Primary Care Partnership
Teamwork in Health

Primary Care

A framework for the future

APRIL 2016

Partners



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& PODIATRISTS

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Foreword

In January of this year, hundreds of community-based healthcare professionals, along with key national and international opinion leaders, united in Maynooth, Co. Kildare, with the aim of working together to prepare a plan to meet some of the many challenges facing the Irish health system.
The inaugural 'Primary Care Partnership' conference was divided into plenary sessions where global leaders in health shared their experiences and expertise.
Participants in the conference – comprising health and social care professionals from across primary care – were tasked with examining a range of areas. The areas covered were as follows:

- How primary care teams can better function with improved access to health and social care services;
- Improving primary care access for home/residential care;
- Prevention is the cure/Healthy Ireland;
- Integrating primary care and maximising technology: data protection, patients and technology;
- Prioritisation of patients/managing the overload;
- General practice/ambulatory care/emergency departments;
- Improving patient care in rural Ireland;
- Improving patient care in an urban deprived environment; and
- Primary care – a vision for the future.

Following the plenary sessions, a number of workshops took place which presented an opportunity for delegates to engage with the many ideas presented and ultimately lay the foundation stone for this framework document and strategy. We believe that this document presents an opportunity for all healthcare professionals to work towards a primary care service that both patients and health and social care professionals deserve. 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 confronting the challenges facing the Irish health system.

Chris Goodey

April 2016
Chairman, Primary Care Partnership, and CEO, NAGP

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Health promotion and preventative healthcare is notoriously complex. In order to succeed, it requires multi-stakeholder involvement from all sectors of society, from local authorities to healthcare professionals. This chapter considers the practical steps that are required to ensure that *Healthy Ireland*, the State's national framework for action to improve the health and wellbeing of the people of Ireland, is more than aspirational and fulfils its considerable potential. **PAGE 9**

INTEGRATING PRIMARY CARE AND MAXIMISING TECHNOLOGY: DATA PROTECTION, PATIENTS AND TECHNOLOGY

This chapter considers the enormous potential for information technology (IT) to drive efficiencies in the health service as a whole, and in primary care in particular. The importance of progressing the information framework has received repeated emphasis from a number of sources. In the past, the will to develop healthcare IT has not been matched with solid progress and development. Despite this, the integration of IT into primary care has continued to develop and expand since the Primary, Community and Continuing Care (PCCC) ICT strategy, but this development has been driven solely by investment from GPs themselves. This chapter explores the possibilities and benefits that standardisation and integration would bring. **PAGE 11**

PRIORITISATION OF PATIENTS/MANAGING THE OVERLOAD

The issue of patient overload is a composite of many problems. This chapter addresses a number of issues, and how they can be addressed, as well as considering the wider picture of providing an adequately funded and resourced primary care system. This chapter also considers the possible benefits derived from enhanced IT and, in particular, how electronic referrals would reduce time spent writing letters, while a text messaging service could be used to remind patients of appointments. A practice website with a dedicated patient portal would allow appointments to be booked online and/or repeat prescriptions to be issued without requiring a visit. With general practice and primary care under increasing pressure, steps must be taken to support GPs and all health professionals, in order to maintain practice viability and provide the best service possible to patients. Stress and burnout among GPs and other healthcare professionals must be addressed in order to maintain recruitment and retention levels. **PAGE 13**

GENERAL PRACTICE/AMBULATORY CARE/ EMERGENCY DEPARTMENTS

Emergency department (ED) overcrowding is an endemic problem within the Irish healthcare system. The establishment of the recent ED taskforce, which is co-chaired by HSE Director General, Tony O'Brien, marks the most recent attempt to solve the issue. It is widely acknowledged that acute medical assessment units (AMAUs), with the support of ambulatory care (a care process intended to get patients quickly and safely back into the community), have been a valuable addition to the healthcare landscape, although their implementation has been uneven throughout the country. This chapter considers the benefits arising out of structured and supported engagement between consultants and GPs, through building relationships as equal partners in care of a shared community, using local liaison committees and new referral pathways. Services can be developed which will help patient care and begin to reduce the chronic pressure felt in hospital EDs across the country. **PAGE 15**

IMPROVING PATIENT CARE IN RURAL IRELAND

The provision of healthcare in the community, where appropriate, has been widely acknowledged as optimal for effective patient care; however, the sustainability of general practice in rural communities is under significant strain to the point where its viability is now in question. This chapter proposes a range of solutions needed to address the existential threats to the future of rural general practice in Ireland including a range of initiatives, from national to local level, that must be implemented to provide a coherent career path for young rural GPs in Ireland in order to save rural practice and ensure that, at the very least, an adequate level of primary care is provided to rural communities across the country. **PAGE 17**

