Defining primary care in the 21st century

September 2017

Primary Care Partnership
Teamwork in Health

Partners

Athletic Rehabilitation Therapy IRELAND

Diabetes Ireland

HCCI Home and Community Care Ireland

isti

Irish Society of Chartered Physiotherapists

INDI Irish Nutrition + Dietetic Institute

Irish Patients' Association

ipha Irish Pharmaceutical Healthcare Association

Irish Practice Nurses Association

NAGP Cumann Naisiunta na nDochtuiri Teaghlaigh

napc national association of primary care

NHI nursinghomesireland

PCS

Patient-Centered Primary Care COLLABORATIVE

SCPI The Society of Chiropodists & Podiatrists of Ireland

Foreword

The Primary Care Partnership conference in March and April brought together health and social care professionals from Ireland and across the world to discuss the future of primary care.

Supported by a multitude of primary care organisations and associations the conference, through a series of lectures and workshops, set participants the task of plotting a path forward for the Irish health system.

Across two days, 32 leading academics, health and social care professionals and advisers discussed lessons learned and transformation to a primary care-led healthcare system. International experts delivered keynote speeches and joined panel discussions alongside their Irish counterparts.

A satellite session on technology in primary care explored technological advances and best practice. Thought-leaders in digital and health technology came together to share their vision for the future and the role that technology will play in primary care.

Comprising GPs, nurses, hospital doctors and a spectrum of other health and social care professionals, the two-day Primary Care Partnership conference provided an open forum for ideas and synergies.

Each day of the conference ended with workshops where the ideas discussed were refined into action plans. Conference participants were tasked with examining a range of areas, as follows:

- Primary care resource centres;
- The role of technology in primary care;
- Transitional funding into primary care;
- Health and social care professionals – a vision for primary care in the 21st century;
- Multidisciplinary integrated primary care; and
- Introducing local integrated care committees nationally.

At the inaugural Primary Care Partnership conference in 2016, a submission document outlining a vision for the future of primary care was drafted. Last year, that document was the catalyst for a significant shift in the public discourse on healthcare reform. Now, all stakeholders recognise the necessity of a decisive shift to safer, integrated, high-quality primary care, for the benefit of our patients.

This submission document aims to influence public discourse to the same extent. This year's conference had a strong focus on seeking solutions to the challenges facing the Irish health system. On behalf of the members of the Primary Care Partnership, I would like to call on all stakeholders to come together to use this document to engage in delivering solutions to the challenges facing the Irish health system.

Chris Goodey

September 2017
Chairman, Primary Care Partnership, and CEO, NAGP

Primary Care Partnership
Teamwork in Health

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Chapter 1

Primary care resource centres

Introduction

Despite promises that the ambitious roll-out of primary care centres (PCCs) and primary care teams (PCTs) would improve community health services, there has been limited progress and significant delays to their construction and implementation.

Sixteen years after the publication of the Primary Care Strategy, significant deficits remain in terms of infrastructure, staff, resources and connections. Waiting times for diagnostics and auxiliary services at many practices remain onerously long.

There is an opportunity for Ireland to follow international examples and transform PCCs into community 'resource centres' on the basis that diagnostics and services in the centres would be made available to all stakeholders in the locality. Primary care resource centres (PCRCs) would ultimately serve as diagnostic and service hubs that support patient-focused care. The PCRCs would allow all GPs to refer equally through one agreed pathway to podiatrists, dietitians, physiotherapists, occupational therapists, public health nurses, counselling and other health and social care professionals.

In addition, the current structure of PCCs serves to foster a culture of competition between general practices. The idea is that PCRCs would be 'neutral territory'; a properly resourced PCRC could bring together GPs and all primary care health professionals in a community independently of location, and allow the full and proper integration of all services under the primary care umbrella. The PCRC would also be a point where public and private health sectors intersect. Careful planning will be required to ensure the success of this proposed model.

What are primary care resource centres?

The current primary care centres only benefit a small number of GPs and patients. If re-designated as primary care resource centres (PCRCs) they can serve as diagnostic and service hubs that support patient-focused care with the full engagement of all local GPs. While PCRCs may not always serve as locations for GP practices, they would serve as resource centres for all GPs/patients in a designated catchment area. This would create an environment where primary care teams can deliver for patients and would bring all GPs and health professionals into the same process, regardless of where their practice was physically situated. It would assist primary care to reach its potential for more care in the community and achieve greater self-sufficiency, with less reliance on hospitals.

Challenges and solutions

Three key benefits of proposed PCRCs are outlined here:

- Population health improvement through public and provider education;
- Access to diagnostics; and
- Improved services.

Education

Public health education will be critical to the success of the PCRCs, and this element will require significant investment, in terms of time, money and resources. Marketing of these educational capabilities will be crucial to ensure buy-in from patients and the wider community. The practice manager would take responsibility for creating a yearly/semester-structured curriculum – education should not take the form of 'one-off' talks, etc.

The entire community would benefit from the education hub, including:

- Patients with chronic illnesses;
- The Travelling community;
- Immigrant and refugee populations; and
- Staff.

Wellness and disease prevention education should also be prioritised. Potential topics include self-esteem, stress, diet, weight management, addiction, alcohol and smoking, and personal health.

Provider education: interdisciplinary learning across all spheres would be provided for staff, students, etc.

- Investment in tutors as a resource will be required;
- This would enable staff to attain continuing professional development (CPD);
- Centres could also be used as locations for GP training scheme.

Scaling through collaboration with other centres and service providers should be feasible:

- Provision of education outreach, eg. to schools, community centres, etc;
- Collaboration with other local resources such as the Rape Crisis Centre, Money Advice and Budgeting Service, Citizens Advice Bureau, etc, for the provision of seminars/classes at the centre.

Technology would be a key element of any educational programme:

- May include live streaming of lectures/classes nationally, online training, 'blended learning'.

