

Integrated Working Sub Group

3 April 2006

Introduction

This paper describes how, through integrated working more can be made of the potential of Northern Ireland's integrated health and social services. It aims to ensure that older people are treated, cared for and supported in the community and enabled to have as much independence as possible.

The development of integrated teams of primary health and social care practitioners can bring major benefits to patients and carers and to the practitioners themselves.

Patients and carers should have the benefits of services characterised by

- Ease of access to services, without the need to refer to separate systems
- Closeness to home
- Continuity of staff, who are known as individuals over time
- Integrated and co-ordinated multi-disciplinary working
- A holistic approach to meeting need
- Linkages with other agencies and the community
- Pathways to specialist and acute care

Primary care practitioners should have the benefits of being

- Known to each other
- Assisted to work together
- Supported by colleagues in other disciplines
- Empowered
- In control of resources
- Able to develop new career pathways

The health and social services system should have the benefits of

- Higher levels of care being provided by primary care teams and the extended primary care network
- Reduced need for admission to hospital
- Reduced need to provide care through nursing and residential care homes

Policy Context

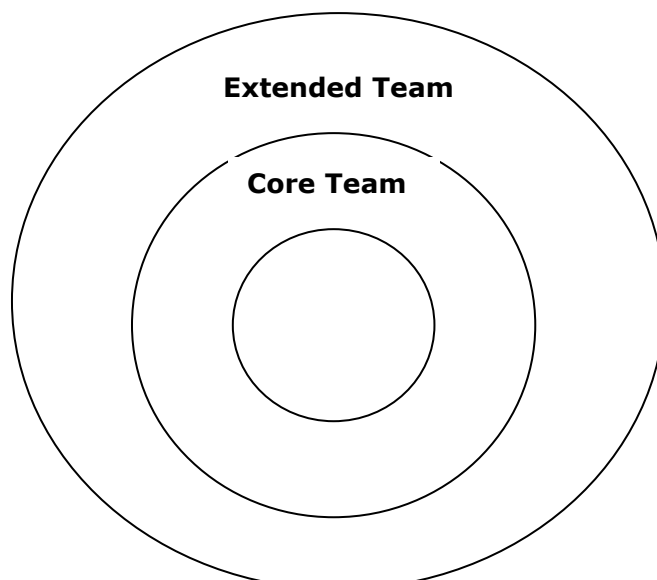
This paper focuses on promoting integrated working in primary and community care. Its starting point is the model of primary care described in the Regional Strategy.

The Strategy states that “we will develop multi-skilled teams and networks based primarily in communities but supported by, and including, people working in hospitals. These teams will focus on either adult or children/young people’s services and will be based in communities but will be deployed flexibly”

The strategy describes a core primary health and social care team which, for adult services, would, it suggested, include GP’s, district nurses, practice nurses, social workers, community pharmacists and administrative staff.

The primary care team should be “supported by an extended team which, for adults, might include specialist community staff, health promotion and public health staff, domiciliary care workers and hospital based professionals.”

This is diagrammatically represented as follows:



Current Position

The core team, the primary care team, is often referred to and traditionally assumed to be central to practice in primary care in the NHS/HPSS.

Research, however, indicates that the primary care team is not a clear entity. Some research has indeed suggested that primary care teams are less team-like than most other entities, which are referred to as teams.

Primary care teams generally lack some or all of the features, which are associated with teams, including:

- Clearly defined membership
- Single point of leadership
- A management structure
- Common agreed objectives and priorities.
- Control of the resources required for and used in their work
- Common bases
- Shared accommodation
- Common administration support
- A single system of assessment
- Common information systems
- Shared records

This paper focuses on primary health and social care for adults and older people but the approach could be applied, in modified form, to services for children and others.

Integration in core priir Patients teams in Northern Ireland

- Down Lisburn Trust has been developing integrated adult and children's primary care teams since 1992. In relation to adult services integrated teams comprised of nursing and social services practitioners and specialist professions are organised on the basis of GP practice lists. Trust staff in these primary care teams are managed through a single management line but with nursing and social work qualified managers providing professional supervision, consultation and support with professional development. Budgets are delegated to localities based on "natural communities", and pooled between a number of primary care teams. Very close working relationships have been established with GP's and practice staff. There has been a major estates programme allowing staff to be based together.

