



Shared care agreements

The BMA business guidance has offered some helpful ideas for practices when looking at the services we provide. Many of us have embraced this guidance but we know the choice to place constraints upon our services is not a decision any of us take lightly.

Several practices are currently looking at SCA as the number of drugs and the patients on them have grown considerably and the majority are being provided without resource. What started as a helpful clinical document to safely delineate responsibilities has developed into an uncontrolled conduit for workload transfer. SCA offer more convenience for patients, reduces workload for secondary care but increases the workload for practices.



Restricting services is certainly not a desirable position however for some it may be a necessary action for practices to remain sustainable. We are aware of a number of approaches being taken across Lothian and thought it might be helpful to set out our thoughts for practices in this position. To be clear this is not the only right way to approach this issue nor is it an ask for practices to cease SCA.

- **Contractual position.** Shared care agreements are not part of core GMS services. They can be ceased with responsibility for care returning to the board. We have clarified this with the BMA and have received the following response confirming our view.

Shared care agreements are fundamentally mechanisms by which practices agree to take on some of the practicalities of delivering ongoing secondary care initiated treatment to patients in closer proximity to the homes of patients. They exist as a courtesy to secondary care colleagues and a convenience to patients, but they are not part of a practice's contract. While Health Boards must come to an agreement with the LMC on the nature and structure of any particular shared care agreement in their area, practices cannot be compelled to take part in one if they choose not to do so.

Every individual practice that agrees to participate in a shared care agreement retains an absolute right to terminate such an arrangement at any time, with responsibility for delivering the care and prescribing provided under such arrangements then returning to the secondary care service that the practice was assisting.

In the current climate of significant financial challenges facing general practice, it should come as no surprise to anyone that practices may no longer be willing to carry out work on behalf of secondary care for which they receive no funding.

- **Drawing a line OR stopping for all.** Ultimately this is a decision for practices based upon the drivers for change they are experiencing. Drawing a line and accepting no new patients under an SCA creates less immediate detriment for patients and for secondary care. It allows time for alternative arrangements to be implemented and is likely to be viewed as a proportionate response. Part of the thinking here is that abrupt cessation of prescribing is likely to result in complaints, negative public/political attention, degraded relationships with colleagues and reductions in secondary care services. This may undo any time and resource savings gained by ceasing the SCA in the first place. The impact of drawing a line would grow over time allowing opportunity for solutions to be found and has a greater likelihood of being acceptable to more practices.
- **Notice.** Unlike enhanced services which are contracts and have a defined notice period there is no contract to provide SCA and therefore no terms to guide a period of notice. Where possible our advice would be to give a reasonable period of notice to enable alternative provision to be found by the board.
- **Communication.** We would advise practices to be clear about the reasons for discontinuing the SCA. While the simplistic answer in many cases may be that it is not funded work it is likely to be helpful to explain the background. While we understand the complexities and inadequacies of GP funding this is not widely understood. We know that funding translates to admin time to maintain lists, phlebotomy time to do bloods and GP time to interpret results and write prescriptions, but many will not.
- **Fairness/Equality.** Practices should adopt a fair and consistent approach with due consideration of any impact ceasing SCA may have on equality and on any specific patient groups. There is helpful advice on the public sector equality duty available [here](#). It is worth reading the guidance but in short the general duties are to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Considering the impact of any action in these terms, mitigating negative effects as much as possible, and applying practice policies consistently is essential. That does not mean practices are prevented from taking action that may have negative effects but demonstrating consideration and mitigation would be important if challenged. Given the demands of each SCA are different there may be legitimate reasons for ceasing one and not another but it may be helpful to develop a practice policy to set out how decisions are reached over SCA.
- **Support.** The LMC office is very happy to discuss any plans practice may have around this topic. The BMA have also recently produced some [helpful advice](#) that is worth considering as part of any decision making process.