Shared care: What is it? Does it work?

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Article points

1. Shared care should form a bridge between self care, professional care and community care.
2. As the patient is the only person who experiences all the different care areas, they should be the primary focus of shared care.
3. For podiatrists treating the diabetic foot, it is important to communicate clearly with the person who has diabetes and not to feel impeded by professional boundaries into other services.
4. Communication and trust is also required between diabetes disciplines, and novel, economically viable solutions to meet NSF guidelines are needed.

Key words

- Shared care
- Integrated care
- Multidisciplinary team

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There is much written about multidisciplinary care within diabetes – integrated services, seamless and shared care – all focussing on diabetes consultants, specialist nurses, GPs and practice nurses. Very few, if any, publications have looked at the role of the podiatrist and their part in this evolving and demanding service. This article hopes to define shared care and examine the role of the podiatrist in this context across both the primary and secondary care settings.

The ideology of a seamless service between primary and secondary care was first described in the government's white paper *Choice and Opportunity – Primary Care: The Future* (Secretary of State for Health, 1996). Prior to this, the *St Vincent Joint Task Force for Diabetes* (Department of Health and British Diabetes Association, 1995) explained that they regarded the improvement of working relationships between primary care and hospital services as essential components towards improving the diabetes services.

According to the *Priority Areas: First Round Evaluation of Shared Schemes* document published by the Department of Health (DoH; 2003a), the term 'shared care' describes the joint provision of care – not necessarily in the same place or at the same time – by members of primary care and specialist teams. This philosophy developed further and is now an essential part of the National Service Framework (NSF) for diabetes (DoH, 2003b) and practise-based commissioning (DoH, 2004). Shared care is essentially driven by a group of motivated clinicians who wish to provide better care to their service users.

In the broad sense, shared care can be considered to equate to teamwork, but there are differences that distinguish the two organisational structures. Teamwork relies upon a common purpose with each member having a clear understanding of their role. Teams work by pooling knowledge, skills and resources with shared responsibility for the outcomes. The team should be able to carry out work and manage itself as an independent group. These ideals would be difficult to meet over a district-wide diabetes team as teams are effective in groups no larger than ten (Pritchard and Pritchard, 1994), whereas a district-wide diabetes service has anything up to 500 individuals!

As Pritchard and Hughes (1995) explained, shared care is required to bridge established boundaries that include self care, professional healthcare and social care in the community. Thus, the patient is key to shared care as they are the only person to experience the various settings in which care is provided. With this in mind, they must be encouraged to be an active partner with responsibility and choice. The aim of this structure is to empower the individual and actively help them to self manage their diabetes. Such a management strategy,

Page points

1. Shared care is where responsibility for the service user is shared between individuals, teams or organisations.
2. Integrated care differs from shared care as it consists of structured, formal agreements made within the multidisciplinary, multicentred shared care team.
3. The NHS aim of providing community-based care has resulted in an increase in multidisciplinary input into patient care from the podiatry practitioner.
4. Developing links with colleagues in the shared care network increases knowledge and improves the patient's experience of the healthcare system.
5. Old-fashioned methods of communication must be avoided to prevent miscommunication and confusion.

when the responsibility for health care is shared between the individuals or teams who are part of separate organisations, or where substantial organisational boundaries exist, is shared care (Pritchard and Hughes, 1995).

With its involvement of a team of multidisciplinary individuals, the diabetic foot fits well into the shared care model. As before, the person with diabetes is at the core of this structure and should be considered as the most important focus.

Does shared care differ from integrated care pathways?

Integrated care was recommended by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) in 1978. It covers care co-ordinated between local services, different levels of health and social care and the various sectors such as education, employment and housing.

Integrated care pathways differ from shared care as they are structured and formalised agreements made within the multidisciplinary, multicentred shared care team. Or, as the National Pathways Association describes it, integrated care determines locally agreed, multidisciplinary practice that, where available, is based on guidelines and evidence for a specific service user group (National Pathways Association, 1998). It should then form all or part of the clinical record, document the care given and facilitate the evaluation of outcomes for continuous quality improvement. It is also a tool by which service provision and care can be audited and improved upon – this is the next stage on from shared care.

Benefits for the patient and practitioner

The current aim for the provision of diabetes services by the NHS is to move towards a community-based, integrated service, where the individual can access the appropriate healthcare practitioner they require for their clinical needs (DoH, 2005). This relies on merging the boundaries of primary and specialist care.

