the various strands. In response to work with areas that have been identified by NTA as requiring input from SMMGP advisors to develop shared care, it has become apparent that one of the reasons that areas do not have a fully functioning shared care scheme is the lack of someone to bring the disparate parts of the system together and co-ordinate it. Accordingly one of the initial actions of the primary care advisor from SMMGP has been to recommend the appointment of a shared care co-ordinator to address this need, with some support and initial mentoring of the appointee often being seen by the advisor as key to helping the scheme to get off the ground, and facilitating links with local GPs who have had training in substance misuse. It would seem that as shared care schemes develop, co-ordination is an essential component of a healthy system – for this to work effectively it would make sense for one person to take on this role. As shared care schemes expand, they will become more complex – it is essential that a named person ensures that all parts work together.

Does it have to be a clinician? There are clinical and non-clinical aspects of co-ordination that need to be covered and at present there are clinical and non-clinical appointees to the post (please see later section for competencies of this role). Whilst it is essential that shared care co-ordinators have a basic knowledge of treatment systems and are aware of good practice within the field of substance misuse, it is not absolutely essential that they have a clinical background. What is essential is that this clinical knowledge resides somewhere **within the system**, and if the appointee does not have a clinical background, then there need to be clear and explicit pathways about how clinical queries are dealt with – either with the support of a GPwSI (see below) or via local specialist services. Practically, it might be easier to appoint a clinician to the role of shared care co-ordinator so that access is easier.

Does it have to be a GP? Identifying a GP who can act as a local champion is also essential, visiting practices and providing input into training - this peer contact is often very effective at convincing GPs that drug users can be safely managed in general practice, and expounding the benefits of this to both patient and GPs. A GP could be employed as shared care co-ordinator and might be very effective in this role. However due to cost constraints, PCTs might wish to consider employing a GPwSI sessionally, especially to jumpstart a new scheme, and in addition perhaps conducting patient reviews at practices and providing supervision, in conjunction with a shared care co-ordinator.

4. Essential elements of shared care co-ordination systems

The role of the shared care co-ordinator is central to developing and bringing together the many different aspects of a shared care scheme and ensuring that the **system** runs smoothly. Accordingly, the successful running of a shared care scheme might entail changes to be made in the way that specialist services work to make them more responsive to the supportive requirement of primary care. It is essential that someone who is highly skilled, and who has enough seniority to deal with the high-level liaison tasks fill this role. It needs to be someone who is credible in that role, with preferably a clinical background so that they can act in an advisory role to clinicians. In the drive to increase treatment spaces, it is important that issues relating to the **quality** of treatment are not overlooked. Good co-ordination of local schemes is essential in ensuring that quality issues do not take second place to quantity concerns and target based drivers.

While not wanting to be rigid about how shared care is provided, to co-ordinate a functioning system it seems that there are some essentials that will need to be met to ensure that the system works.

Tasks of the role will thus include:

- Liaison between primary care and specialist drug services
- Ensuring lines of communication are open and effective
- Provision of clear protocols
- Delineating clear roles and responsibilities of all parties in shared care agreement, including GPs, key workers, pharmacists and specialist services
- Ensuring robust clinical governance pathways
- Ensuring appropriate audit of clinical activity and performance management

In addition to good clinical skills, knowledge and experience around substance misuse, below are some of the essential tasks that need to be covered by the system of shared care co-ordination – for some developing schemes/co-ordinators, these might be current training needs.

- Ability to undertake multidisciplinary work – DATs, PCT, NTA
- Understanding of models of Care
- Implementing change without line management responsibility i.e. working to change how specialist services support GPs
- Understanding of and implementing of the new contract for GPs – LES/NES
- Working with pharmacists as part of the primary health care team, especially in providing supervised consumption and needle exchange and implementing the new pharmacy contract in respect of this
- Production of good practice protocols
- Ability to work with practice staff – prescription clerks, practice manager, practice nurses
- Performance management/audit/clinical governance issues
- Influencing the commissioning process
- Providing training to GPs and other HCPs
- Ensuring that there is a shared care monitoring group, that all stakeholders are represented, that the meetings happen and that they are minuted
- +/- Budget management
- +/- Line management responsibility for primary care liaison clinicians as schemes develop
- +/- Provision of clinical advice, caseload reviews of GPs

Currently people from a number of different professional backgrounds undertake the key role of shared care co-ordinator/worker. But there is no specific training structure at present that looks at the needs of shared care co-ordinators, and thus no standardised minimum for clinical knowledge or experience, other than that set locally. This is especially important as often shared care co-ordinators or workers are advising GPs around prescribing. There does seem to be the start of a 'professionisation' of shared care co-ordinators in acknowledgement of the specific roles and responsibilities of this role

There is also no professional accountability structure analogous to the governing bodies of the RCGP, RCN and RPSGB. Some good regional networks exist currently that provide peer support, advice and some training to members. Shared care co-ordinators also participate in other primary care networks or action based learning sets e.g. PANN in London.

