Public Health Agreement for the Shared Care for Patients with a Drug Misuse Problem in Primary Care

1 April 2021 to 31 March 2022

SURREY
COUNTY COUNCIL

1.0. Introduction

1.1. All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This specification outlines the more specialised services to be provided.

1.2. This specification outlines the more specialised care being offered above that normally provided through essential and additional services that General Medical Services are contracted to provide. No part of this specification by commission, omission or implication defines or redefines essential or additional services.

1.3. In the delivery of any service commissioned on behalf of the Council, Providers must demonstrate awareness and be responsive to the accessibility and needs of undeserved groups in attempting to access services.

1.4. As part of delivery of this service:

- Anonymised activity data will be shared with local Clinical Commissioning Groups (CCGs) to support understanding of and improvement in provision.
- Practices will receive information on related local public health services relevant to our patients.

2.0. Background

2.1. All practices are expected to provide core services for all their patients. Prescribing is a core service and for some patients it is well recognised that General Practice may be the most appropriate setting in which to manage their substance misuse, including the prescribing of Opioid Substitute Treatment under a shared care arrangement. The purpose of this agreement is to enable this to happen in a way that is safe and acceptable to both individuals receiving the service and the Council.

2.2. The specification of this service for substance misuse is less than that outlined in the previous national enhanced service since to majority of supervision and co-ordination will be carried out by the local Community Substance Misuse Team.

2.3. GP Shared Care is a partnership between GPS, Pharmacists, the Community Drug and Alcohol Team and the individual receiving the service, with the aim of providing a service to individuals who are stable and engaged in strengthening their recovery. It provides for Opioid Substitute Treatment providing for suitable clients and supervised dispensing, where required, while working at the same time with other aspects of the individual's life the enhance the opportunities for successful recovery outcomes. This will be achieved through collaboration between the four parties and include a written care plan for each individual.

2.4. GPs will work in the context of the local network services, supported by key working and specialist service provision provided from the Community Drug and Alcohol Team. The aim is to ensure uncomplicated communication links between the stakeholders involved in each client's care.

2.5. In the delivery of any services commissioned on behalf of the Council, Providers must demonstrate awareness and be responsive to the accessibility and needs of undeserved groups in attempting to access services.

3.0. Aims and objectives

3.1. The aim of shared care is for GPs to offer treatment to stable clients who have been through the local Community Drug and Alcohol Team in order to support them in their longer term recovery. Individuals receiving the service will have been assessed as suitable for continued care from a GP and will be fast tracked to the Community Drug and Alcohol Team should they become chaotic and unsuitable for treatment in a shared care setting.

3.2. GPs will be provided with training and support through the appointment of a Shared Care Worker who GPs can contact for advice, information and assistance. The drug specialist worker will provide a key working role to individuals engaged in the Shared Care, offering additional therapeutic interventions that may be required beyond a prescription. The service is based on the following principles:

- To make the treatment of opiate users accessible and normalised within the health care system.
- To work within national and local guidelines to provide standardised referral, assessment and treatment.
- To ensure shared expectations by using a written agreement with individuals.
- To treat individual with respect and empower them to make informed choices.
- To maintain confidentiality by discussing with other professionals only those issues relevant to individuals' care; and ensuring that written and computerised records are securely stored.
- Ensuring that prescriptions and prescribed medications are correct and available at the proper time, providing that individuals attend appointments at the correct time.

4.0. Scope and definition of the service

4.1. Client group: This specification refers only to the individuals whose main presenting problem is opiate use and who have been assessed and agreed as appropriate to engage in shared care treatment.

4.2. Eligibility and exclusions: eligibility to the service will be determined by the assessment process operated by the Community Drug and Alcohol Team. This team will make a holistic assessment of each individual and determine the probability of successful treatment in a Shared Care setting and successful outcomes.

4.3. In addition to the holistic assessment the following criteria will apply:

- The individual is stable on Opioid Substitute Treatment prescribed medication including Methadone or Buprenorphine.
- The individual is not currently demonstrating a continuing problematic use of prescribed medication, other drugs or alcohol.
- There is no current aspect of the individual's mental health that will interfere with ability to comply with the requirements of the individual care plan.
- Pregnancy will result in Opioid Substitute Treatment prescribing responsibility returning to the Community Drug and Alcohol Team.
- Any partner in the Shared Care agreement can withdraw from providing as part of the agreement following a review of an untoward or risk assessment.

4.4. Screening and assessment

4.4.1. The care co-ordinator (normally the Community Drug and Alcohol Team Shared Care Worker) will establish the suitability of the referred client for the shared care scheme, based on the client's desire to meet the requirements of Shared Care community prescribing and other relevant social and environmental factors. Where necessary the Shared Care Worker will advise on alternative services for individuals who are not eligible for the Shared Care scheme.

4.4.2. A care plan for each individual must be agreed between the Shared Care Worker, the GP and the client. This must set out the recovery objectives for the client and the services to be included in the care plan in order to meet those objectives. The main elements of this must normally be reviewed on a rolling 3 month basis or earlier. In addition there must be a written agreement signed by the individual and the Pharmacist in relation to the supervised dispensing agreements.

