Reducing High-Intensity Primary Care Demand Through Neighbourhood-Based Integrated Care

How Sefton Integrated Care Team and Primary Care collaborated to proactively support high-intensity users, improve patient outcomes and release valuable GP capacity.

Summary

The High-Intensity User (HIU) Pilot at Bridge Road Medical Centre was developed to test whether a proactive, multidisciplinary approach could reduce unnecessary demand on primary care while improving outcomes for patients with complex needs. Delivered through collaboration between the practice and the Integrated Care Team (ICT), the pilot identified patients with frequent unplanned contacts with the surgery and offered holistic assessments and coordinated support.

Using a Population Health Management approach, patients with 12 or more contacts within a three-month period were proactively identified and invited to participate. Nine patients received comprehensive assessments, with eight subsequently discussed through multidisciplinary team meetings involving the GP, practice care coordinator and ICT professionals.

The pilot demonstrated that many frequent attenders had unmet health, well-being, and social care needs that were contributing to repeated GP contacts. Through coordinated interventions, patients were connected to a range of services, including social care, mental health support, medicines optimisation, physiotherapy, occupational therapy, and falls prevention.

The results showed a reduction in unnecessary primary care utilisation, equivalent to 67 GP appointments avoided and 804 minutes (13.4 hours) of GP time released. The pilot highlights the value of neighbourhood working, demonstrating how Integrated Care Teams and Primary Care can work together to deliver proactive, person-centred care that is both sustainable and scalable across wider populations.

The Neighbourhood Model in Action

Integrated Care Team + Primary Care Partnership

- The pilot brought together:
- GPs
- Integrated Care Team Care Coordinators
- Community Nurses
- Adult Social Care
- Pharmacists
- Mental Health Services
- Physiotherapists
- Occupational Therapists
- Falls Prevention Teams
- Health and Wellbeing Services
- Police

Through holistic assessments, MDT reviews and coordinated care planning, patients received support that addressed the root causes of repeated GP attendance rather than simply treating presenting symptoms.
This demonstrates the strength of neighbourhood working: delivering the right support, from the right professional, at the right time.

Key Insight

- More than 100 minutes of GP time were saved per patient through proactive multidisciplinary intervention.
- Releasing Capacity
  The pilot reduced avoidable contacts and freed GP appointments for patients with acute clinical needs.
- Reducing Repeat Demand
  Rather than repeatedly responding to symptoms, the model addressed the underlying causes driving frequent attendance.
- Strengthening Collaborative Working
  The pilot increased awareness of ICT services and demonstrated the value of shared responsibility for managing complex patients.

Pilot at A Glance

Why It Matters

Population Health Management enables services to:
✔️ Identify high-demand patients earlier.
✔️ Understand underlying drivers of service use.
✔️ Target interventions where they will have greatest impact.
✔️ Move from reactive care to proactive support

Scalable Opportunity

The model is:
✔️ Sustainable.
✔️ Reproducible.
✔️ Scalable across Sefton, Liverpool and wider neighbourhoods.
✔️ Capable of releasing valuable GP capacity while improving patient outcomes.

1. The Challenge

High-intensity users place significant demand on primary care services.

2. The Neighbourhood Model in Action

The pilot brought together 10+ health and care services. Through holistic assessments, MDT reviews and coordinated care planning, patients received support that addressed the root causes of repeated GP attendance rather than simply treating presenting symptoms.

3. Population Health Management Approach

Using agreed criteria, the practice proactively identified patients who:

- Were aged 18+
- Had 12+ contacts with the surgery within three months
- Were not already receiving ICT support
- Consented to participate

4. Benefits for Patients

More Personalised Care
Patients received holistic assessments that considered:

- Physical health
- Mental health
- Medication needs
- Functional ability
- Social circumstances
- Community support requirements

Better Access to Support
Patients were connected to services they may not otherwise have accessed, including:

- Social care
- Mental health services
- Falls prevention
- Community therapies
- Medicines optimisation
- Health and wellbeing support

Improved Self-Management
By addressing unmet needs and coordinating care, patients became less reliant on repeated GP contacts.

Findings:
The Bridge Road Medical Centre

9 Patients received comprehensive assessments

12 Minimum GP contacts per patient in 3 months. Each patient on an average visited the GP surgery once every week.

3 Months Post Intervention Results

67 GP appointments avoided

7.4 Average GP appointments avoided per patient

13.4 Hours — Equivalent GP time released

804 Minutes — GP clinical time released

89 Minutes — Average GP time released per patient

“I believe we can call the pilot a success from the point of view of reducing patient contacts with General Practice.“
Dr E McDonnell Bridge Road GP

“8 showed a significant reduction in the number of contacts made to us in the 3 months post d/c (discharge) from the ICT, and as it is now some 6 months since the pilot ended for most of the patients, I can say that the reduction in contacts has persisted.“
Dr A Hilton Bridge Road GP

When Primary Care and Integrated Care Teams work together as a single neighbourhood team, high-intensity users receive more coordinated support, unnecessary demand is reduced, and scarce GP capacity can be redirected to those who need it most.