Taking the RCGP Part 2 is to be encouraged for all co-ordinators and it would be useful to consider providing a uni-disciplinary day (analogous to those already existing for pharmacists, nurses and patient advocates) that addresses some or all of the above core competencies. There is the problem that people who are not GPs, pharmacists or nurses can not currently access the electronic components of the Part 1, and also that some co-ordinators no longer do direct clinical work

It might be that some GPs who are fulfilling a more strategic role within their own localities would also find some of the above training topics useful.

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Appendix: Proposals for taking it forward

SMMGP proposes that the system of shared care co-ordination is formalised and the development of this role within the system of shared care is supported by the NTA, specifically by:

1. An NTA endorsement of the shared care role, and its' importance in directing the successful running of shared care and primary care prescribing in general (with DH support of this role being placed within PCTs). This would include ensuring that there is a shared care co-ordinator as part of the treatment plan (or that all essential aspects of shared care systems are accounted for by named people).
2. In support of the above it is proposed that a network analogous to the way that regional managers of the NTA work with DAT co-ordinators and providing some level of accountability. To increase shared care in developing areas SMMGP primary care advisors have often advocated the appointment of a shared care co-ordinator and have taken on a continuing mentoring role for these people. As a natural progression of the measures that they have recommended this could be developed, possibly by setting up more formal mentorship programmes with shadowing of other co-ordinators and/or clinical services (which fits in with the requirement for the RCGP2 field visit), guidance, sharing of protocols and working with regional fora.
3. That the role of the shared care monitoring group is emphasised and that how this fits into the DAT structure and informs decision making is clear e.g. members of the SCMG might sit on the treatment planning subgroup and/or joint commissioning group, in acknowledgment of the increasing numbers of drug users being treated in primary care.
4. SMMGP supports this acknowledgment of the distinct role of shared care co-ordination by providing a shared care co-ordinator 'spot' in 'Network' and/or space on the SMMGP website.
5. SMMGP supports the delivery of a 3rd national conference for shared care co-ordinators, and develops a series of regional events in partnership with the NTA to look at the development and delivery of local systems of shared care, taking the successful East Midlands shared care day as a template and rolling this out to other areas. THIS WOULD REQUIRE FUNDING FROM THE REGIONAL OFFICES.
6. Regional fora are already set up in London/South East and the North West for support and discussion around specific issues of the co-ordination role – this could be expanded to include separate fora for all regions. SMMGP primary care advisors would be able to use their local contacts to identify people who might attend and take an active role in setting these up. They should also make use of regional action learning sets e.g. London PANN for ongoing clinical updates. POSSIBLY THE NTA REGIONAL OFFICES COULD SUPPORT THESE E.G. HELPING FUND A VENUE OR FACILITATOR.
7. Development of a national job profile defining core competencies by SMMGP – this would fit with Agenda for Change job evaluation (probably as a clinical manager) and DANOS. FUNDING REQUIRED TO UNDERTAKE THIS
8. Training programme – initially this would consist of a training needs analysis (by meeting with shared care co-ordinators at the RCGP national conference to 'idea shower' perceived needs and then seeking a wide consultation on this initial process via regional networks and SMMGP website).

Taking the RCGP certificate in the management of Drug Misuse Part 2 is to be encouraged for all co-ordinators and SMMGP could co-ordinate a uni-disciplinary day (analogous to those already existing for pharmacists, nurses and patient advocates) that addresses some or all of the above core competencies. There is the problem that people who are not GPs, pharmacists or nurses can not currently access the electronic components of the Part 1, and also that some co-ordinators no longer do direct clinical work to fulfil the clinical case part of the assessment. Since shared care co-ordinators would do not receive funding to do this from DH, if this was seen to be an essential training need THEN THE NTA COULD CENTRALLY FUND A NUMBER OF PLACES. It is imperative that co-ordinators who are providing advice to GPs have at least the same level of training as a GPwSI (increasingly RCGP Part 2 training is being made a necessary but not sufficient prerequisite for this role), or have access to a clinician who can function at this level.