Diagnostics

The provision of diagnostic services at a PCRC would be immediately beneficial, allowing for rapid access and reducing waiting lists. Ultrasound, X-ray and phlebotomy services on-site would be of significant benefit. The PCRC could also be the site of minor surgery rooms, eg. biopsies, mole assessment, ingrown toenail treatment, etc. On-site ultrasound services could be used in:

- Differential diagnosis of minor injuries;
- Midwifery (Doppler);
- Vascular assessment;
- Podiatry; and
- Physiotherapy.

Clinical governance of diagnostics would be key, as some disciplines using the PCRC will be qualified to interpret results:

- Avoid duplication of imagery;
- Presence of radiographer on-site to link in with hospital radiologist.

Other diagnostic services could include:

- X-ray;
- Retinal screening;
- DXA scanning;
- Blood testing; and
- Warfarin clinic.

Services

The PCRC should house the full complement of primary care and associated services, including: public health nurse, physiotherapy, podiatry, occupational therapy, speech and language therapy, dietetics, dentistry, social work, psychotherapy and counselling.

Other services provided at the PCRC could include: smoking cessation, falls prevention, alcohol and drug addiction, memory clinic, audiology, community mental health, minor surgery, sexually transmitted infection (STI) screening, cardiac rehabilitation, and palliative care.

- The PCRC could play host to outreach from hospital specialists, eg. from neurology, geriatrics, endocrinology.

Secondary services could also be provided, including ophthalmology, antenatal clinics, frail elderly services, health promotion, Alcoholics Anonymous meetings, community welfare officers and bereavement counselling.

- Telemedicine would enable outreach of services. This could help overcome problems with regard to access.

This diverse array of services would be underpinned by a strong administrative structure and comprehensive IT system. Strong transport links and adequate parking would be important, as would extended opening hours to ensure and enable accessibility.

Workshop attendees were in consensus that the move to a patient-centric model of care was critical. The actual building of a PCRC should not just be designed by an architect, but by medical professionals cognisant of patient needs, as well as patients themselves. The PCRC could essentially function as a '21st century parish hall', a place for the entire community to converge and avail of health services. Integration of public and private care would also be achievable at a PCRC, with self-employed health professionals expressing interest in being part of such a team. The current PCC model is out of date and must be modernised and made more patient-friendly; the focus must be switched from buildings to the development of relationships among stakeholders in a way that allows all health professionals and GPs to engage effectively with patients and the community.

Conclusion

A PCRC would serve to overcome many of the current problems in primary care service delivery, by providing a 'one-stop shop' with rapid access to essential primary care services, specialist care, diagnostics and education.

Workshop attendees agreed that there is a lack of logic with regard to the present situation regarding the development of PCCs which are focused on moving GPs to new sites. Relocation of GP services to a 'new PCC' disrupts the history and geography of community health services, and is not patient-friendly, potentially causing difficulties for elderly or infirm patients, among other problems.

In contrast, a PCRC could be a patient-led, patient-centric initiative. This would 'flip' the current medical model, and the centre could ultimately function as a hub for patients, giving them autonomy and entering into care on a collaborative basis. A patient-centric approach would empower patients, giving them the skills, confidence and knowledge to change their lifestyle and behaviour in an enabling 'parish hall' environment. Central to its success would be appropriate governance and leadership; there was consensus at the workshop that a governance professional, and not a medical professional, would be the leader of the PCRC.

Technology will play a critical role in the link-up and integration of services, while PCRC development could be future-proofed against adverse demographics, with adequate planning for chronic disease and population health. The PCRC could also house an education centre, used for patients, staff and the community. Ultimately, the PCRC would function as a community health hub.

The workshop was chaired by Dr Ronan Fawsitt and Dr Andrew Jordan

Chapter 2

The role of technology in primary care

Introduction

With the appointment of the Health Service Executive's (HSE) first chief information officer (CIO) in 2014, a new and necessary focus was placed on the role of technology in the healthcare system. Richard Corbridge, the person tasked with digitally transforming that system, has credited general practice for its innovative approach to technology in the primary care setting.

The HSE CIO and chief executive of eHealth Ireland, Mr Corbridge has stated that GPs have made more progress when it comes to adapting and employing technology than any other segment of the healthcare system. Currently, Irish general practice is the only segment that fully utilises digital technology in the management and operation of its business, but much of the investment required to achieve this has been self-funded. It is the only part of the system that has an electronic health record for most patients.

However, a one-way system of communication akin to what currently exists will never lead to a better-functioning system, regardless of how well general practice is performing in the digital space. Integration of technology between all primary care services, and with secondary care, is essential.

However, simply applying technology to a system will not automatically make that system more efficient, more effective or more successful. Technology is useless unless it is combined with people and processes. Using the acronym, NT + OO = COO, workshop co-chair Hal Wolf explained how new technology (NT) combined with old organisation (OO) simply results in costly old organisation (COO).

Themes such as connectivity – across the entire health ecosystem; communication – a central repository; and security – within a cloud-based IT system, emerged from this workshop. They were highlighted as necessities to fully utilise digital capability in primary care. The need for relevant training and adequate resources was also stressed. The goal, essentially, is to reach a point where technology complements the work of the GP and other primary care professionals. Getting the balance right, however, is critical and will be challenging.

GPs may be unsure how to add in new services without improved resources. Video consultation in these circumstances could prove difficult. Specialty video consults could be a viable option. Increased use of email could be a challenge, but there is proof it also reduces unnecessary visits.

Challenges and solutions

Resourcing enhanced or modified IT infrastructure will be an important consideration, with decisions to be made on access to funding where new IT equipment is needed. Moreover, who will provide IT support? Will connections be secure and speedy enough? Such questions will need to be answered.

