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CONFERENCE ABSTRACT

Practice Abstract on the Application of Integrated Care

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Elaine Colgan, Mark Lee

Department of Health Northern Ireland, United Kingdom

Given pressures of an ageing population, rising expectations and ever-developing technology a new approach to General Practice is needed, focussing on early intervention and prevention, with more responsibility for diagnosis and coordination of care and focussing not just on ill-health but the physical, mental and social wellbeing of populations. A major shift in primary care delivery is required, underpinned by reconfiguration of the physical estate and investment in technology.

A co-located multi-disciplinary team (MDT) approach establishes an integrated, GP-centred, primary care workforce model. Patients' first appointment will be with the most appropriate team member –nurse, pharmacist, physiotherapist, mental health specialist, social worker or advanced nurse practitioner. A local survey of 42 GP practices estimated 38% of 12,500 contacts could have been handled by another practitioner. The MDT will actively keep their patient population well, embedding analytics to support early intervention, social prescribing and referrals to community-based services.

The aim is to shift to a holistic approach, focussed on wellbeing, aiming to address the underlying issues that may be driving ill health as well as treating the symptoms, preventing ill-health from occurring by identifying opportunities to intervene early and build resilience. Investing in a first contact model should improve outcomes, reduce costs, resolve issues more quickly and improve access. We expect a proactive approach to help address health inequalities, addressing groups who currently under-use services. The IHI's 'Plan, Do, Study, Act' approach will structure the change, guided by 10 principals – developed with staff and patient involvement – grouped under Starfield's 4 C's of primary care.

Roll-out begins in two areas of Northern Ireland – rural and urban – from autumn 2018, with 203k and 75k patients respectively. Stakeholders include staff, clinicians and representative bodies, healthcare commissioners and providers, community and voluntary organisations, patients and carers. Patients have been involved in development from inception, including through a Service User and Carer Reference Group. Regional workshops and meetings with external bodies informed the project.

Our strategic document, Delivering Together, recognises that roll-out of MDTs will be iterative and take place over at least 5 years.

Impact will be assessed consistent with government outcomes, measures and indicators. Patient experience and user feedback will be sought annually.

As well as a shift to team working, technology innovation may be used to facilitate interaction with other professionals and patients, providing predictive analytics to influence care, and a wider range

of screening tools, such as for poverty and loneliness to inform social work interventions. Teams will refer patients to local services addressing social needs.

Funding of £5m in 2018/19 will begin roll-out. Savings are anticipated with reduced ED attendance and secondary care referrals. Longer term, MDTs will be the new model for primary care, utilising existing resources better.

The diversity of location and population of the first two areas will enable transferability of the model throughout Northern Ireland.

Independent evaluation is being commissioned.

The active learning approach will feedback lessons learned into further expansion of team working and regional scale-up. First findings due 2019.

Keywords: multi-disciplinary teams; practice model; primary care; general practice; transformation