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Think local, act personal: Lessons from an integrated primary care initiative for frail, older people

Introduction

An increasing number of older people living at home with complex needs challenges health and social care systems. SUSTAIN or 'Sustainable Tailored Integrated Care for Older People in Europe' is a 4-year project which aims to support and monitor improvements to established integrated care initiatives for older people living at home with multiple health and social care needs. A primary care medical centre in the South East of England was selected as one of 14 case sites delivering integrated care for this population.

The 'Over 75 Service' is led by senior practice nurses and delivered by a team of general practitioners, community nurses, social care workers, voluntary sector staff, health trainers and care navigators. This paper presents an evaluation of the implementation of this service and explores explanations for success. A Patient Participation Group (PPG) gave feedback on the service and the evaluation.

Methods

SUSTAIN uses a multiple embedded case study design (Yin, 2013) and an implementation science approach. Data was collected from multiple sources including interviews and focus groups with Over 75 Service managers and professionals (n=7), steering group minutes (n=9) and field notes, staff hours data. Data was analysed thematically.

Results and Discussion

A key decision, made early on in the design of the service, was to use the Dalhousie frailty screening tool which enabled a shared vision and understanding of frailty. Collaboration and multidisciplinary teamworking was facilitated by effective multidisciplinary team meetings, which provided a vehicle for establishing personal contacts, sharing information, promoting understanding of individual roles and responsibilities and increasing knowledge of available services. There was a culture of inclusiveness with all agencies valued equally for their contribution. Positive interpersonal relationships were key to the success of the service and direct, personal contact was highly valued.

Organisational structures supported the development of close working relationships and collaboration as one individual from each organisation was assigned to the Over 75 Service. The practice matrons were a single point of contact for service users and staff and were able to share information and provide advice and support to the team.

Specific challenges were short-term funding contracts, increasing demand and a lack of capacity to deliver some services. There were also challenges around data protection, access to data and unwieldy IT systems hindering information sharing.

Conclusions

A highly localised organisational structure, positive interprofessional personal relationships and a shared vision were important ingredients facilitating successful implementation of the Over 75 Service.

Lessons Learnt

Relational continuity is an important enabler of integrated care initiatives for older people with complex needs in a primary care setting. However, delivery is dependent on the availability of adequate resources.

Limitations

Although results are context-specific, lessons can be learnt about what works in terms of delivering integrated care for frail, older people in this setting.

Suggestions for further research

Further research is needed on the scale and spread of integrated care initiatives in primary care.

¹Yin, R.K. (2013) Case study research: design and methods. Sage Publications.