There are opportunities to greatly enhance communication between GP and patient and among health professionals. A number of examples were highlighted:

- Facilitating online requests from patients for prescriptions or appointments should be a seamless process through purpose-built software.
- Antiquated methods of communication from secondary care to primary care is an issue. Workshop participants highlighted the paper-based correspondence that still exists from hospitals back to GPs. Such correspondence must then be scanned by the GP in order to digitise it so that there is a record on their system. Not only is this time-consuming, but it is a riskier way to share important patient information.
- Electronic referrals should be available for all specialties, and software should give the option of downloading and attaching images/photos as required.
- Communication within the primary care setting would benefit from improvement, for example, between GP and pharmacy. Workshop participants acknowledged that the rolling-out of electronic prescriptions is imminent and welcomed this development.

GPs are unaware of waiting times in various hospitals and refer patients according to geographic consideration. There can be huge delays at the GP-hospital interface, for example receiving results and discharge summaries. There is a view that Healthmail is not always being used effectively by primary care providers.

There is a lack of standardisation across primary care IT infrastructure.

In terms of security of patient health records, digitisation of patient data should be expedited. Furthermore, it was noted that patients have no online/web-based access to their own health records. In this and other contexts, it was acknowledged that privacy and data protection are concerns for some patients.

There is inadequate promotion of medical apps that can

enable patients to take ownership and greater control of their health and illnesses. However, in that context, information overload is a possible consideration. Does the patient need the volume of information that mobile health apps and websites are capable of providing? Do they need more education to process this information? Do they need GPs and other primary care practitioners to interpret this information for them?

Coding for illnesses has not been done, traditionally, in Ireland. Would training be available for practice nurses to do this?

There are concerns that video consultation/mobile messaging can create even more work for the GP or primary care practitioner. It is an additional pathway to the practitioner and it demands time of that practitioner. The number of interactions between patient and GP or practitioner increases with video consultations/mobile messaging.

It is clear that human-to-human interaction is critical in some circumstances. Could increased use of technology hinder that special relationship, or could it strengthen that relationship?

GPs and primary care professionals cannot be responsible for all decisions pertaining to a more integrated and connected IT infrastructure between primary and secondary care. National leadership is required and must be policy-driven.

Solutions to some of the existing challenges may include the following:

- Electronic referrals should be implemented across all primary and secondary care services.
- Discharge information should also be available digitally and without undue delays that currently exist.
- Patients should have access to an online portal containing their medical history.
- Training of practice staff would help to optimise the IT available: to carry out preventative screenings; to contact patients; and to code/classify diseases. This would give GPs more time to do their actual jobs. A 'choose and book' system, similar to that in place in the UK, would inform GPs and other primary health and social care professionals of hospital waiting times and would give patients the option to travel outside of their catchment area if the waiting time was shorter in another hospital. Mobile apps available in the US can update patients on hospital locations and their waiting times, assisting them in choosing the right hospital for them.
- Encourage patients to use mobile apps to self-monitor aspects of their health. This can then be communicated to the GP which could, potentially, enhance efficient retrieval of information in a consultation.
- Encouraging patients to use mobile health apps can empower them, and aid their independence and ability to communicate with the GP, practice nurse or other health and social care practitioner.
- Text messaging is a simple and effective means of technology through which to communicate with patients. This can reduce missed appointments.
- Concern about the additional time taken to process video consultations/mobile messaging was allayed by suggesting the implementation of a workflow hierarchy. For example, patient-to-GP emails can be pre-screened – automatically or by staff – to filter the urgent from the less urgent. The GP does not have to see all such correspondence.
- Technology can facilitate the issuing of lab results, for example, simultaneously to GP and patient, with the exception of a negative result or when the law requires direct communication between GP and patient.

Conclusion

Unsurprisingly, technology has an integral role to play in our primary healthcare system with many benefits for practitioners and patients. However, striking the balance between a constructive and destructive impact is a challenge.

GPs are concerned that the already-stretched service provided in many parts of the country will erode further with the demands of greater access by the patient to video consultations, mobile messaging and healthcare apps if the same resources within their community are expected to provide the new delivery capabilities. The key consideration for GPs is to ensure that technology benefits and complements their resources.

General practice has been leading the way when it comes to utilising technology in practices but this has been done in a disjointed and individual manner and self-financed by the various practices. There is a call for leadership at national level to implement a clear policy regarding technology's place in primary care and the standardisation of IT systems.

Better use of technology is a major contributor to an improved healthcare system but there is a general acceptance of the need to address our antiquated IT systems. Integration of technology between secondary care, general practice and other health and social care professionals must be addressed as a priority.

This workshop was chaired by Mr Hal Wolf and Mr Mark O'Connor

Chapter 3

Transitional funding into primary care

Introduction

It is long-established Government policy to provide as many services for the patient as close to them as possible, ie. within the community. This policy was a key cornerstone of the landmark Primary Care Strategy published in 2001.

Various healthcare policy documents and governments since then have reiterated the commitment to provide more services within primary care and recognise that this move will be a major factor in reducing the current unsustainable pressure on our hospital system. However, the reality is that this will require significant investment.

In the past two decades, general practitioners (GPs) have increased the amount of services they provide within their practices, and through multidisciplinary care as part of the wider primary care team (PCT), but these extra services have not received funding in the manner required. Many services have been set up by GPs themselves at their own cost, and chronic disease management is not part of the current General Medical Services (GMS) contract. GPs have seen a disproportionate cut in funding to their services under the Financial Emergency Measures in the Public Interest (FEMPI) mechanism, with c.38 per cent reduction in Medical Card funding, which has ultimately resulted in rationalisation of services they have initiated and developed outside of the current GMS contract.

The only recent new funding for primary care has come from the incomplete diabetes and asthma cycles of care, and the revised Rural Practice Framework, while the under-6s GP contract has overburdened practices that have signed up to the low-remuneration/high-visit volume service.

Challenges and solutions

Irish general practice is under crippling pressure, as demand for services increases, and the manpower crisis worsens. Young (and not-so-young) GPs continue to emigrate to countries offering better work/life balance, GP training places are not being fully filled due to lower application levels, and older GPs are retiring earlier than desired. A recent study[1] by the Irish College of General Practitioners (ICGP) shows that uncertainty of a viable future is the major deterrent for graduating GPs to stay and practice in Ireland.

