Shared Care

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Definition

- The joint participation of primary and secondary / specialist care physicians in the planned delivery of care supported by an adequate education programme and information exchange

Importance

- Main role is in the management of patients with a long term condition
- Currently more than 15 million people in the UK have a long term condition
- People with long-term conditions account for
  - 50-80% GP appointments
  - 64% hospital appointments
- Cost of providing care for this group of patients accounts for up to 70% of the total health care budget

Some long term conditions in gastroenterology

- Coeliac disease
- Barrett’s oesophagus
- NAFLD
- Autoimmune liver disease
- Alcoholic liver disease
- Inflammatory bowel disease
  - Ulcerative colitis
  - Crohn’s disease

Purpose of shared care

- Shared care is commonly used to improve the co-ordination of care and communication between primary and specialist care services for people with long term conditions

- Often involves a shift away from hospital care and the hospital based specialist

- A way to reduce the overall cost of care without any loss in quality and safety

Advantages of shared care

- Delivery of care closer to home
- QUIPP
- Personalisation
  - Health and care services tailored to needs of individual patients
- Reduced fragmentation of care with increased integration and improved continuity of care
- Stronger links between primary, secondary and tertiary care
- Improved patient and provider satisfaction
- More efficient use of scarce resources and improved cost effectiveness

Current shared care of gastroenterological conditions

- Patients who need treatment with Amber light drugs
  - Azathioprine, 6 Mercaptopurine, Methotrexate
- Inflammatory bowel disease
  - Ulcerative colitis
  - Crohn’s disease
- Autoimmune liver disease
- Treatment is initiated in secondary care with follow - up prescribing in primary care

Options for managing long term conditions

- Long term hospital clinic follow-up
- Discharge into primary care
  - Clear guidelines about management
  - Monitoring and frequency of investigations
  - Surveillance e.g. for neoplasia
  - Criteria for re-referral to secondary care
- Annual hospital follow up
  - Outpatient
  - Virtual clinic
  - Clinician /CNS
- Shared care

(Active patient / carer involvement)

Uncomplicated Coeliac disease

- 35 year old with confirmed Coeliac disease I year ago
- Stable on Gluten free diet
- Normal TTG, Improved histology, normal bone density

- Annual follow-up (in surgery)
- Clinical parameters and weight
- TTG
- Dietary history
- Periodic bone density and suppliments as needed

Referral criteria for coeliac

- Weight loss
- New symptoms which do not resolve
  - Lymphoma, ulcerative jejunitis, PEI
- Issues with dietary compliance
- Lab abnormalities – TTG, Hb, etc

Uncomplicated IBD

- 45 year old patient who has left sided colitis 3 years ago
- Relapse free for more than a year
- Stable on medical treatment –5ASA
- Normal lab parameters and Calprotectin

- Regular review (in surgery)
- Monitor renal function-6-12 monthly
- Referral for surveillance colonoscopy after 10 years

Referral criteria for IBD

- Relapse which does not respond to treatment
- Recurrent relapses
- Steroid dependence
- Significant lab abnormalities
  - Hb, inflammatory markers, calprotectin
- New or red flag symptoms
- Symptoms to suggest acute complications

Uncomplicated Barrett's Oesophagus

- 68 year old patient with a 15 yr h/o reflux symptoms
- Endoscopy –hiatus hernia and 5 cm segment of Barrett's mucosa.
- Biopsies- confirm Barrett's, no dysplasia
- Asymptomatic on PPI, patient informed and educated

- Clinic discharge
- Maintain on PPI
- Surveillance endoscopy

Referral criteria for Barrett’s

- Worsening reflux symptoms or dyspepsia
- Dysphagia
- Red flag symptoms
- Endoscopic reassessment
- Concerns about possible neoplastic change

Examples of what is not suitable

- Coeliac
  - Refractory, Pancreatic insufficiency
- IBD
  - Immunomodulators, biologics
  - Strictures, fistulae, unstable disease, short bowel
- Barrett’s oesophagus
  - Stricture
  - Significant oesophagitis

Advantages

- Care closer to home
- Avoids the need for hospital appointments
- Cost savings
- Reduced hospital waiting lists
- Shorter times to see new referrals
- Meets requirements for new to follow-up ratios

Disadvantages

- Lost to follow-up
- Increased work load for GP colleagues
- ? Potential for poor management
- ? Potential for missed complications
- Roles and responsibility