IMPROVING PATIENT CARE IN AN URBAN DEPRIVED ENVIRONMENT

The Irish College of General Practitioners study, *Irish General Practice: Working With Deprivation* (Osborne, 2015), revealed that almost all services are used more by those on the lower rungs of the income ladder, and that those people have the greatest need. Most observers accept that patients with Medical Cards visit the GP more frequently than fee-paying patients – up to three times as often. For GPs working in deprived environments, the challenges involve multiple morbidities and health issues, with many patients presenting with HIV, hepatitis C, drug issues and homelessness. The effects of deprivation create not just health problems but behavioural problems too, and the supports to deal with these issues are not readily available. This chapter proposes a range of supports that could be put in place to support patients in urban deprived areas and the health and social care professionals who care for their needs. **PAGE 19**

PRIMARY CARE – A VISION FOR THE FUTURE

This chapter considers some of the issues facing primary care, in particular the problem that, to a certain extent, primary care remains under-utilised and under-valued. There is a perception that the sector has lost its identity, largely due to concern and confusion regarding the future of primary care. The chapter sets out a vision for primary care which is collaborative and advocates for greater cooperation between the Irish College of General Practitioners, Department of Health, Health Service Executive, National Association of General Practitioners and other health and social care professionals. **PAGE 21**

How primary care teams can better function with improved access to health and social care services

INTRODUCTION

According to the Health Service Executive's definition, a primary care team (PCT) is 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 at 'primary' or first point of contact with the health service.

The concept of the PCT is a 'one-stop shop' for everything that a patient may require. This can include the general practitioner and practice nurses, but also public health nurses, physiotherapy, dietetics, psychology, podiatry and speech and language therapy, for example. There are numerous clinical services that can be provided under the umbrella of primary care. These services should be appropriately integrated in order to provide timely and coordinated care to the patient. While the PCT is a virtual concept and may not be housed within one building, primary care centres (PCCs) continue to be developed and built by the HSE; as of July 2015, there are 44 PCCs in Ireland, seven of which are in the greater Dublin area. Fourteen new PCCs will begin construction this year, funded by what is the State's first healthcare public-private partnership (PPP) project.

THE PROBLEMS

- The primary care professionals present at the conference agreed that the concept of the PCC versus the PCT was a difficult one for people to grasp; while the PCC is within one building, the PCT may, particularly in rural areas, be spread over a large geographical area and exist within the virtual setting. The definition of a PCT is not well understood, and this impacts patients trying to access services that can be provided in their community.
- A deficit between strategy and roll-out of primary care teams was observed. There is a gap between what constitutes health policy and what is happening on the ground; as the HSE is leading the roll-out of PCTs and PCCs, the attendees agreed that it is incumbent upon them to clearly define who or what should be included as part of a team, saying the lack of clarity is currently leading to confusion among team members. There is a need for standardisation of teams and the failure to do so is exacerbating gaps in service access.
- Discrepancies between urban and rural PCTs were also noted; often, in urban areas, members work closely together but in rural teams, members may be linked to service providers they are unfamiliar with by virtue of being in the same large geographical area.
- A lack of team cohesiveness was highlighted, and it was explained that in many cases there is not a full team, with some necessary services unavailable.
- Some attendees agreed that the concept of the PCT had been politically driven but adequate resourcing had not been provided; in many areas, while the basic primary care services such as GP and public health nursing are provided, there is no drive to fund the full complement of services as part of a complete PCT.
- Lengthy waiting times and difficulty in accessing primary and secondary services was also seen to be a significant issue for the majority of those present. Health and social care professionals said they are overburdened in terms of appointments.
- The problem of funding and training of practice nurses was raised; indeed, education and training of all team members was deemed to be a priority.
- The lack of an adequate IT platform negatively impacts communication between members and the work of the team. Electronic referral forms are not being used exclusively; written referral forms are still being received, often containing insufficient information regarding the patient.
- Attendance at meetings was a significant problem for all members, particularly GPs. GPs are the only members of PCTs that are not HSE employees, and their attendance at meetings is not recompensed. It was felt that participation in team meetings was not economically viable for GPs; their business depends on their presence, and meetings can interfere with patient appointments.
- There can be difficulties in navigating the public and private health sectors for patients.
- Privacy and patient confidentiality during team meetings was seen as a major issue. Some delegates said they disliked discussing their patients in front of other members of a PCT not involved in their care due to issues of confidentiality. It was felt by some that data protection should preclude them from doing so, and felt that sharing patient information made this information less secure. This also creates problems in terms of patient consent, and patients may not wish to have the members of the extended team hear their medical information. Implicit versus explicit consent from patients was discussed and the lack of a secure website/access system was also highlighted, yet this is not identified as being an issue in the acute setting where patients are routinely discussed as part of multidisciplinary team consultations.

THE SOLUTIONS

- Standardisation of what constitutes a full PCT is warranted. This would enable the identification of gaps in services and also help to define what is needed in terms of funding and resources.
- Issuing guidelines/protocols would aid in not only developing a clear picture of what the PCT does and is aiming to achieve, but would also help to facilitate the smooth coordination of services.
- Elucidation of the roles of everyone within the PCT who interacts with patients is needed, eg. case manager, team

leader, network manager; knowing their exact role, their value, and their responsibilities would help the team to run more smoothly. In addition, pathways to care must be clearly defined and mapped.