Locum GPs are also in very short supply and their costs have significantly increased, without adequate financial cover from the Health Service Executive (HSE).

There is a serious mismatch between the level of services desired by Government, patients and primary care staff to be provided within the community and the current amount of funding provided by the HSE.

The HSE's capital budget was slashed during the recession and has always been far more focused on the secondary sector. GPs require capital funding to offer enhanced services. The Indicative Drug Target Savings Scheme (IDTSS), while it had some issues, was the last large-scale capital funding scheme aimed at primary care and paid for significant IT and equipment investment in general practices.

Certain services, such as warfarin clinics, chronic disease management, some blood and disease tests/services, and others, are funded in secondary care but not in primary care. Yet many GPs offer these services at a loss.

The health budget is allocated on an annual basis, making long-term planning, particularly in the primary care sector, very difficult. There has been funding in the past for various pilot schemes, which, while often successful, never get off the ground as funding ran out.

GPs cannot refer public patients directly for diagnostics like X-rays and ultrasounds in most areas. Most patients end up having to attend emergency departments with a letter for these services from their GP.

Change and a major rebalance of the health service is badly needed. This is not an easy task, as you cannot create a vacuum by withdrawing funding from secondary care and placing it in primary care.

Solutions to some of the existing challenges may include the following:

- Properly resourced primary care can deliver more efficient, streamlined and integrated services and better patient outcomes that will save on costs to the secondary care sector.
- Making substantial change to how a model of care works requires investment. The plans for increased, comprehensive national primary care services require a transitional fund over a phased time period. The concept of transitional funding is not new and has been tried in many sectors, both public and private.
- Funding must be increased for primary care to a more realistic proportion of the overall health budget; FEMPI cuts must be reversed.
- A review of current spending in community services could identify any areas of wastage/duplication and redirect funds to where necessary.
- Multi-annual budgeting for the health services is key,

so real change can happen with regards to planning and funding of new services.

- Funding services like warfarin and various chronic disease clinics could create significant savings for hospitals. Studies show improved international normalised ratio (INR) results for patients managed locally by their GP team, for example.
- Fund and offer direct access to diagnostics for GPs. There are fears that this could 'open the floodgates to unnecessary tests' but GPs are long used to being prudent gatekeepers for services. Quick and convenient access to diagnostics means earlier diagnosis, better outcomes and long-term savings. The private sector could offer good value and quick access here.
- Tax breaks for primary care infrastructure and equipment – these were offered to private hospitals and nursing homes so why not primary care, where they will directly benefit the whole patient population, private and public.
- Incentivisation through introducing targets.
- Consideration should be given to some type of medicines scheme, including rational and generic prescribing, with saved funds being re-diverted to investment in primary care. Weighted payments for the severity of disease that chronic disease patients have, ie. case-mix system, should be considered.
- Investing in technology to connect the secondary and primary care sectors and maximise service efficiency and patient convenience. Healthlink and ePrescribing are positive examples of this, but far more needs to be done so that GPs and the hospital system can connect seamlessly. Telemedicine, such as video consultations with GPs, as well as other PCT members, can be expanded but must be remunerated. Wearable and mobile technology also offer positive benefits for chronic disease data monitoring and management.
- Fund the roll-out of some traditionally hospital-based services in primary care centres – ie. community-based psychiatry, geriatrics, physiotherapy, medicine reviews by pharmacists, to name a few. These would reduce referrals to secondary care and reduce GP workloads while improving patient care.
- Increase the scope of practice (upskilling, task shifting, etc) of public health nurses and other community-based allied health professionals. Practice nurses already successfully run vaccination and chronic disease clinics. However, they need funded education and a more significant role in PCTs.
- Funding GPs to attend PCT meetings will increase GPs who are engaged. Currently, GPs are the only members of PCTs not paid to attend meetings.
- Introduce HSE-funded liaison officers to meet with GPs who are not part of PCTs, to link them into services and provide them with what they need to provide the best service to patients.
- International experience – other healthcare systems have introduced the changes/models of care that Ireland wishes to achieve, ie. Canada and the UK, and we can learn from both their successes and failures.

Conclusion

Increased funding for primary care is absolutely essential. To provide the level of services long promised by Government and desired by those working in the sector, major investment is needed. This will lead to better-quality services, improved outcomes and patient satisfaction, and will save money in relation to patient dependency on the secondary care sector. Given the ageing population, keeping patients well and within their community for as long as possible is vital to ensuring the long-term sustainability and success of our public health system.

The workshop was chaired by Dr Emmet Kerin and Mr John Hennessy

1. Planning for the Future Irish General Practitioner Workforce – informed by a national survey of GP trainees and recent GP graduates. [https://www.lenus.ie/hse/bitstream/10147/617140/1/Planning_for_the_Future_Irish_General_Practitioner_Workforce.pdf]

Chapter 4

Health and social care professionals – a vision for primary care in the 21st century

Introduction

The purpose of this workshop was to explore ways in which the delivery of primary care can be improved through better integration of all health and social care professionals.

This team-based approach to delivery of primary care can be defined as "the provision of health services to patients by two or more health providers who work collaboratively with patients and their caregivers to accomplish shared goals and achieve coordinated, high-quality care".

There is a general acceptance among all primary care health and social professionals that team-based delivery of care will produce more patient-centred primary care, better outcomes for the patient, and relieve the pressure on the overburdened secondary care system.

There is less agreement about how this integration should be brought about and how it should operate. Workshop participants noted that the team approach was not, in general, well established across Ireland, although there are notable exceptions. They agreed that its successful introduction requires, in many practices, significant changes in the culture and organisation of care, and in the nature of interactions among colleagues and with patients. They also agreed that there was a need for education and training, especially in the area of information technology (IT), and for some common understanding about the ways in which primary care personnel and patients perceive their roles and responsibilities.