This has influenced the Trust's readiness for new build accommodation in the form of Health and Care Centres.

- Newry and Mourne Trust aligned both community nursing and social work practitioners for older people with GP practices in the mid-1990's. This has been reported on favourably by GP's in the recent SHSSB Review of Care Management.
- South and East Belfast has developed a pilot integrated primary care team model in the Ormeau/Newtownbreda area since 2001. This is based on GP practice lists. Teams include district nurses, social workers and OT's. There has been significant engagement of GP's. A research nurse has undertaken evaluation. The South and East Belfast Health and Care Centres are being designed to support integrated primary care team working.
- Craigavon and Banbridge Community Trust manages primary care and older people's services in a single Directorate and has a significantly integrated model.
- Causeway Trust launched integrated primary care teams in Ballycastle in January 2006 and will extend this in Ballymoney later in the year. The involvement of domiciliary care will be tested.
- A wide range of teams have been developed as part of the extended primary care network. These have a range of names such as hospital at home, rapid response nursing, stroke, palliative care and community rehabilitation. Practitioners involved include district nurses, community nurses, occupational therapists, physiotherapists, social workers, domiciliary care workers and nursing/health care assistants. Such teams exist in integrated form in most Trusts.

The Core Primary Care Team – Membership

The core primary health and social care team will have members who practice within the team every day and members who work in the team on a sessional basis.

Those who have a daily role will, as a minimum, include GP's, practice nurses, treatment room nurses, district nurses, social workers/care managers for older people and assistant and administrative staff.

AHP's may work on a daily basis as team members but often will have a sessional commitment, as may other specialist staff. What is important is that they function as and are recognised as full members of the team.

Similarly some practitioners who have a daily role will work across more than one team in undertaking their role.

Developing The Core Primary Care Team

A number of specific actions are recommended as means of developing core integrated primary health and social care teams.

Recommendations:

1. The GP practice patient list should be the common patient/client list for the team
2. There should be clarity on team membership
3. A managerial partnership should be developed between the manager of Trust team members and GP practice leadership
4. Primary care teams should be grouped in natural localities with a population of 30, 000 or more
5. Budgets should be devolved to management teams in natural communities or localities
6. All disciplines should be respected, enabled to contribute to achieving best practice and engaged in management
7. Uni-disciplinary systems, including professional forums, should be in place to ensure professional/clinical supervision, consultation, professional appraisal and CPD
8. As far as possible team members should be based together
9. All disciplines should contribute to a single assessment through a shared assessment framework
10. Practitioners should have appropriate access to each other's information systems

1. The GP practice patient list should be the common patient/client list for the team

Achieving a common group of service users is the pre-requisite for having a real primary care team.

While organising services on a geographic basis might have many advantages in terms of efficiency and achieving inter-agency working and links with communities GP's and practice employed staff cannot provide services on a strictly geographic basis.

Their responsibility is to the patients who choose to register with the practice. There has, however, been an increasing pattern of practice lists being predominantly drawn from geographic localities of reasonable size and accessibility.

It must also be recognised that the one choice which all patients have about how they access care is the selection of the GP practice whose list they join. Often this indicates where they wish to access services.

As the core primary care team must bring together GP's and practice employed staff with Trust staff a common set of patients and clients can only be achieved if the GP practice list is adopted as the grouping around which the team is designed and for whom all members provide services. Successful initiatives, such as those in Down Lisburn and South and East Belfast, have adopted the GP practice list as the basis for deployment of Trust staff.

Where patients live outside the natural geography of the list arrangements can, and have, been made for them to have the part of their services provided by Trust staff provided by a Trust team based in their area of residence. Therefore while full commonality of client/patient list may not be achieved between practice and Trust staff very high levels, in excess of 90%, would be the norm.

2. There should be clarity on team membership

Primary Care practitioners should be clear on the team or teams of which they are a member and of who their fellow team members are. The use of the GP practice patient list should underpin this. Some practitioners will be a member of several teams. They may need to work across two or more teams in order to have a full workload, or to ensure that service users get an equitable share of available service, or they may be specialists with sessional commitment to several teams. What is important is that they and other team members are clear that they are full members of the team.