- In-service education regarding the roles of the various members of the team was also seen as a possible solution, as this would address the current lack of understanding and clarify the 'rules of engagement'. There was a lack of understanding about the clinical and therapeutic roles and qualifications of the team members. There should be increased resources and education of members in order to streamline the process and avoid duplication of administrative and other tasks.
- Awareness within the community that there is a single point of access would aid not only the patient, but also the team members in accessing each other's services when referring patients on.
- With regard to the physical/virtual infrastructure of the PCT, it was suggested that teams could be linked to a particular GP practice, rather than simply by geographical area. Aligning teams to individual practices would facilitate integration and efficiency.
- A possible solution for attending team meetings was the use of telemedicine, with 'virtual attendance' at a designated time by the GP. This would be particularly useful in rural areas. Email was also suggested as a potential means of discussing patients.
- There should be a facilitator at each meeting in order to provide the agenda and record the minutes.
- GPs may have both public and private patients. The fact that GPs are not HSE employees yet a core member of the PCT must be addressed, and it was suggested that GPs should be incentivised to participate fully in the team. This would also include provision of locums, etc.
- With regard to IT, it was felt that a functioning and universally-employed IT platform would greatly enhance efficiency and communication. E-referral must be more widely utilised to decrease the current paperwork load, and enabling the use of an electronic signature would also greatly improve efficiency.
- Funding and resourcing was a universal theme. It was agreed that reversal of cuts made by the Financial Emergency Measures in the Public Interest (FEMPI) Act would be a first step in restoring general practice and primary care services. The possibility of a ring-fenced budget for each PCT was suggested; this could be spent on resources, in-service, education, etc. Spending €10 on an effective PCT will save €100.
- Investment in the PCT as a unique entity is required – it is currently seen as an 'add-on' to everyone's role.
- Issues of privacy and patient confidentiality could potentially be addressed by either assuming implicit consent or signing a consent form at the point of entry to services. Data sharing and data confidentiality must be addressed as the PCT is privy to a huge amount of potentially sensitive data across practices.

SUMMARY

The primary care team concept is seen as a sound one, but there is a significant gap between policy and practice, and clarification of a number of aspects of their work is required. Clear identification of the role of the team, as well as its individual members, is needed, and what constitutes a PCT should be defined and standardised.

Various supports are needed to ensure all members can function as part of the team smoothly and efficiently, such as modern IT infrastructure, which would enable improved communication and integration between members. Ongoing education and enhanced resources for team members is also a fundamental requirement. Aligning PCTs to GP practices rather than organising them by geographical area would also facilitate better integration of teams. GPs, as non-HSE employees, must be incentivised and compensated for their participation.

Data protection and patient confidentiality must be addressed, as the level of consent given by the patient and the ability to share data is uncertain and this is causing concern for PCT members.

The current PCT model requires recognition as a different entity and needs the appropriate investment by Government to ensure its success as a strategy for improving patient care.

The workshop was chaired by Ms Jennifer Feighan and Dr Conor McGee

Improving primary care access for home/residential care

INTRODUCTION

As the population ages, and as the Government places more pressure on families to look after the elderly outside the public hospital system, the pressure on primary care providers increases accordingly. General practitioners are at the front line in helping families to cope with the intense input that is required when a family goes into crisis with an elderly relative. People are at their most vulnerable and often unable to cope. Many GPs have noted that, among some older people, there may be a sense of apprehension about entering long-term care. Dementia is increasingly a problem, and not just in the older age groups. There are other spiralling health issues such as diabetes and other comorbidities.

The overriding concern expressed by all healthcare workers is the random nature of care. Those who make the most noise get the best service – this is not equitable. There seems to be no best-practice model or systematic approach; everything is left to the individual family to arrange, with whatever help they can get from their GP, public health nurse or other members of the primary care team. The Health Information and Quality Authority (HIQA) model is based solely on medical considerations and completely ignores the holistic approach of a social model that GPs and care workers have, for so long, been trying to introduce.

THE PROBLEMS

There are four main problems to be addressed:

- There is a fundamental lack of integration and coordination between all the available supports, including clinical and social supports. This manifests itself as a disconnect between what each patient needs and the services and facilities that are actually provided. The system focuses on clinical symptoms, with a lack of focus on wellness. Patients need a holistic approach that takes their social circumstances and mental wellbeing into account. The public health nurse (PHN) is often the front-line worker coordinating this care, but there are not enough of them; they are stretched beyond the safe limits of capacity.
- There is a lack of capacity across the healthcare system to provide the necessary care and supports.
- The availability of services and facilities is uneven across the country, and this 'postcode lottery' means that there is inequitable access to care. Access to care becomes random, with a lack of uniformity of services across the country.
- There is no statutory right to home care in Ireland. The quality and availability of information about services is poor. This creates difficulties for families in navigating the system.

