

## Appendix 1

### DEFINING SHARED CARE

At the AWPAG meeting on 13<sup>th</sup> July a paper was discussed on Shared Care. In this paper it states there is a need for clarification as to 'what is shared-care' and 'what is near-patient testing'.

GPs have traditionally prescribed things which they would be unlikely to initiate, and have tacitly supported specialists to supply and monitor certain drugs (possible as a consequence of 'cost-shifting' from a tight finite budget to the formerly 'open ended' GP budget). GPs have always been uncomfortable with these arrangements, partly because they are concerned about accepting legal responsibility for prescribing a drug which is unfamiliar, partly because they feel that this work has 'shifted' to them with no additional resources. However, they have usually agreed to these requests, often recognising the considerable convenience for patients (particularly if the hospital is some distance away).

The new GMS contract sought to deal with some of these concerns by developing enhanced services, for which practices receive payment around a specified service and which includes clear shared care guidelines – helping to reduce concerns about legal liability. However, the boundary that placed treatments into a National or Local Enhanced Service was never clearly defined in the new GMS Contract:

Part of the debate is the point at which other drugs that require monitoring, ideally via shared-care arrangement, which many GPs have continued to provide over several years, now becomes incorporated into enhanced services, which the LHBs commission and pay general practice for – in addition to "core services". A concern is that anything now deemed "shared-care" or "near-patient testing" will result in GPs declining to supply treatment if it is not part of an Enhanced Service which is paid for. This passing back of people needing supervised/monitored prescribing to hospital care could cause problems of capacity in secondary care, and if paid for by an enhanced service, could prove costly, or even unaffordable.

It is important to recognise that in addition there are several drugs which many GPs have become comfortable to both initiate and monitor, which in the past may have been deemed "hospital only" or shared-care, but are now largely routine (for example, ACE Inhibitors in heart failure). Some GPs may still feel the supply and use of these treatments is an Enhanced Service.

The other element of this is *Near Patient Testing* (e.g. for warfarin or disease-modifying drugs in rheumatoid arthritis), for which fees are now paid within the new contract, and which also needs to be placed alongside *Shared Care*.

In all of these arrangements, in whatever format, the most important element is to ensure patient safety.

#### **New GMS Definitions**

Supporting documentation for the new GMS contract states:

*"The treatment of several diseases within the fields of medicine, particularly in rheumatology, is increasingly reliant on drugs that, while clinically effective, need regular blood monitoring. This is due to the potentially serious side-effects that these drugs can occasionally cause. It has been shown that the incidence of side-effects can be reduced significantly if this monitoring is carried out in a well-organised way, close to the patient's home.*

*The near patient testing service is designed to be one in which:*

- (i) therapy should only be started for recognised indications for specified lengths of time*
- (ii) maintenance of patients first stabilised in the secondary care setting should be properly controlled*
- (iii) the service to the patient is convenient*
- (iv) the need for continuation of therapy is reviewed regularly*
- (v) the therapy is discontinued when appropriate*
- (vi) the use of resources by the National Health Service is efficient.*

*This national enhanced service will fund:*

*(i) a **shared care** drug monitoring service in respect of the following specified drugs:*

- (a) Penicillamine*
- (b) Auranofin*
- (c) Sulphasalazine*
- (d) Methotrexate*
- (e) Sodium Aurothiomalate.*

The contract goes on to state:

*This could also cover **all 'amber' lists drugs** where shared care is appropriate.”*

## **Legal Liability**

Concerning legal liability in “shared-care” prescribing, Midlands Therapeutics Review and Advisory Committee (MTRAC – see [www.keele.ac.uk/depts/mm/MTRAC](http://www.keele.ac.uk/depts/mm/MTRAC) ) advises:

*Considering the prescribing of drugs by general practitioners on the recommendation of hospital consultants, it is believed that a doctor will not be found negligent in a court of law if he can convincingly demonstrate that he acted in accordance with a responsible body of relevant professional opinion.*

*If a GP has:*

*taken steps to become familiar with the effects and side-effects of a drug he prescribes, using evidence of a balanced nature,*

*is able to monitor that drug completely (or satisfies himself that adequate monitoring is taking place),*

*and has access to effective consultant support if a problem arises,*

*then it is unlikely that he will be found negligent if a problem subsequently develops.*

This implies that to prescribe securely/appropriately GPs, rather than deciding individually, need locally agreed shared-care arrangements. MTRAC go on to discuss what a shared-care agreement should look like, which minimises the legal risk to GPs:

**> Individual, patient-by-patient arrangements**

*Effective Shared Care Agreements should be patient-specific and encompass all aspects relevant to that particular patient.*

**> A reasonably predictable clinical situation**

*Clinical responsibility should be considered for transfer to primary care only where it is agreed that the patient's clinical condition is stable or predictable.*

**> Willing and informed consent of all parties**

*This includes patients, carers and doctors. Consenting parties must have sufficient, accurate and timely information in an understandable form. Consent must be given voluntarily.*

**> A clear definition of responsibility**

*The shared care arrangement should identify the areas of care for which each partner has responsibility and where, if appropriate, the specialist resources are available to the general practitioner. This should be patient specific.*

**> A communication network**

*Agreed communication should include a telephone contact number for use when problems arise, and fax and email numbers if appropriate. Progress reports should be produced to an agreed time-scale with regular review.*

**> A clinical summary**

*This should include a brief overview of the disease, the product's licensed indications, therapeutic classification, dose, route of administration and duration of treatment, a summary of adverse effects, monitoring requirements and responsibilities, clinically relevant drug interactions and their management, peer-reviewed references, and contacts for more detailed information.*

**> Emergency support**

*Contact numbers should include those for out-of-hours queries.*

**> Training**

*Any training required by general practitioners and their staff should be identified and provided to a satisfactory standard by the specialist department seeking the shared care arrangement.*

**> Funding**

*It should be recognised that resources available in Practices and Trusts are not uniform. Funding difficulties should be directed to the PCT (LHB).*

**Other Considerations**

For these arrangements to work it is important that clear systems are defined – such as in the MTRAC model, or Red Amber Green (RAG) lists, so that Trust medical staff and GPs are aware of the shared-care arrangements and they are implemented appropriately. There needs to be clear documentation with appropriate patient information explaining arrangements to patient and/or carers.

## **Towards a definition of shared-care?**

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, as suggested above, 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).

*Near patient* testing may be different as it also covers the situation where a specialist initiates treatment, or recommends initiation of treatment (for example, warfarin) but may not be involved in subsequent follow-up. The responsibility for monitoring treatment then lies with the practice, and in *most cases*, the prescribing GP accepts responsibility for continuing drug therapy, and legal responsibility for prescribing.

It seems reasonable that, if the criteria are met for shared-care, as long as the GP is informed, trained and can prove 'competence', the LHB should consider whether it is appropriate that a payment be made via an Enhanced Service contract. The responsibility for payment via the Enhanced Service contract lies with LHBs and hence is outside the remit of this paper.

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