Some participants felt that communications from the Health Service Executive (HSE) about primary care teams (PCTs) could have been better, in terms of frequency and content. Many would like to have seen more of a lead taken by the HSE in this critical development of primary care.

Challenges and solutions

A summary of barriers to integration includes the following:

- Lack of knowledge and understanding on the part of the patient of the different roles played by the PCT and network staff.
- A 'silo mentality' on the part of team members about their own roles in patient management.
- Patients not empowered to ask the right questions to get the best care.
- Conflict/confusion about medico-legal accountability for case management.
- Vested interests between different specialists/team members.
- Non-inclusion of some specialties in the team.
- Disruption of long-term patient/carer relationships.
- Lack of time to attend meetings.
- Lack of administrative support.
- Lack of a common language between health specialists and between specialists and patients.
- Poor communication between team members and between team and patients – caused by team members working in different localities, poor technology/systems, and sometimes by patient literacy.
- The likely impact of a new GP contract.
- Lack of funding for electronic interventions.
- Motivating people to overcome 'status quo mentality'.
- Resistance to technology/lack of IT skills.
- Lack of secure data protected Healthmail for GPs.
- Difficulty recording and analysing outcomes/data to show benefits of PCT interventions.
- Electronic referrals to hospitals.

Objectives and solutions to challenges in this area may include the following:

- Improve communication to patients about the different roles played by the PCT and how each serves the patient's needs. Create leaflets/videos for social media explaining what team members do and how they work for the patient.
- Educate patients to become their own agents of change in maintaining and managing their own health. Hold forums/public meetings for better understanding/joint learning – for both health professionals and patients. Use the *Meitheal* approach.[1] Set up primary care resource centres (PCRCs). Encourage the HSE to take a bigger educational role (which it already does in other areas, eg. via Facebook and Twitter).
- Motivate team members to engage with the team approach, and develop acceptance for the concept of team responsibility.
- Write a charter for the PCT (leaflet or video).
- Hold forums/public meetings for the team to inform and motivate; GP motivation (and reimbursement) and

team responsibility for patient management should be addressed in the new GP contract.
- Ensure that each PCT discusses and agrees case management protocols locally. Describe responsibilities in the PCT charter; communicate this to patients via leaflets or videos.
- Put the structures in place to enable team management of cases. Invest in IT systems for patient records and sharing of data between team members; invest in premises where team members are co-located. Develop 'eHealth personas' for the patient within each specialty/team member, which are constantly visible to secondary care, and primary care teams.
- Improve use of technology by team members. Invest in education of team members through attendance at courses, or in-house tuition; introduce smartphone/tablet applications for sharing data. IT can be applied to: clinical decision support; computerised disease registries; computerised provider registries; consumer health IT applications; electronic medical record systems; electronic prescribing; and telehealth.
- Ensure that all team members are represented on the PCT. Some of the 'newer' professions are not always on the radar for the established team members, or the patients. Expand definition of professions that are regulated and define roles by better communications.
- Improve access to diagnostics for GPs and develop secure and private electronic health records. Invest in IT to improve connectivity with diagnostic providers. Health IT allows better management of patient care through the secure use and sharing of health information.
- Improve use of metrics to prove efficiency. Introduce electronic recording of anonymised evidence and data so that outcomes can be measured, evaluated and shared.

In summary, the team approach is not, in general, well-established across Ireland. Its successful introduction will require, in many practices, significant changes in the culture and organisation of care. There is a silo mentality on the part of some team members about their own roles in patient management, and vested interests in maintaining control (of patient care).
There is a need for education and training, especially about the roles and status of different team members, and in the area of IT. There is also a need for some common understanding about the ways in which primary care personnel and patients perceive their roles and responsibilities. Patients need to be empowered to ask the right questions to get the best care.
There is some conflict and confusion about medicolegal accountability for case management. This will require further exploration and engagement from staff.

Conclusion

The new GP contract needs to encompass not just the GP but the whole PCT, and it needs to address PCT motivation and communications.
Better communications and inclusiveness between team members is a priority – both electronically and face-to-face. There is a need to work as a team to promote the concept of 'wellness' – keeping people out of hospital.
Funding is required: to enable co-location of team members; for inter-disciplinary education of team members; for the electronic hardware and software to enable better communications; and to educate and empower patients.

This workshop was chaired by Ms Claire Donnelly, Dr Siobhan O'Connor and Ms Mairead Aherne

[1] Meitheal training is based on active participation, reflection and skills development. This leads to participants gaining confidence, being able to build on their own experience and put new learning into action.

Chapter 5

Multidisciplinary integrated primary care

Introduction

Providing patients with multidisciplinary integrated care leads to optimal outcomes, convenience and patient satisfaction. According to the Health Service Executive's (HSE) definition, a primary care team (PCT) should be a 'one-stop shop' involving a multidisciplinary group of health and social care professionals who work together to deliver local, accessible health and social services to a defined population of between 7,000 and 10,000 people. Reforming and improving community healthcare services is vital, given the well-documented increasing and unsustainable demand on secondary healthcare services, our ageing population and the trend towards delivering care as close to the patient as possible. Much of the chronic disease management currently taking place in the expensive secondary care system would be better delivered in the community at much lower cost and at greater convenience to the patient. However, this is entirely dependent on a related and substantial increase in capacity and resources in the community in terms of general practice and properly functioning PCTs.
However, while there are many of examples of well-functioning integrated community services and PCTs, there are also plenty of examples of poorly performing or non-functioning teams. Many GPs are not part of a PCT or are involved in poorly functioning PCTs. In addition, there is a lack of awareness and communication within many community-based healthcare services, as well as confusion and lack of knowledge among patients about local healthcare services.