3. A managerial partnership should be developed between the manager of the Trust team members and GP practice leadership

It must be recognised that the two main groups of staff who need to be brought together in a primary care team – Trust employed staff and practice employed staff - have separate management lines and

lines of accountability. What needs to be achieved is to bring these two strands together through practice management and Trust management working collectively, creating a virtual single system of management through a partnership in management.

This does not compromise individual and managerial accountability about which there must be clarity.

It does give potential for better governance, creating opportunity for multi-disciplinary issues to be addressed consistently and seamlessly across the entire primary care team.

For each practice list the practice leadership and the Trust manager must work closely as the management team. Building a unified primary care team will require active leadership by both parties. Success requiring a joint commitment to collaborative working and an ability to reach appropriate compromises. Only a close and equal partnership can deliver the best results.

4. Primary care teams should be grouped in natural communities or localities

The requirements and responsibilities of both practice and Trust must be acknowledged and respected in designing management arrangements. While practice employed staff can be managed on a single practice basis many Trust management functions require larger units of management. Such responsibilities include:

- Management of community care resources. Meeting the needs of people, particularly older people, at risk or in need in the community or requiring timely discharge from hospital into care homes or complex and resource intensive packages of community care, is a critical statutory responsibility. It requires flexibility of resource deployment across a significant client base if delays because of lack of availability of resource are not to occur. A single primary care team based budget could not meet fluctuations in demand.
- Staff deployment. Managing staff deployment, including cover for absences arising through leave, training, illness, maternity leave and turnover, in such ways as to ensure satisfactory staffing levels requires staff to be managed across a number of teams. Given that, in a primary care team, there may be a single handed practitioner, or a small number of practitioners, in each discipline there needs to be flexibility to manage and deploy resources across primary care teams and to pool resources to meet contingencies.

- Deploying specialist practitioners. Specialist practitioners generally have to work across a large patient/client base comprised of the lists of a number of primary care teams.

These and other responsibilities require that Trust staff in a number of primary care teams be managed by a single Trust manager or management team.

This is best achieved through grouping primary care teams. This should be organised on the basis of federations of primary care teams in natural communities or localities. A population base of 30, 000 or more should provide sufficient scale. Consideration could be given to smaller grouping in sparsely populated rural areas but only subject to some support and flexibility being agreed between localities. In urban areas larger population bases would generally be appropriate and advantageous.

This grouping of primary care teams on a natural community/locality basis will assist primary and community care to work with other agencies and to engage communities and community leadership. It can also ensure that primary and community care addresses the needs of the small number of people who are not registered on a practice list. It can encourage approaches such as community development and health promotion, which go beyond individual treatment and which foster partnerships in meeting need and promoting health and wellbeing.

The combination of practice patient list based teams and the federation of such teams on the basis of natural communities is effective. It can promote effective primary care team development, effective management and working with other stakeholders and agencies to meet need in more comprehensive and creative ways.

5. Budgets should be devolved to management teams in natural communities/localities

While some budgets will be primary care team/practice based, and while a small number will be held centrally by Trusts, wherever possible budgets should be devolved at least to the natural communities/localities.

This would include, for example, community care funding for older people, salaries and wages and goods and services budgets for staff working in the locality and the travel expenses budget.

Primary care team practitioners are best placed to identify need, to prioritise the allocation of limited resources and to manage care and treatment. Devolving budgets should empower primary care, speed decision-making, improve responsiveness to local need and give clarity of accountability.

Experience of devolving budgets has been encouraging in achieving effective use of resources and the management of budgets within available resources.

Further benefits could be obtained from sharing budgets allocated for enhanced services. This could be explored under the new commissioning arrangements being introduced following the review of public administration.

6. All disciplines should be respected, enabled to contribute to achieving best practice and engaged in management

For integrated teams to operate effectively the main professional strands must be respected. No discipline or disciplines can be dominant. GP's, nurses, social workers and AHP's each have specific expertise and areas of practice in which they should be the lead discipline. Recognising this will bring better results and is essential to securing ownership by each discipline of integrated working arrangements.

Management arrangements must ensure participation by each main discipline in management. The Down Lisburn model, for example, has required a nurse qualified and a social work qualified manager for each of its localities. These operate as a single management team working with a locality GP and the GP's in each practice in the locality. This secures the participation of the three disciplines while separate management arrangements have been in place for AHP's.