THE SOLUTIONS

- Lack of coordination: PHNs do a superb job – but there are simply not enough of them to provide the service that is needed. A lot rests on their shoulders but they have too many decisions to make, and too much to cope with. There is no option but to increase the number of PHNs and give them specific responsibility around coordination and dissemination of information to clients. There must also be improved, and more comprehensive, information technology (IT) systems to manage the huge and complex volumes of data. There needs to be regular structured primary care meetings. Some of these need to be face to face, but many more could be virtual meetings, conducted electronically (eg. via telemedicine).

  The right to care has to be supported by adequate advocacy and information. Many people experience huge difficulty navigating the system and usually have to do this when they are at their most vulnerable and possibly confused or elderly, too, especially if they have no younger family. There are frequently concerns among the elderly about giving up a lot of personal information.

  A critical point identified by both GPs and nurses, as well as private care providers, is that it is vital to develop better systems around the transfer of patients from secondary care to home residential care. It is inadequate to merely transfer clinical records. More time needs to be invested in pre-discharge routine. There needs to be better integration with all multidisciplinary teams to develop a holistic care approach. Everyone needs a voice so that a more seamless, inclusive and safe discharge process emerges. We need consensus on what constitutes 'safe discharge'. A positive idea that emerged from the workshop was to develop a system of 'client diaries' which couple the patient's medical history with their personal, social and emotional history. These client diaries would facilitate the many people who have moved to residential care to access the appropriate primary care when they need it.

  GPs and other healthcare providers need to embrace new technology to help those in care, particularly those who live alone. For example, sensors that detect falls, or other critical data, are hugely efficient and valuable. A coordinated approach to using technology could produce savings and efficiencies for residential care, as well as improving quality of life.

  Equally, patients who move in the other direction, from residential care to secondary care, require the continued support of primary care after they have moved, but the current system does not permit this integrated support. Often, the result of this disconnected model is that GPs micromanage to compensate; this is unsustainable.

  In addressing the random nature of care across the country it is important to note the impact of HIQA on care levels. In many cases, it demands standards that cannot be complied with, and services are withdrawn.
- Lack of capacity: even within the constraints of limited financial resources there are some solutions that could be rapidly implemented. If existing resources were better allocated and organised this would increase capacity and

services. For example, an analysis should be undertaken into what patients actually need so that resources can be allocated more efficiently. Funding should be transferred from secondary and tertiary care to primary care so that patients may be kept well for longer, and kept out of hospital. All healthcare professionals need to be trained to do more in creative new ways. Nurses could be trained to take on more primary care roles. It may be possible to arrange more physiotherapist visits to a home, removing the need to transport patients. This better allocation of existing resources needs to be extended to long-term planning, too.

- Equity of access: a more streamlined and integrated planning approach is essential to ensure fairer access to care. Resources need to be matched to population size and growth, and healthcare workers need to be consulted about their close knowledge of the communities they serve so that there is better planning, as well as better use of services and resources in the future to meet projected demand. This review needs to factor in the quality of personnel, and promote better leadership. Critically, we need to develop and introduce a best-practice model, and promote it through centres of excellence.
  Another critical aspect of improving equity of access is by leveraging technology to maximise the potential to reach remote communities. This system is well developed in Australia, for example. Above all, we need to change the mentality that says you need to be ill to get treatment; this philosophy means that when resources are scarce, as they always will be, illnesses (and patients) are prioritised and some go untreated. We need to develop a new mentality that says we will give preventative care to people, and we will empower GPs, local staff and patients to take more preventative care decisions.
- Statutory right to home care: we need to enact legislation that recognises the pivotal role of primary care, and gives a statutory right to care. Critically, we need to change the public's view that people have no personal responsibility for their own health; that the State will always be there to pick up the pieces. This 'nanny State' view has developed quite naturally as a consequence of ever-increasing State control and influence over our lives. We must change this to a view where everyone acknowledges that each one of us has a fundamental responsibility for our own primary care – to eat properly, to avoid behaviour that presents a high risk to health, to exercise, and so on.

SUMMARY

The solutions are multi-faceted and hinge on better management and resourcing, and a holistic approach to understanding and managing patient care.
A greater number of PHNs with greater responsibilities, more IT solutions, and regular structured primary care meetings are key requirements. Nurses and other key members of the primary care team can be empowered and trained to take on other responsibilities.
Better communication and information is needed, making better use of technology.
A more streamlined and integrated planning approach is essential to ensure fairer access to care. We need to develop and introduce a best practice model, and promote it through centres of excellence.
We need to develop a preventative care mentality and empower GPs, local staff and patients to take more preventative care decisions. We need to change a common public view that people have no personal responsibility for their own health.
We need to enact legislation that recognises the pivotal role of primary care and gives a statutory right to care.