Challenges and solutions

Eligibility for community healthcare services is inequitable, far more so than hospital-based services. Only Medical Card patients can avail of certain services, some of which even those with funds or private healthcare services cannot access. This is unfair and has created a two-tier service. The development of PCTs has been piecemeal and uneven in geographic and resource terms. Some PCTs function better than others, have more resources and are located in HSE-funded buildings or co-located with general practice teams. Some PCTs have very little GP input and there may be a negative view of PCTs by GPs. Greater GP 'buy-in' and participation is needed, but this will require incentivisation as GPs remain the only PCT members not reimbursed for their time attending PCT meetings and the leadership roles they may take on. PCTs cannot function properly without GPs assuming and being resourced to provide overall clinical leadership. Many GPs feel that PCT meetings are 'a waste of valuable time', irrelevant to them, poorly organised and achieve little. There also remain issues around PCT protocols, ie. clinical leadership, sharing of information, ensuring patient confidentiality and protecting against inappropriate disclosure, that have yet to be resolved. A 10-year review of the 2001 Primary Care Strategy found that 40 per cent of GPs were not part of a PCT. There remains a significant minority of single-handed GP practitioners, many of whom need to be better linked to other community healthcare services.
Some areas have very few community mental health services, which leads to high and potentially inappropriate prescribing of antidepressants and other psychiatric medications to patients who would better benefit from access to psychology, cognitive behaviour therapy, and other mental health ancillary services.
Lack of diagnostics in the community is a key issue and must be addressed as a priority. Patients are being sent to emergency departments simply to access vital scans and are being sent for outpatient appointments because the GP cannot access the necessary diagnostics while a hospital-based doctor can. GPs need to be able to directly refer patients for X-rays, ultrasounds, CT scans and other relevant diagnostics.
Communication is a major stumbling block for many PCTs and is hampering optimal integration of community services. There is also inadequate communication and formal pathways between other community healthcare services such as public health, community ophthalmology and mental health services.
There are also significant communication issues between primary and secondary care – discharging patients back into the community without communication and supports in place, lack of knowledge within the hospital sector about the services provided in the community, etc. With the latest roll-out of community healthcare organisations there is further confusion and communication issues about clinical and managerial responsibility in the community. The advances made using Healthlink and eReferral have been welcome but need full national roll-out and would be further enhanced by the use of a unique patient identifier across the whole healthcare system.
Manpower issues, particularly regarding GPs, are also a serious stumbling block in regards to providing adequate community healthcare services. The aspiration of GP-led primary care as envisaged in the Oireachtas Future of Health Committee report will be just that, an aspiration, without re-imagining general practice in Ireland as an attractive career choice for medical undergraduate and postgraduate

doctors. An indication of how low the career choice of GP has fallen is the fact that, for the first year ever, 10 GP training places were unfilled this year. In the past, applicants outnumbered posts for GP training by a factor of 4:1.
Out-of-hours GP services again are uneven and the level and quality of services can vary according to where patients live. This issue also applies to out-of-hours community mental health services, pharmacy, etc, and means patients seek help in the expensive hospital system due to an inability to access the appropriate service in the community.
The majority of community-based healthcare services are sickness-focused, and do not promote wellbeing, patient empowerment or self-management.
Solutions to the aforementioned challenges may include, but are not limited to, the following:

- Funding for community healthcare services must be significantly increased if GP-led primary care and multidisciplinary integrated care are to become a reality. A single-tier community healthcare structure with access based on medical need, not ability to pay, is envisaged as the ideal.
- Introduce/increase community clinics for traditionally hospital-based services, like geriatrics, psychiatry, maternity, minor surgery, etc. Having such services available in the community improves quality of care and outcomes, reduces outpatient referrals and hospitalisations, and helps elderly patients, in particular, remain in the community for longer and is extremely cost-effective. As evidenced by the Deloitte and Touche report, €1 invested in primary care and general practice saves €5 elsewhere in the healthcare system.
- Increased investment is needed for PCTs to function optimally. The investment should be in diagnostics and staff, particularly in support of practice nursing and health and social care professionals, rather than in physical buildings. Practice nurses have a key role to play in management of chronic disease in the community and should be supported and their numbers significantly expanded to a ratio of 1.5-2 for every GP. Having community access to dieticians and physiotherapy, for example, leads to improved patient outcomes and reduced GP workload.
- Improved lines of communication between PCT members and all community-based services are vital. Part of this solution is having health staff use the same technology/email platforms. Healthlink is a positive example of this. The use of video meetings of team members, and also private forums/apps, where relevant information and ideas could be shared before meetings, could lead to shorter times required for actual physical meetings. Support for IT investment in general practice and wider community healthcare from the HSE is necessary to achieve this goal as the current financial burden and risk associated with this investment in IT is the responsibility of general practice teams.
- Investment in technology is necessary to increase patient access to community healthcare services – eg. video medical consultations with GPs, practice nurses, mental health professionals, wearable medical technology, ePrescribing and eReferrals.
- The HSE needs to fund and expand continuing professional development (CPD) for community healthcare staff – not just GPs, but practice nurses, too – to upskill and maximise skillsets so clinicians are working to the higher end of their licence. Providing CPD points for attending PCT meetings would be an added incentive for attendance.
- Increased administration support for PCTs/community-based healthcare services is required. This could include patient case managers for those with complex multimorbidity. Such support would help to 'merge' services and increase working-together opportunities. For patients discharged from hospital back to the community, such admin support could help better link patients to the necessary services. This support could also better co-ordinate the care of patients who need multiple medical services.
- Fund GPs to attend PCT meetings and to take on leadership roles with the PCTs and the communities. This will increase GP engagement and overall success of PCTs. Properly funded maternity cover needs to be addressed for community healthcare staff.
- Introduce more 'wellness' and health promotion services, tackling key issues such as mental health, smoking cessation, obesity, etc. Such services will lead to long-term benefits in better population health and savings to the health system.
- Incentivise healthcare staff to work in the community. A new GP contract is key to helping reverse the GP manpower crisis and attracting young GPs to work in primary care in Ireland.
- Consider introducing 'innovation funding' that PCTs, for example, could apply for, in order to introduce innovative services/technology/diagnostics to best meet their own patient population needs.
- Define and improve patient pathways for integrated community healthcare services and provide better information for staff and patients on services available.