Concerns in secondary care

- Out of sight is out of mind
- Regular monitoring for side effects
- Regular monitoring for complications
- Early referral in case of problems
- Referral for surveillance procedures or investigations
- Regular CME for GP colleagues about concerned conditions

Concerns in primary care

- Increased burden of work
- Increased responsibility
- Be up to date with current treatment guidelines /CME
- Guidelines for surveillance
- Guidelines for re-referral
- Easy access to secondary care

For this to work

- Mandate from primary care
- Shared care agreements
- Identify suitable patients
- Clearly defined criteria for monitoring, review and re-referral
- Clear pathways for communication
- Understanding of roles and responsibilities
- Easy access
- Patient and carer involvement

Summary – shared care

- Good for overall patient care
- Not suitable for all conditions
- Requires active patient consent and involvement
- Requires good communication between primary and secondary care
- Requires quick and reliable fall back arrangements
- Should be subject to audit, governance and patient satisfaction surveys
- Can reduce the overall cost of health care

Mandatory requirements

- GPs need to be able to and willing to take on care
- The clinical responsibility of drug prescribing and it’s consequences rest with the person prescribing the medication
- GPs therefore need to be fully aware of the drugs and dosage prescribed, the monitoring necessary and dealing with side effects
- Excellent communication channels between primary and secondary care
- Explained and accepted by patient / carer

Responsibilities of secondary care

- Initiation and stabilisation of therapy (3-6 months)
- Notification to the GP that treatment has been commenced
- Baseline monitoring until the patient has been stabilised
- Patient / carer information and education
- Shared care arrangements in place
  - Request to GP to take over prescribing
  - Receipt of shared care documents
- Information about any dose changes
- Maintain good communication

Responsibilities of primary care

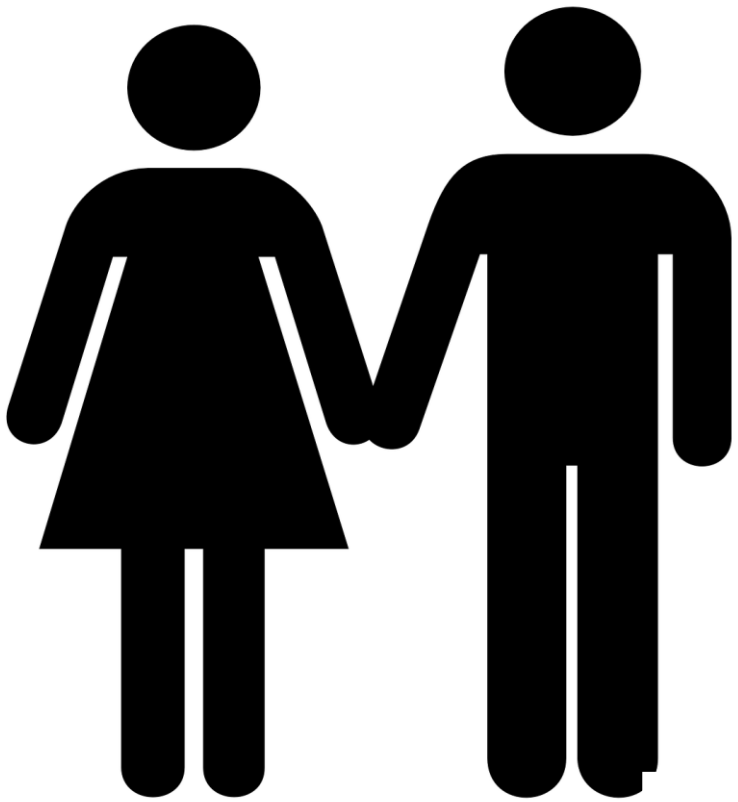
- Reply to the request for shared care
- Ensure shared care arrangements are in place
- Ensure and confirm in adequate information sheets and monitoring information along with timing of the needful is available
- Monitor treatment as stated in shared care protocol
- Confirm with specialists what changes should trigger urgent referral back
- Maintain good communication

Other requirements

- Contact details for immediate advice and support
  - Consultants
    - Telephone and email contacts
- Contact details for medicines information
  - Hospital pharmacy
- Out of hours contact information
- Information sheet with adequate guidance about the drug

B.E.S.T Event

Wednesday 20th January 2016



- **Sexually Transmitted Infections/HIV**
- **Domestic Abuse**
- **Cervical Screening**