The workshop was chaired by Mr Tadhg Daly and Mr Michael Harty

Prevention is the cure/Healthy Ireland

INTRODUCTION

Healthy Ireland is the State's national framework for action to improve the health and wellbeing of the people of Ireland. The main focus of the strategy is on prevention and keeping people healthier for longer. *Healthy Ireland's* goals are to: increase the proportion of people who are healthy at all stages of life; reduce health inequalities; protect the public from threats to health and wellbeing; and create an environment where every individual and sector of society can play their part in making the country healthier. The strategy, which ends in 2025, has been described as an economic imperative given the rise in healthcare costs and the demographic pressures facing the country. The number of people aged 65 years and older grew by 14.4 per cent since 2006, and the number aged 85 years and over grew by 22 per cent. It is forecast that the percentage increase will continue to grow at a rate of nearly double the EU average. From 2000 to 2009, Irish public healthcare spend more than doubled, in real terms, to €15.5bn per annum. Approximately 40 per cent of the day-to-day expenditure on health deals with issues related to tobacco, alcohol and diet and obesity. Alcohol, which is responsible for a wide range of health and social harms, has an annual cost of €3.7bn. Although the costs relating to obesity and tobacco are less, they are still significant, totalling €1.2bn apiece. Approximately 5,000 people die of tobacco-related diseases in Ireland every year, while 700,000 die across Europe. Those who don't die usually end up with severe respiratory/cardiovascular disease, which places a major burden on the health system. Alcohol and drugs increase risky behaviour and are associated with mental health problems, which have a significant personal impact on those who experience them. Alcohol alone is implicated as a factor in many suicides. Mental health issues result in costs related to loss of productivity, premature death, disability, and additional costs to the social, educational and justice systems. In 2013, there were 11,000 presentations in emergency departments (EDs) of deliberate self-harm, while, in 2012, 541 people lost their life through suicide. Although the latter figure has subsequently decreased, suicide remains a serious challenge to Irish society. It is estimated that the economic cost of mental health problems in Ireland is €11bn per year.
A key aim of *Healthy Ireland* is to help make people responsible for their own health. As trusted healthcare professionals who are a central part of the communities they serve, general practitioners can play a key role in this process. GPs are leaders in their field; are highly educated and skilled; and have close relationships with patients and their families. They are, therefore, extremely well placed to help people make healthier decisions in their own lives. The whole multidisciplinary team in primary care, including all health and social care professionals (HSCPs), can play a major role in health promotion.

THE PROBLEMS

- Although GPs have the potential to make a significant contribution to realising the aims of *Healthy Ireland*, there are significant obstacles to prevent this from happening. GPs are facing a manpower crisis. Approximately 55 per cent of GPs are over the age of 55, while recent data produced by the Irish College of General Practitioners (ICGP) shows that many GP trainees are considering leaving Ireland.
- The recent under-6s agreement has meant that GPs are busier than ever. The proposals to extend the agreement to other groups mean that general practice is going to come under more pressure. As things stand, GPs don't have the time or the resources to provide patients with detailed consultations on how they can be healthier.
- Resources are also needed to measure outcomes. Preventative healthcare is complex and systems need to be put in place to ensure that the advice provided by GPs is making a difference to patients. As a result of pressures on healthcare finances, different funding models should be considered to raise the resources necessary to expand services.
- Resourcing and incentivising GPs is only one part of the puzzle. The population itself needs to be incentivised to take greater responsibility for their own healthcare, which is a chief aim of *Healthy Ireland*. One reason for the problems with alcohol, tobacco and drugs is that many people are making poor health choices. This is often the result of a lack of education and information, which causes destructive patterns of behaviour. The problem is often worse in economically deprived areas, which comprise almost 40 per cent of the population.
- Rates of both coronary heart disease and diabetes are higher in the most deprived section of the population, with rates decreasing gradually as deprivation decreases. Risk factors such as body mass index, cholesterol and blood pressure are also persistently higher among low-income social classes. People from less affluent groups are less likely to participate in moderate-to-high levels of physical exercise, and are more likely to eat fried foods and to smoke. Smoking rates are highest (56 per cent) among women aged 18-29 years from poor communities, compared to 28 per cent of young women from higher social classes. Figures also show that 9 per cent of three-year-olds in lower socio-economic groups are obese, compared to 5 per cent in higher socio-economic groups; and at least one-fifth of children in all social classes are overweight. There is also a lack of incentives for people to make healthy choices. The message on how to live healthier lives needs to be made clearer to all social groups than has been the case until now.

THE SOLUTIONS

- Resources/manpower: before GPs assume additional responsibility in preventative healthcare, the capacity of the profession needs to be increased. This requires detailed workforce planning and for Government and healthcare management to acknowledge the very

real capacity challenges facing general practice. The negotiation of a new GP contract offers a real opportunity to provide greater resources to general practice in order to expand the role of GPs in the area of prevention and allow for the creation of dedicated health promotion positions, with protected roles, within primary care teams. Extra resources would allow GPs to conduct risk assessments of patients and provide a greater role in health education and promotion. It is important that outcomes are measurable in order for the contribution played by general practice to be recognised. Enhancing capacity would also allow general practice to help prevent and manage chronic diseases, which are often the result of lifestyle factors.