Conclusion

Properly resourced GP-led primary care can transform the Irish healthcare landscape for the better leading to improved patient outcomes and wellbeing and reduced healthcare costs. The range of services currently available to patients within the community can be enhanced and increased with HSE support and funding. Whole population coverage for proper integrated community care is vital but the resourcing of this needs to be activity-based.

This workshop was chaired by Dr Liam Glynn

Chapter 6

Introducing local integrated care committees nationally

Introduction

Despite increasing investment in the health service, waiting lists, emergency department (ED) overcrowding and delayed discharges continue to be significant challenges. In 2016, more than 1,362,000 ED attendances were recorded – 5.4 per cent more than expected. Almost 40,000 of these patients waited more than 24 hours. On one day at the end of December 2016, over 5,900 patients were waiting longer than 15 months for an inpatient or day-case procedure, and 53,334 were waiting longer than 15 months for a hospital appointment. On the same day in December, 436 patients were subjected to delayed discharge because of inadequate community placement and services.

The common thread between these three separate issues is that they all occur at the interface between primary and secondary care. These perennial problems cannot be addressed without fostering a culture and a structure for business engagement between general practice, community services and hospital services.

For more than 20 years, the Irish College of General Practitioners (ICGP) St Luke's Liaison Committee in Carlow-Kilkenny has successfully cultivated engagement between local GPs, community partners and the hospital. More than a GP liaison group, the Carlow-Kilkenny approach is based on a model of integrated care. It has created a 'hospital without walls', where GPs have strong relationships with the hospital and are involved in all levels of service development. Monthly meetings (now called a local integrated care committee [LICC]) act as a forum that builds relationships, encourages ideas and agrees change. All GPs and consultants in the area are invited to attend, and everyone is equal. Other participants include hospital and community PC management, mental health and public health colleagues. The approach is built on face-to-face contact, mutual respect, trust and innovation. This culture of GP-hospital-community engagement has led to a series of local initiatives including the creation of Caredoc, the GP out-of-hours co-op and the establishment of the first acute medical assessment unit (AMAU) with direct GP access.

The model has been extended to other hospitals in the Ireland East Hospital Group as LICCs. LICCs have been established at a number of sites including St Columcille's Hospital, Loughlinstown, and Midland Regional Hospital, Mullingar. This is a bottom-up approach to integration that is supported by local doctors and management. The Primary Care Division of the HSE has now agreed to support the development of LICCs at other sites outside the Ireland East Hospital Group (IEHG) to improve communication and engagement, and other sites have begun, including Tallaght, Cork and Ennis.

Introducing the LICC model nationally will bring with it a number of benefits:

- Builds relationships – face-to-face contact breaks down barriers. Rather than communicating by letter or email, the LICC allows GPs and consultants to meet and communicate directly, which builds relationships, trust and mutual appreciation.
- Nurtures innovation – as evidenced by the achievements of the ICGP St Luke's Liaison Committee in Carlow-Kilkenny, when given the opportunity to collaborate, GPs and consultants can devise effective long-term solutions to problems and inefficiencies.
- Empowers GPs – it is well recognised that general practice is facing a manpower crisis. Many of our young GPs are leaving the country, and few are returning. Our young graduates are often disillusioned by the reality of general practice in this country, with the barriers of fragmented care which hinder the profession in achieving its potential. Empowering GPs through the LICC model will go a long way towards improving morale and services locally. GPs in individual hospital catchment areas may come together to examine commonality of need, with the purpose of creating priorities for the LICC to tackle collectively.

Challenges and solutions

However, a number of issues need to be addressed in order to deliver these benefits:

- Clarity – there must be a clear vision of what the LICC model is, how it functions, what its goal is, and who is involved. Terms of reference need to be agreed locally. A proposed definition is that the LICC is a process of positive and meaningful engagement between GPs, hospitals and local management for the benefit of patients. Its central function is to build relationships between GPs and consultants in the first instance, and then between clinicians and

management, with the flexibility to involve other health professionals as the need arises. It must be recognised that this is a process, and essential to its success is the development of mutual respect, appreciation and trust. Ideally, as this culture change builds more integrated care, members of a successful LICC may develop a mandated, accountable and representative role within the evolving community healthcare organisations (CHOs) and hospital groups, and vice versa.

- GP buy-in – there is a risk that some GPs will see the LICC as another meeting that they are obliged to attend in addition to faculty meetings, practice meetings, continuing professional development (CPD) events, etc. Some work is required to convince GPs to engage. An important element is to recognise that GPs are independent contractors. Their time is valuable and, as such, they must be remunerated for their attendance and contribution. To further encourage GP participation, LICC meetings should qualify for service leave, similar but extra to study leave, and consideration should be given to awarding double CPD points for participation. An essential factor in encouraging GP buy-in is ensuring that the process delivers real, tangible benefits for GPs and patients in their day-to-day practice. In this regard, small wins will make a big difference in the long term.
- Hospital buy-in – hospital management and consultants must see the LICC as a process that they need to be involved in. There are clear benefits to consultants and hospitals through enhanced communication, service development and patient flow. The process will give consultants and GPs the opportunity to innovate in an agreed manner and this innovation may be supported by colleagues and management.
- Equity and respect – a central tenet of the Carlow-Kilkenny project has been the principle that everyone is equal. Relationships nationally between GPs and hospital colleagues tend to be poor and there is currently no uniform mechanism for close business relationships between the fragmented service providers. Part of this may be due to the fact that most hospital doctors have no experience of general practice, while all GPs have done some training in the hospital setting.
- The LICC is built on partnership and parity. In order to achieve that, steps must be taken to cultivate a better understanding of general practice among hospital-based colleagues. Consideration should be given to creating a system that allows hospital management, administrators, and perhaps junior doctors, to spend time in general practice. Medical schools and postgraduate training bodies must introduce the concept of integrated care to medical education.
- Funding and support – having access to funding would be a game-changer for the LICC model. To foster parity, meetings should be held in a third-party location, which would require some financial support. Also, a secretary/administrator may be required. Innovation funding for local service development would be transformative for LICCs. This would allow local clinicians to be involved in some budgetary decisions on patient care. Relatively small investments here could deliver real benefits for a shared health community. For example: improved GP access to diagnostics; a clinical pharmacist review service to evaluate and advise on complex prescribing; virtual clinics for rapid consultant opinion; discharge co-ordinators to liaise with the community pharmacist, GP and hospital team following discharge of at-risk groups; rapid access pathways for frail elderly with complex needs; and enhanced child assessments for those with autism or special needs, or improved community child and psychiatry services.

