Opinion & Debate

Infrastructure to support modern primary care: the NAPCRG debate update

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In December 2012, at the North American Primary Care Research Group (NAPCRG) conference in New Orleans (USA), associates of *London Journal of Primary Care (LJPC)* from London (UK) and Cleveland Ohio (USA) hosted a forum entitled 'Local Health Communities for Integrated Care'. The forum was attended by senior practitioners/academics from different countries who debated the infrastructure needed to support collaboration at primary/community care level. They drew on lessons from West London's integrated care pilot¹ and Cleveland's 'Promoting Health across Boundaries' initiative.² Participants at the forum recognised international need for case studies of community-oriented integrated care (COIC), including primary- and community-care leadership of collaboration for integrated care, and continuous improvements of whole systems of care.

In November 2013, at the NAPCRG conference in Ottawa (Canada), *LJPC* associates from Quebec (Canada) and London (UK) hosted a second forum to continue this conversation.

In preparation for the Ottawa Forum, in October 2013 *LJPC* invited its readers to rank 11 aspects of integrated care in respect of their importance to research. Table 1 shows the results in order of most 'votes' overall (weighted formula). It also shows the first four (of 11) 'votes' of 61 respondents. Table 2 shows additional comments made by 30/61 respondents.

While 'Patient Involvement' and 'Extended Multi-disciplinary Primary Care Teams' were perceived to be the most important aspects (and indeed 29/61 respondents gave them their first 'vote'), the overall ranking pattern is more complicated. There is an argument for saying that all of these aspects are important, and their

perceived importance may relate to their perceived neglect at present. Recognising the wide range of qualitative comments offered in Table 2, these initial results illustrate the range of research still needed to understand how the infrastructure of primary care can be developed, and, as discussions at the two conferences elaborated, more progress can be made in developing research that examines primary care in context.

Deliberations of participants at the 2013 Ottawa Forum

Participants from different countries at the Ottawa forum reviewed the *LJPC* data in the light of their experiences. They reached the following conclusions:

1. It is important to evaluate case studies of COIC, but both funders and local leaders often prefer discrete projects with more focused outcomes and this makes it difficult to gain funding for COIC
2. A key aspect of success in case studies relates to the mechanisms that facilitate shared vision
3. Case studies of COIC can benefit from the literature of participatory research, complexity science and COIC, that similarly aim to achieve local collaboration to improve the health of whole communities
4. When evaluating case studies of COIC, researchers and practitioners encounter a series of contested questions that deserve scrutiny in their own right:
 - What are the features of modern primary care, and which of them deserve particular examination?

Table 1 Priority aspects of integrated care to research

Most Votes Overall	First four (of eleven) priorities made by 61 respondents	1	2	3	4
1	Patient involvement	16	14	6	5
2	Extended multidisciplinary primary care teams	13	13	7	9
3	Fast and effective communication between different practitioners	7	9	5	8
4	Shared care for long-term conditions	5	6	10	10
5	Leadership of ongoing whole system improvements	11	4	1	4
6	Geographic clustering of primary care organisations to facilitate collaboration	5	3	10	4
7	Public health and community regeneration at local level	2	5	4	11
8	Interdisciplinary, work-based learning	1	2	6	3
9	Technology-assisted decision making	1	1	7	3
10	Ongoing data about the impact of collective effort	0	3	3	1
11	Cross-sectoral joint ventures	0	1	2	3

- Which aspects of a case study of COIC should researchers evaluate?
- How can leaders of collaborative improvements accommodate the multiple agendas of different stakeholders within a case study?
- How can a community and researchers make sense as a whole of quantitative and qualitative data from a case study site?
- What tactics help leaders to engage stakeholders in case studies of multi-disciplinary collaboration, and re-engage them at later stages?
- What training for participation and leadership helps to maintain continuous interorganisational quality improvements within case studies?
- In what ways should the roles of primary and community doctors, nurses and managers develop to enable them to take full roles in COIC?
- What are the implications of COIC for workforce planning and staff development, including CPD for trained staff?

Table 2 Additional comments made by 30 respondents about researching integrated care

Sufficient flexibility in the organization forms

Effective workforce planning for tomorrow's world, with greater involvement of non-medical professions

A proper, functional and fair strategy for ensuring the primary care receives the appropriate level of funding taking into account that this sector cares for >90% of the population without recourse to secondary care services.....we've been waiting for too long - it is now time that we ensure that proper funding for community services take place

Effective practice organisation

System capacity & outcomes

Protected time for leading clinicians to communicate and plan.

Community-based shared resources (care coordination, registry management, community health workers, pharmacy consultants, patient educators, etc

Common guidelines with agreed key objectives. Network practice working either federated or geographical
Time

Integrated primary care including social care and complementary practitioners

Continuity of leadership, continuity of strategy, ensure benefits can be measured, ensure fully resourced and minimise competition between providers - use the money wasted on formal procurement to invest in longer term collaborations between existing providers of healthcare

E-health record

Involvement of frontline staff in decision making

Flexible working

Protected time to learn

Revival of personal care

Extensive, accessible, and affordable referral system for behavioural and psycho-social health

Compassionate care of colleagues with difficulties

Joint consultation with secondary care consultant and secondary care provider

Joint consultations with secondary care consultant and secondary care provider

Change for change's sake

Practitioners' wellbeing and resilience

Sharing of data through technology

Is Family Medicine becoming de-humanised? There's a notable hole where PRACTITIONER RESILIENCE ought to be! The Pulse survey drew in 2200 GPs. To determine the risk of burnout, the MBI explores three components: exhaustion, depersonalization and personal achievement. >90% were at least at level 1 of the MBI; >40% were at level 3!

Caring compassionate approach for staff-use of Balint/reflective practice

Financial integration between community, primary care, secondary care nurse-led health promotion and screening efforts

Annual cycles of inter-organisational improvement at local level

Democratic control of policymaking by HCPs

Research and support to staff development in managing care

Incorporating nurse practitioners in the provision of primary care; nurse-led health promotion and screening efforts

LJPC invites you to submit papers that illuminate these issues.

REFERENCES

- 1 Steeden A. The Integrated Care Pilot in North West London. *London Journal of Primary Care* 2012;5:8–11.

www.radcliffehealth.com/ljpc/article/integrated-care-pilot-north-west-london (accessed 03/02/2014).

- 2 Aungst H, Ruhe M, Stange K. Boundary spanning and health: invitation to a learning community. *London Journal of Primary Care* 2012;4:109–15. www.radcliffehealth.com/ljpc/article/boundary-spanning-and-health-invitation-learning-community (accessed 03/02/2014).