- Education/community engagement: behavioural changes can only occur through education and engagement. People need to be provided with the necessary 'tools' to be healthier. We need to impart the message that staying healthy is a duty, not just a right. Education initiatives are needed, particularly in disadvantaged communities, to help people manage their own health and make healthier decisions. People in deprived areas need to be engaged on their own terms. In communities with literacy problems, such as the Travelling community, community outreach is particularly important. In general, health promotion messages should be tailored to address the needs of particular populations. Use should be made of existing community resources and voluntary/advocacy groups that already have strong links with local populations and who can also link in with GPs, as well as other health professionals. Partnerships with all levels of the education system and employers (who could facilitate initiatives such as the popular 'bike to work' scheme) should be encouraged. Local authorities need to ensure that physical infrastructure, such as walkways, is provided to enable people to live healthier lives. Communities could be engaged through expansion of the 'Tidy Towns' competition into a 'Healthy Tidy Towns and Cities' competition. Technology and social media could also be put to greater use, but it is important that they are linked with health professionals and educators so that the information provided is evidence-based and contextualised. TV can also play a vital role. The point was made that a recent *Late Late Show* segment in which the amount of sugar contained in soft drinks was displayed was a good example of how to deliver an effective, clear-cut public health message. It is important to build 'coalitions of the willing' to achieve the buy-in necessary to effect genuine individual and societal behavioural change.
- New funding models: there is a need to look at different funding models for health promotion as a means of raising money to allow for initiatives, such as the expansion of the roles of GPs, to be developed, and also to incentivise people to look after their own health. Direct taxation measures should be considered, and also the creation of health levies on particular products (sugar tax, etc.). Insurance companies can make a contribution to help fund general practices to keep their clients, who are also the patients of the practices, healthier. This would have benefits for the companies themselves (both health insurers and life insurers), who would not have to spend as much on health insurance costs. Cheaper insurance may be made available to people who prove they are looking after their own health. Formal discussions between GPs and insurers would be useful in determining potential funding models that would both raise money for additional services, while also incentivising people to make healthy decisions.
- All disciplines in the primary care team, and all HSCPs, can play a major role in health promotion in primary care. For example, physiotherapists are required to address issues of physical activity and chronic disease management in COPD, arthritis and cardiac failure; dietitians are required for effective management of diseases such as coronary artery disease and diabetes; and so on. There is a requirement to resource all disciplines in developing these roles.

SUMMARY

Health promotion and preventative healthcare is notoriously complex. In order to succeed, it requires multi-stakeholder involvement from all sectors of society, from local authorities to healthcare professionals. The most difficult challenge is ensuring that people take more responsibility for their own health. As trusted healthcare professionals, GPs can make an important contribution in this regard by providing lifestyle information and advice, conducting risk assessments and measuring outcomes. To do this, however, additional resources are required. It is imperative that GPs are not given additional responsibilities before the resources are provided. A premature extension of responsibilities would place further burden on an already stretched service. Links should be developed between GPs and other organisations within the voluntary and community sector to 'tool up' citizens to take greater care of their own health. Messages should be tailored depending on the targeted population, with deprived areas being a particular priority. Greater use should be made of technology, while funding from health insurers remains an untapped resource with significant potential. *Healthy Ireland* provides a strong roadmap for improving the health of the nation over the next 10 years, but practical steps are needed by governments to ensure the strategy is more than aspirational and fulfils its considerable potential.

The workshop was chaired by Dr Leisha Daly and Dr Ambrose McLoughlin

Integrating primary care and maximising technology: data protection, patients and technology

INTRODUCTION

Information technology (IT) has enormous potential to drive efficiencies in the health service as a whole, and in primary care in particular. The importance of progressing the information framework has received repeated emphasis from a number of sources: the 2001 Deloitte and Touche report on *Value for Money in the Health Services;* the 2001 primary care strategy, *Primary Care: a New Direction;* the 2003 Brennan report; and the 2003 Prospectus reports, among others.

The 2001 primary care strategy, *Primary Care: A New Direction,* promised: "The potential of modern information and communications technology will be exploited to help health professionals provide safer and more integrated care to their clients/patients and to achieve value for money."

The subsequent *Primary, Community and Continuing Care ICT Strategy and Action Plan* (2005) reported the following key findings:

- General practice IT systems were reasonably well developed;
- General practice messaging was making good progress;
- The information and communications technology (ICT) landscape was basic, with a lack of fundamental infrastructure and enablers;
- A lack of healthcare profession-focused systems;
- A need for joined-up systems aligned with integrated care.

The key recommendations were:

- Agreed governance and management;
- Development of infrastructure, information sharing, education and training, and standards;
- A focus on managing benefit and risk.