The degree of culture and attitude change required of each and every discipline is significant. Fundamental is an inclusive approach building confidence and mutual respect and partnership in management.

7. Uni-disciplinary systems, including professional forums, should be in place to ensure professional/clinical supervision, consultation, professional appraisal and continuous professional development.

Deploying and managing staff in multi-disciplinary rather than uni-disciplinary teams means that the operational manager will often be from a different discipline to that of supervisees.

Arrangements therefore have to be put in place to ensure that professional standards are met. Significant issues are:

- Professional/clinical supervision and consultation
- Appraisal
- CPD

Managerial supervision by the team manager can address many issues. Each member of the team should, however, also have access to supervision by an appropriate person from his/her own discipline. This can take a number of forms depending on the standards and practice in the discipline. It can include supervision by a senior professional or peer supervision.

Similarly each practitioner should have access to an appropriate source of professional advice or consultation.

Appraisal will normally require the participation of the operational manager and the professional/clinical supervisor to agree knowledge and skills demonstrated against the KSF outline. Both should participate in formulation of the personal development plan.

In some Trusts professional forums have been established for disciplines, or specialisms within disciplines. These supplement operational management systems ensuring opportunities for professionals to meet in a uni-disciplinary context for professional development and for peer support. Such arrangements can prove at least as effective as undertaking these responsibilities through a uni-disciplinary operational management structure.

It is important that where the operational management structure is not discipline based effective systems to support CPD are in place.

These arrangements need to extend to members of the primary care team who do not hold professional qualifications such as administrative and assistant staff whose expertise often requires to be supported, developed and updated.

Opportunities exist for such professional forums to include practice employed as well as Trust employed staff. Similarly Trust staff can benefit from training and development opportunities provided for practice staff but made available also to Trust team colleagues.

8. As far as possible team members should be based together

“Developing Better Services” will lead to considerable improvements in the accommodation available to primary care teams. As far as possible primary care team members should be based in shared buildings. Within these buildings natural and important linkages between disciplines should be supported.

Some Trusts have made use of shared team rooms for disciplines such as district nurses, social workers/care managers for older people and AHP’s.

Evaluation in Down Lisburn Trust identified that among staff who did not share a team room with another discipline a significant number had concerns about doing so. There was a positive attitude to inter-disciplinary sharing of accommodation amongst those who had had the experience of doing so.

Accommodation should be used in such a way as to promote team working and to maximise the accessibility of team colleagues. This should generally include multi-disciplinary sharing of team rooms.

Teams can be based in Trust Health/Health and Care Centres or in GP practice owned accommodation. The new way of working is supported by the development of Health and Care Centres which have been given highest priority in the primary and community care capital programme. They are characterised by shared and quiet working areas, formal and informal meeting areas and social spaces, all designed to break down barriers and to encourage communication and team development. They include shared interview, clinical and treatment areas and rooms.

Where all members of the team cannot be based in a shared building other accommodation in the locality, which is readily accessible, should be considered.

9. All disciplines should contribute to a single assessment through a shared assessment framework

The overall purposes of the Single Assessment Tool are to help ensure that:

- Service users and carers do not have to experience repetitive questioning from the wide range of health and social care professions who collect the same information.
- As much information as possible should be captured on one form which may be completed by any professionally qualified primary care practitioner. This can identify a breadth of health and social care needs. Additional specialist and profession specific

assessments will additionally be undertaken by other practitioners as appropriate. This will allow a complete picture of a service user's assessed needs to be available.

- Co-ordinated service user planning and collaborative working is supported allowing achievement of best outcomes for the service user to be obtained.

The Department has commissioned from the University of Ulster the development of a single assessment tool which will support assessment of both individual and community locality need and which will inform locality commissioning.

10. Practitioners should have appropriate access to each other's information systems

In the absence of common information systems practitioners within a primary care team should have appropriate access to each other's information and information systems.

The development of PCIS will provide a common system for Trust employed team members. Linkages between PCIS and GP information systems are important to enable the appropriate sharing of information.

Clarity on primary care team membership and the development of close working relationships between team members should provide the basis for confidence in sharing information.