For the Diabetes Specialist Podiatrist this means increasing the multidisciplinary input into patient care. Therefore, increasing the skills not only of others involved in the treatment of diabetic foot disease but also of the podiatrist is necessary. Such an approach increases the ability of healthcare professionals to know when to refer on and to whom – thereby providing a more effective patient pathway. It is by developing close links with colleagues that individuals within the care pathway become familiar with their co-workers, making the patient journey easier to co-ordinate. This in turn enhances the ability to respond to urgent and emergency referrals within NICE guidelines as one can be confident that they are appropriate and timely referrals (NICE, 2004). The overall idea of shared care promotes the ideals of the NSF for diabetes (DoH, 2003b).

The person with diabetes also benefits from shared care: they receive multidisciplinary input in a timely manner with care delivered at a local level. Such an approach can limit visits to hospital for out-patient appointments and reduce length of stay if admitted. This approach has been effective in the Norwich and Central Norfolk area where a joint screening and prevention programme for foot and cardiovascular disease reduced inpatient stays for diabetic foot ulcers between 1997 and 2002 (National Diabetes Support Team, 2006).

A joint wound care policy can assist continuation of treatments along with good communication between colleagues. Smith et al (2004) demonstrated that a significant improvement was made in the delivery of diabetes care and psychosocial outcomes when they introduced a shared care programme to North Dublin, Ireland. The study showed an increase in patient participation, a decrease in nonattendence of appointments and improvements in communication at the primary–secondary care interface.

Negative aspects of shared care

There is some difficulty in sharing clinical information due to inefficient systems – for example, letters can take up to a week to make their way to the GP and even then they may not be read! The quality of letters can also cause problems in communications. Miscommunication of information to the person with diabetes can result in confusion and must be avoided.

Individuals may find that extending the role of the podiatrist can cause concern among other healthcare professionals as they may feel that professional boundaries have been overstepped. Communication is key to dealing with misconceptions of colleagues' roles (Johnson and Goyder, 2005).

Among podiatry peers, such an approach may be seen as somewhat maverick. For example, interactions and co-ordination with a tissue viability nurse could lead the podiatrist to debride a leg ulcer to help facilitate healing. Individuals may find working within a multidisciplinary diabetes team more effective than working in a single profession team such as the podiatry department. Working within a multidisciplinary diabetes team means utilising skills in what could be deemed foreign territory. These issues can create feelings of isolation, but a patient-centred approach is essential for the overall wellbeing of the person with the diabetic foot ulcer as they are the ones who live with the condition 24 hours a day, 7 days a week (Freeman, 2003).

Working towards shared care

There can be a shortage of skills among healthcare professionals when dealing with the diabetic foot (Mohiddine et al, 2004). This may be a shortcoming that individuals are aware of but it still must then be addressed with appropriate education. Working together to produce treatment formularies and guidelines is essential in providing equity of care and promoting skills.

Communication is key to success and needs to occur between all stake holders (Housley et al, 2006) and according to the NSF for diabetes, this should also include patient groups (DoH, 2003b). Regular meetings, joint clinics and joint domiciliary visits between clinicians can promote the multidisciplinary aspect of shared care. This will also help to break down misconceptions of individual roles, in particular the opinion that podiatrists are a caricature of toenail- and corn-cutters.

Page points

1. In the financial climate of today's NHS, having money to make change is very rare, so thinking outside the box is essential.
2. With the continued increase in the number of people with a diagnosis of diabetes it is essential that proportionally more healthcare professionals are involved in the care of the diabetic foot.

Patient-held records are essential to the process of shared care (DoH, 2003a). They empower the patient to become the key figure in their care and allow all healthcare professionals involved to communicate effectively. The commitment required for this scheme to be successful is enormous and instilling motivation in all has been a challenge.

To manage change takes time and money. In the financial climate of today's NHS, having money to make change is very rare, so thinking outside the box is essential. How can we do this better? What skills do we already have that we can utilise?

Conclusion

This paper demonstrates that integrated care pathways are the natural progression from shared care but are, at this present time, more of a utopia than an easily achievable goal. The process should begin by developing communications to facilitate joint working on policies and protocols and sharing experiences. With the continued increase in the number of people with a diagnosis of diabetes (DoH, 2002), it is essential that proportionally more healthcare professionals are involved in the care of the diabetic foot in order to prevent an epidemic of amputations. It is time for the converted to challenge the sceptics by breaking down traditional barriers and developing relationships and trust (Johnson and Goyder, 2005). ■

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