THE PROBLEMS

- In primary care, a considerable amount of avoidable time is spent trying to access information from other sectors within the health service, particularly secondary care services. With the outsourcing of dictation services, there can be significant delays before information related to a patient's secondary care is received by the treating general practitioner. Consequently, the GP is often dependent on the patient to relay information about their secondary care journey. This raises important issues around accuracy and miscommunication. Access to real-time information, eg. blood test results and additional consultations, would not only have clinical benefits but would also reduce the waste of resources incurred in repeat diagnostics or referrals.
- It is not unusual that, when communication is received, information may have been omitted. Discharge letters can often be received with no diagnosis defined or excluded. When such detail is required to inform the patient's primary care management, there is no system of direct communication with the hospital specialist. It may be that a primary care professional (PCP) requires clarification on a medication change which occurred during the patient's hospital stay, but it can take days to access the relevant information.
- IT has the ability to resolve the majority of communication gaps within the health service, but a lack of standardisation and integration between processes and systems is a major hurdle.
- Many geographical areas of service division have implemented local initiatives. Unfortunately, the system itself is fragmented and the processes underlying these initiatives are not standardised through the healthcare arena. The inconsistency in processes is no doubt fuelling the most fundamental problem, which is lack of integration between all primary care services, between primary and secondary care, within secondary care, and between public and private services.
- While HealthMAIL is an example of how IT can benefit healthcare communication, the service is not without its challenges. While the service has been adopted by over one-third of all GPs, adoption by other PCPs and secondary care specialists may be an issue.
- On any IT project, integration will require buy-in from all sectors and, as such, it is important that the information is accessible and tailored to the needs of the individual PCP. There has been little or no consultation with grass-roots PCPs in terms of what information each requires and in what format, not only to ensure that the relevant data is available, but also to ensure that the important information in a large bulk of irrelevant data is identified. The lack of involvement with PCPs on the ground has not only prevented their input into future developments, but has also resulted in PCPs having little awareness of the future direction of healthcare IT in Ireland, eg. standardisation, accreditation, legislation, strategy, etc.
- Among PCPs, there is general uncertainty and concern regarding data protection and the legal responsibilities of individual professionals. There has been a lack of communication and training on the provisions and requirements of data protection legislation. In particular, there is ambiguity regarding who has ownership of the data, who is responsible for maintaining the data and monitoring security, who is responsible in the event of a breach of security, who has access to the information and whether the information should be accessible by third parties such as private insurers.

THE SOLUTIONS

- The e-referral system is a step in the right direction and should be expanded in the short term to include referral between different primary care services and between specialist services in secondary care. The system should be

made available to out-of-hours services to accommodate referral between general practice and emergency departments.

- Building on the success of the e-referral initiative, an e-discharge programme should now be established. The system should include a mandatory information set to be provided before the discharge communication can be issued. Such a process would ensure that communications are received in a timely fashion and that important clinical information is not omitted, hence accommodating the transition of patient care back to the community. However, it is critical that there is accountability and quality assurance in all e-referral/e-discharge systems to ensure that referrals/discharges are received and appropriately actioned.
- So that the e-communication programmes succeed in reducing the communications gap between primary and secondary care, a system of direct communication between GPs and the hospital clinical team should be created to facilitate urgent queries regarding patient care, eg. medication changes on discharge, etc.
- HealthMAIL should be expanded to include all PCPs and systems should be put in place to protect against spam and non-clinical communications.
- The continuum of care would be further supported by having real-time access to diagnostic results and treatment plans made by specialists during a patient's hospital stay.
- For patients awaiting admission or hospital appointments, having access to real-time information on waiting times would mitigate many of the frustrations surrounding this issue.
- Standardisation and integration will be essential to the optimisation of IT in healthcare. Standardised data sets and processes must be created and rolled out across the entire system. To ensure that the data available is to the benefit of each professional, it may be necessary to divide the data into useful categories, eg. weight and height information should be readily accessible for dietitians, etc. This will require consultation with stakeholders to determine the information requirements of each service provider.
- IT projects must be integrated between and across all sectors: primary care, secondary care and emergency care services; and between public and private sectors, ideally. Recognising the investment and progress in IT development that has taken place in general practice, it would make practical and financial sense to build on this foundation and integrate IT with the rest of the system to existing GP technology. Should GPs be required to modify IT systems to integrate with secondary care programmes in the public system, the cost of such modifications should be absorbed by the Health Service Executive (HSE)/Department of Health. Ongoing practice development support should be considered as part of a long-term plan to ensure that PCPs are kept up-to-date on IT advances and to optimise the use of technology.
- The use of IT systems should be mandated to ensure buy-in across the system.
- Training and education on data protection is much needed. A structured education programme would do much to alleviate the uncertainty and concern surrounding this issue. To support self-employed practitioners in attending this essential education, financial support should be provided to compensate for lost income and incurred locum costs.
- Clear policy and guidelines on data ownership, information sharing, consent, etc. should be developed, and should coincide with the creation of a central Government agency that would be responsible for the protection and maintenance of data.
- A blueprint for the future development of healthcare ICT in Ireland must be created and disseminated to all relevant stakeholders, including care providers and patients. Additional GPs with first-hand knowledge of the day-to-day complexities of general practice should be encouraged to join the Council of Clinical Information Officers as a matter of urgency, in order to inform future developments.

SUMMARY

In the past, the will to develop healthcare IT has not been matched with solid progress and development.
Despite this, the integration of IT into primary care has continued to develop and expand since the Primary, Community and Continuing Care (PCCC) ICT strategy, but this development has been driven solely by investment from GPs themselves. At present, IT coverage among GPs is significantly more than 95 per cent; and more than 95 per cent of those systems are accredited. However, a lack of standardisation and integration with other elements of the health sector now represents a considerable barrier to progress.
The creation of the HSE Office of the Chief Information Officer offers an opportunity to refocus efforts on developing IT to create an integrated, efficient, cost-effective primary care service.