Conclusion

Poor integration between primary and secondary care gives rise to some of the most intractable difficulties in the health service. The ICGP St Luke's Liaison Committee in Carlow-Kilkenny shows that a formal, structured process of collaboration and face-to-face communication between local GPs, consultants and management builds relationships, fosters innovation and, ultimately, streamlines services. But the process must be built on mutual respect and a genuine partnership between GPs, consultants and local management.

This LICC model has the potential to deliver considerable benefits if rolled out nationally, but to do so will require buy-in from both GPs and the hospital. Measures will be required to encourage GP participation. General practitioners want to engage, but they want to engage as equals. They want representation at the interface between primary and secondary care, but the process must be real and the voice of general practice must be heard.

The purpose of the LICC is to deliver tangible benefits for patients, general practice, the hospital and local management, both in hospitals and community. Successful shared projects will encourage and sustain the LICC model. To do this will require support from senior and middle management in hospital and community. The model will require funding to facilitate participation, and the provision of an innovation fund has the potential to enable the process to deliver real local change in our health services.

The workshop was chaired by Dr Ronan Fawsitt and Dr Liam Glynn

Workshop chairs

Máiréad Aherne
Irish Nutrition and Dietetics Institute

Máiréad Aherne has held varied roles such as senior community dietitian in HSE Midlands and paediatric dietitian in Temple Street University Hospital. Following this, Máiréad became Community Dietitian Manager in Dublin North and, most recently, has taken up the post of Community Dietitian Manager in Primary Care, Dublin South West/Kildare/West Wicklow (September 2015).

Claire Donnelly
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Claire Donnelly worked for a number of years as a physiotherapist in the NHS in Wales, specialising in respiratory care. In the late 1990s she spent three years as a volunteer in Uganda. Claire is currently the Physiotherapy Manager for HSE Services in Offaly, where she has responsibility for the physiotherapy services in the acute, disability and primary care settings.

Dr Ronan Fawsitt
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Dr Ronan Fawsitt is a full-time GP partner in a large mixed urban/rural practice based in Kilkenny City. He is Chairman of the Kilkenny Faculty of the Irish College of General Practitioners (ICGP) and of the Carlow-Kilkenny ICGP-St Luke's Hospital Liaison Committee. He is Chair of the GP Advisory Group for Ireland East Hospital Group (IEHG) and serves as Primary Care Lead on the IEHG Executive Management Team.

Dr Liam Glynn
GP and NUIG Lecturer

Dr Liam Glynn is Senior Lecturer in General Practice in the College of Medicine, Nursing and Health Sciences, National University of Ireland, Galway, and is Adjunct Senior Clinical Lecturer, Graduate Medical School, University of Limerick. He was awarded his medical degree in 1995 from Trinity College, his MSc degree in 2003 and his MD in 2007, both from National University of Ireland, Galway.

John Hennessy
National Director, Primary Care Services, HSE

John Hennessy is the HSE's National Director of Primary Care. He played a lead role in the substantial reorganisation of health services in the West, including the Mid-West hospital services and the Galway Roscommon hospital group. His constant priority throughout was on strengthening patient safety, reducing risk and improving outcomes for acutely ill patients.

Dr Andrew Jordan
Chairman, NAGP

Dr Andrew Jordan is a member of the Dublin South West Faculty of the Irish College of General Practitioners. He was the GP representative for the development of primary care teams in Tallaght following the introduction of the Primary Care Strategy in 2001. He is a member of the GP Liaison Committee at Tallaght Hospital. He is involved in undergraduate teaching for RCSI and Trinity College Dublin.

Dr Emmet Kerin
President, NAGP

Passionate about protecting the integrity of general practice in Ireland, Dr Emmet Kerin is motivated by the NAGP movement to represent the interests of GPs and their patients, to shape the future of primary care and to ultimately improve patient outcomes. Dr Kerin is actively involved in medical education, working as a lecturer in the Graduate Entry Medical School, University of Limerick.

Mark O'Connor
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Mark is an experienced Senior Manager with 18 years of strategic sales/marketing, account management and project management experience in ICT consultative solution selling with large public sector agencies. He is positive, goal-orientated and he values education and continuous development. Mark is passionate about developing people and systems to drive results.

Dr Siobhán O'Connor
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Dr Siobhán O'Connor MSc PhD ARTC is the Vice-President of Athletic Rehabilitation Therapy Ireland since its foundation in 2009 and is the current chair of the ethics committee. She is a lecturer and final year clinical co-ordinator on the BSc Athletic Therapy and Training programme in the School of Health and Human Performance in Dublin City University.

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Hal Wolf is a Director with The Chartis Group and National Leader for its Information and Digital Health Strategy practice. Mr Wolf is respected internationally as a healthcare and informatics executive. He leads the firm in supporting providers and healthcare organisations in the development of integrated information, digital health and precision medicine strategies.

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Teamwork in Health

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