The Extended Primary Care Network (see Appendix)

The core primary care team will be supported by other specialists and specialist teams who collectively should comprise the extended team or network. These may provide direct support care and treatment, education and training and professional advice.

The network will include, from community services, for example,

- sessional specialist staff, such as CPN's and other mental health workers
- continence, tissue viability and other specialist nurses
- rapid response nursing team
- home from hospital team
- community rehabilitation team
- out of hours services
- domiciliary care workers
- GPs with special interest

- case manager for those with complex health needs

From other health and social services

- hospital outreach, including geriatrician and psychiatry of old age
- nursing and residential care homes
- health promotion
- community pharmacists and pharmacy advisors

From other agencies

- supported housing services, including floating support and long term peripatetic support
- voluntary organisations
- community organisations
- leisure services
- education
- environmental health
- police

Potential Developments, Benefits and Impacts

The core primary care team has potential to bring major benefits to older people and others with health and social care needs.

Ensuring appropriate use of hospitals and care homes

The development of multi-disciplinary primary care teams with a common client/patient base promotes a shared focus on the same service users and a greater capacity to deliver and co-ordinate care. Opportunities, challenges and problems are shared. The team is therefore well placed to work to the common objective of providing as much care and treatment as possible in the community.

This should be reflected in

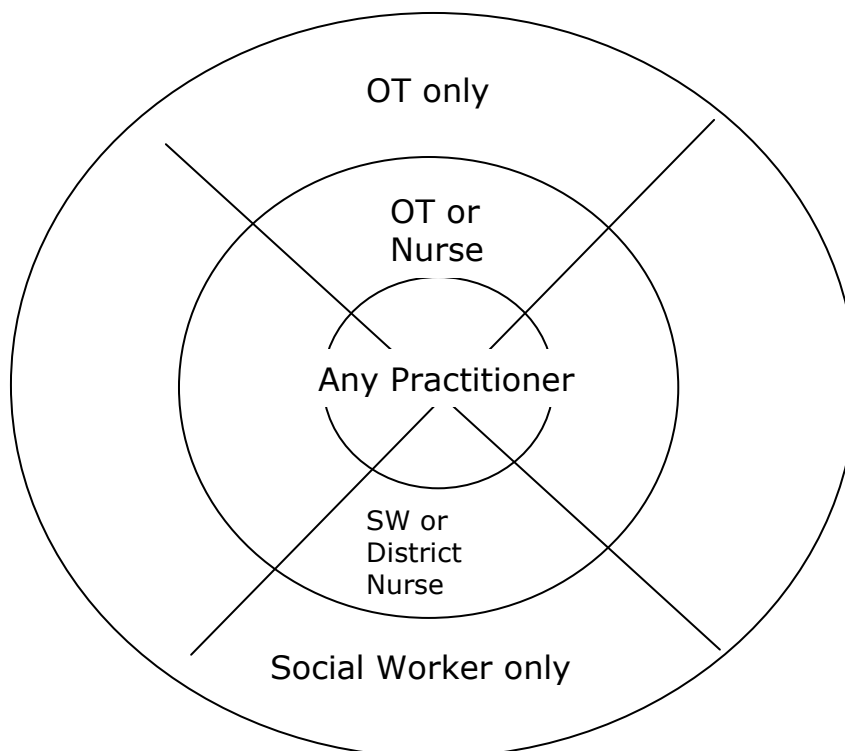
- Avoiding people being admitted to hospital where higher levels of care can be provided, led and co-ordinated by the primary care team supported by specialist services in the extended network.
- Early discharge from hospital to a range of services co-ordinated by the primary care team.
- Reducing the need for people to leave their homes to be admitted to long term group living in residential and nursing homes

Changes in Working Practice

As close teamworking is developed across disciplines opportunities for efficiency in working practices should be evident.

The diagram illustrates the extent to which members of the primary care team could use their skills to assess for or to provide aspects of service.

- Assessment for a provision of a simple service may be within the competence of any practitioner in the team (inner band of the circle).
- A less straightf Provision of Aids it or service might be undertaken by practitioners from some specific professions (middle band of the circle).
- Complex assessment and specialist service provision will be within the competence of only one profession (outer band of the circle).