5.0. Description of the core service and care co-ordination

5.1. The Shared Care Worker will provide expert advice in substance misuse to the GP and:

- Assist the GP in drawing up a care plan and an agreement with the individual setting out shared expectations.
- Offer monitoring sessions, appropriate psychosocial interventions and opportunities to attend groups.
- Assist the GPs to monitor the prescribing regime and ensure that saliva/urine testing takes place as agreed in the care plan.

- Liaise with the GP on a regular basis providing up to date information on the individual's progress including providing a written update on a three monthly basis.
- Liaise with other agencies involved in the care of the individual and make referrals as appropriate.
- Assist the GP in reviewing the care plan in the event of a breach of agreement, non-compliance with treatment, lapse, relapse or problematic drug or alcohol misuse and recommend appropriate action, including the prompt return of the individual to the Community Drug and Alcohol Team.
- Assist the GP in completing the relevant monitoring and national drug treatment monitoring system forms at initial assessment, three months, six monthly thereafter and at exit from Shared Care scheme.
- Complete the monthly client list/s and take copied to supervision sessions.
- Ensure compliance with national ad local clinical guidelines, treatment protocols, policies and procedures.

5.2. The GP will need to offer monthly face to face appointments and every quarter a shared meeting with the shared care worker, in addition to:

- Screening (Hepatitis, HIV), vaccinations (Hepatitis A and B and cervical cytology).
- Provide Opioid Substitute Treatment prescriptions for the duration of the treatment episode as agreed in conjunction with the shared care worker.
- Work towards the goals and objectives outlined in the care plan and cease to prescribe if the individual fails to comply with agreed plan.
- Comply with the national and local guidelines regarding prescribing and supervised consumption.
- Inform the shared care worker if the individual requests additional prescriptions and jointly review the care plan if required.
- Record brief details of each individuals attendance, health and social circumstances and participate in three monthly clinical review and audit.

5.3. The Pharmacist will provide dispensing services (including supervised consumption in a designated area) as required and:

- Ensure that the prescription is not supplied if the individual is apparently intoxicated by drugs or alcohol.
- Ensure that medication dispensed for supervised consumption is swallowed.
- Inform the shared care worker or GP of missed doses and withhold dispensing if three or more days doses are missed.
- Report the following to the GP or Shared Care Worker – frequent missed doses or avoidance of supervised consumption, unacceptable behaviour, intoxication with drugs or alcohol, deterioration in health or other health concerns.
- Contact the shared care worker with any problems concerning the prescription.

6.0. Training and accreditation

6.1. Those GPs who have previously provided services similar to this service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the service and shall be deemed professionally qualified to do so.

6.2. It is expected that the doctor will already have or will complete the Royal College of General Practice (RCGP) course part 1 within six months of signing up.

6.3. At a minimum, the doctor (supported by a substance misuse worker within the community drug and alcohol team) should have the skills to:

- Contact the shared care worker with any problems concerning the prescription.
- Identify and treat the common complications of drug misuse.
- Carry out an assessment of a patient's drug use.

- Assess and refer appropriately, patients for drug misuse substitution treatment; utilise the range of commonly used treatment options available for treatment including pharmacological interventions.
- Undertake an alcohol use assessment via the AUDIT screening tool
- Provide harm reduction advice to a service user or his or her family.
- Provide drug information to carers and users as to the effects, harms and treatment options for various common drugs of use.
- Test (or refer for testing) for other viruses, including HIV, Hepatitis C, liver function tests.
- Offer vaccinations for Hepatitis A and B.
- Work in an appropriate multidisciplinary manner.

6.4. The doctor should also actively engage with development and networking opportunities provided by the local provider to ensure ongoing PDP within the area of work.

7.0. Appraisal criteria

7.1. The appraisal criteria will include both the generalist and special interest aspects of the work.
7.2. Arrangements for continuing professional development will be agreed, including regular monitoring meetings attended by participating practices and specialist service providers.

8.0. Monitoring and payment

8.1. Payment will be made quarterly in arrears.
8.2. All claims are made via the quarterly claim form provided by the public health team or where agreed by public health, additional local mechanisms that have been developed to submit claims via a CCG or local GP federation can be used.
8.3. Practices must provide the required data monitoring activity to support their claims. Failure to provide this may result in the claim being delayed until the information is provided.
6.4. Claims submitted will be validated via annual data reporting from the iaccess team (SABP) with information on numbers of clients engaged in shared care and their GP. Iaccess are your primary partner in the delivery of the shared care public health agreement. Please contact publichealthclaims@surreycc.gov.uk for appropriate contact details to liaise with them prior to submitting your claim.
8.5. See appendix 1 for payment structure.
8.6. The Council has the right to audit a practice against the claims received. Reasonable notice will be given to the practice prior to the audit.

Appendix 1

Payment structure

Retainer Fee – single amount payable when providing patient support (quarterly claim) - £254.35
Maintenance fee (per patient, per quarter) - £89.02