Home Care Service Assessment

Examples might be the provision of aids and assessing need for home help/domiciliary services.

While most aids may require an OT assessment the middle band in the diagram represents those aids which a physiotherapist or a nurse might also be able to provide. The inner band represents the very simple aids which any practitioner could provide.

Similarly a social worker would assess the need for a complex package of domiciliary care (outer band) a district nurse might, however, be able to identify the need for additional home help/domiciliary care support for a period because of deterioration in a patient's health (middle band).

Accepting the assessment of another professional would allow a service to be provided more quickly, professional time to be saved and the requirement for a patient or carer to explain the need to another person on another occasion to be avoided

Domiciliary care

Domiciliary care workers have a critical daily role in the support and maintenance in the community of people who would otherwise require admission to institutional care. In particular they support large numbers of older people. There is a high incidence of district nursing patients also being domiciliary care clients. The development of links between district nurses in the primary care team and the domiciliary care workers who support the team's patients could improve the quality of care and the capacity to maintain very vulnerable people safely in the community. Domiciliary care workers could play a significant role in monitoring of health and well being of vulnerable people on behalf of the primary care team and reporting concerns.

There is potential to draw domiciliary care workers into the core primary care team as full and consistent members.

Generic Assistants

The integrated team provides opportunities for the development of generic health and social care assistant roles. In delivering services in a generic and joined-up way the generic assistant's practice becomes a force for integrated working within the primary care team.

The generic assistant can be allocated tasks by a number of professional practitioners and in undertaking these can bring several strands of service together in a way which is patient/client focused.

A significant advantage for those who receive services is a reduction in the number of individuals who they need to relate to, and in particular a reduction in those who come into their homes.

A single generic assistant may, for example, undertake the work for a district nurse and an occupational therapist. Good practice has been demonstrated in children's services where a common assistant has been used to support the work of child care social workers and health visitors. Recently generic assistants have been undertaking domiciliary care and housing support duties.

Case Management

The proposals for the development of case management would support primary care team in maintaining people with significant health needs in the community with reduced admissions to hospital. The core integrated primary care team should provide a sound platform on which to build case management.

The case manager would naturally be one of the specialist practitioners who would be identified as a sessional member of the team.

Unscheduled and out of hours care

The new arrangements for out of hours medical provision arising from the GMS contract provide the potential for greater integration of services. There is an opportunity for a single point of access to medical, nursing, social work and mental health provision. This will support integrated working and prevent hospital admission.

Close interface between Accident and Emergency and all out of hours provision will enhance the capacity of primary care initiatives for chronic disease management.

Housing

Housing support is an essential component of promoting and enhancing primary and community care. It can assist the primary care team to maintain people at home. Housing support can be delivered either independently or integrated as part of an overall care and support package tailored to meet individual need.

The primary purpose of housing related support is to develop an individual's capacity to live independently within accommodation of their choice by helping them maintain or remain within the home of their own, prevent the breakdown or loss of tenancy or

independence and build the capacity of an individual to gain or regain independence.

The reasons for requiring housing support are many and varied and can include the development of age related or progressive conditions, the death of a significant loved one resulting in loss of independence, accidents or incidents such as an acquired brain injury or road traffic accident which result in changing circumstances or loss of independence, and homelessness due to reasons such as mental ill health, addiction problems or social circumstances.

The strategic need for housing support services within Northern Ireland is assessed, planned and delivered through the supporting People Programme, a strategic partnership between Health and Social Services Boards and Trusts, the Probation Board for Northern Ireland and the Housing Executive.

The Supporting People programme, launched in April 2003, is administered by the Northern Ireland Housing Executive which aims to commission high quality and strategically planned housing-related services which are cost effective, reliable and complements existing care services.

The programme provides both floating support in people's own homes (short term, non-means tested) and accommodation based housing support services to vulnerable people to help improve their quality of life and promote independence.

Housing support workers can work closely with primary care teams increasing the capacity of the teams to maintain people in the community.

Community Pharmacy

The community pharmacist should increasingly be seen not just as part of the primary care network but with potential to become part of the core primary care team.

Community pharmacy can be regarded as an 'open door' of the Health Service and 90% of older people regularly utilise the services of the same community pharmacy.

The development of additional professional roles has increasingly enhanced pharmacists' potential roles within the core primary care team.

'Medicines management' encompasses a range of activities intended to improve the way that medicines are used, both by patients and by the health service.

Medicines management services directed at older people are designed to ensure that patients gain maximum benefits from their medicines and are not exposed to adverse incidents arising from excessive, inappropriate or sub-optimal doses of medicines. Integrated working arrangements are now developing within the primary care team so that community pharmacy can contribute to the care of older people through ongoing medication review, improving patient concordance with prescribed medication, developing care programmes and services for 'at risk' patient groups. These can include falls prevention, protocols for patient counselling and self-medication, health promotion and multidisciplinary research, audit and drug utilisation review.

The implementation of 'Making it Better – A Strategy for Pharmacy in the Community' has progressed a number of new initiatives designed to improve the quality of patient care specifically in

- managing prescribed medicines – through dedicated medicines taking assessment programmes
- managing chronic conditions - offering a better quality of life to patients with these conditions and helping to improve the outcomes of treatment
- repeat dispensing – offering provision of advice to promote compliance, treatment monitoring, education, in addition to a gateway to medicines taking assessment and medication review
- managing common ailments - giving patients reassurance and advice, with or without the use of non-prescribed medicines
- extension of medicines governance to primary care – identification and reporting adverse events and near misses informing the development of safe medication protocols and policy
- promoting and supporting healthy lifestyles - helping people protect their own health

- hospital discharge arrangements – through the optimisation of medicines appropriateness, length of supplies and transfer of pharmaceutical care information between secondary and primary care

The extension of prescribing rights to pharmacists will improve access to medicines for patients and improve patient choice.

Work is ongoing in building partnerships between community pharmacy practices and the communities they serve.

This supports a community development approach aimed at enabling communities to contribute to the development of health and social services specific to local needs of older people.

Specially trained pharmacists can play a role in providing prescribing support to primary care. In this context there are a number of pharmacists working at individual practice, Local Health and Social Care Group and HSS Board level. These pharmacists also contribute to the medicines management agenda. Examples of the key areas of involvement include prescribing analysis and feedback; formulary development and maintenance; review and management of repeat prescribing processes; and medication review.

Governance

The closer managerial, organisational and working arrangements between practice and Trust staff across disciplines provides potential for improved governance. In particular

- As identified in the paper training and development can more readily be provided across the full range of staff.
- Systems, protocols and procedures can be more effectively shared, agreed and implemented.
- Effectiveness of joint working on risk assessment and management can be increased.

Commissioning

The development of integrated primary health and social care teams based on GP practice lists and managed and co-ordinated on a locality bases provides a sound basis for practitioners and teams to engage with commissioning. It should result in the empowerment of both practitioners and the localities and communities in which they work. Local needs and views can be identified, quantified, and communicated through those structures to the new Local Commissioning Groups. The understanding brought will be based on

a multi-disciplinary approach which draws on the full range of expertise, creativity and challenge which this way of working promotes.

The Local Commissioning Groups should develop from September 2006 as part of the Review of Public Administration. It is intended that they will allow primary care practitioners to make decisions about how services are delivered in their areas.

Under the proposed arrangements a significant portion of the health and social care budget will be devolved to these local groups, probably on a capitation basis. They will have increasing authority to commission services. While the Department and the Health and Social Services Authority will determine the standards and targets to be achieved the LCGs will determine how best this can be provided.

Implementing Change

Making the most of the potential of health and social services requires new ways of working based on multi-disciplinary practice. While much progress has been made in developing specialist multi-disciplinary teams it is important that this approach is brought to the work and organisation of primary health and social care practitioners who work at the core of the community service. It is they who are most likely to have on-going and consistent relationships with service users. They can ensure that the response to need is co-ordinated and service user centred. They can only do so to best effect, however, if they are enabled to work in multi-disciplinary teams and networks.

Good practice in the development of multi-disciplinary primary care teams has been demonstrated in Northern Ireland. What has not yet been achieved is co-ordinated implementation of best practice throughout Northern Ireland.

This paper draws on what has been learned from practice across Trusts in Northern Ireland. It provides guidance on a framework for implementation while allowing scope for responsiveness to local circumstances and initiative.

APPENDIX - Primary Care Network