The workshop was chaired by Mr Richard Corbridge and Mr Niall Sinnott

Prioritisation of patients/managing the overload

INTRODUCTION

Increased waiting times and decreased access to service are hallmarks of current-day general practitioner-led primary care. Increasing numbers of patients per GP brings inherent problems in terms of managing the overload and prioritising patient needs. GPs are reporting burnout and stress much more frequently, and the issue is contributing to high emigration among primary care GPs and other health and social care professionals (HSCPs).

Increased eligibility for Medical Cards, as well as the introduction of free GP care for under-6s and over-70s, has led to notable increases in patient volume. In addition, the ageing patient demographic and growing and diverse population continues to contribute to the issue of patient overload for many of those working in primary care. Another factor has been the shift from secondary care to primary care for management of chronic diseases. Adequate funding and resourcing for these population shifts and task transfer has not been forthcoming. More efficient management of patients is needed as practices and primary care teams (PCTs) deal with these growing numbers of patients. Prioritising patients is an issue that many practices are already engaged in, and the best ways to do this must be identified, for all members of the PCT. Workload pressures negatively impact both service provider and service user, and solutions are needed that will attenuate these and result in an enhanced service.

THE PROBLEMS

- There is a general consensus that doctors are seeing an increased workload.
- Reduced access and limited availability: access and availability for patients is seen as the main issue when it comes to patient overload. Decreased access to the GP or other healthcare provider is now a reality for patients. GPs have higher numbers of patients to care for on any given day, with more consultations.
- Patient dissatisfaction and confrontation: there is a feeling among healthcare professionals that patients are dissatisfied with the care they receive, due to constraints placed on GPs because of increased workload. Concerns have been raised about confrontation occurring due to limited availability, something that was previously not an issue. Patient expectations are increasingly difficult to manage, as they are influenced by television, etc.
- Inability to treat/manage acute patients: patient overload can mean that acutely unwell patients cannot be managed and treated within the surgery; these patients may then end up in emergency departments. Doctors have said they no longer have the time to treat these patients.
- Inappropriate visits/do-not-attends: some patients may not be using GP and primary care services appropriately and can visit the surgery unnecessarily. Conversely, there is a significant problem of patients not turning up for appointments.
- Complex consultations: consultations are increasingly more complex; this is due to a number of factors, including the ageing patient population, increased ethnic diversity (language), and increased burden of chronic diseases and multi-morbidities.
- Language: the lack of interpreter/translator services for those who do not have English as their first language is a significant problem. These consultations take significantly longer. There have been incidences of young children trying to explain their parents' health problems. This is inadequate and often inappropriate.
- Waiting times for health appointments with other members of the PCT: HSCPs are also experiencing a patient overload, which has led to increased waiting times. The overload of the health and social care professions means access is becoming more difficult. Long referral times also deter doctors referring to other services, and bring patients back to GP surgeries if they cannot access other services.
- Stress and burnout: this is seen as a growing problem for medical staff, who feel overworked and overburdened. More patients means more administrative duties. Health professionals are increasingly working longer hours.
- Negative impact on relationships with colleagues: relationships with colleagues in primary and secondary care become more difficult to maintain because of patient overload.
- Decrease in 'spare time' for specific tasks: increasingly, the GP's and HSCP's time is consumed 'fighting fires'; this reduces available time for education and continued learning.
- Task allocation: this is seen as a major issue – is the right person doing the right job? This is relevant in terms of doctors spending time carrying out childhood vaccinations and routine phlebotomy, for example, which is seen as a poor use of doctor time.
- Administrative burden: increased patient workload also means more time spent on administration. Telephone calls and non-face-to-face contact with patients is seen as extremely time-consuming. The medico-legal/regulatory burden has also been identified as a problem.
- GPs require more resources, including payment, to meet patient demand and the increased workload coming from the community and also from secondary care.

THE SOLUTIONS

- Funding for healthcare assistants: trained healthcare assistants could carry out a number of minor tasks and procedures; proper training would need to be provided and a staff budget/staff subsidies would be needed for this. These healthcare assistants, similar to the physician assistants being piloted in the hospital system, could carry out ECG, suture removal, wound management, etc. This has been shown to be a success in the UK and many feel it would also work well in Irish primary care. Indemnity/

registration issues would have to be addressed, and this will have to be driven so that buy-in from Government is achieved.

- Increased use of technology: there are myriad ways technology could reduce administration and streamline services. A practice website with a patient portal is one possibility. This could allow patients to make appointments online and apply for repeat prescriptions. Patients could then be emailed for confirmation. This would reduce the burden on administrative staff, as well as the GP.
- Electronic referrals: current standardised referral forms must still be printed out and signed, and scanned electronically. An electronic referral form used within primary care services for psychology, physiotherapy, dietitian services, etc., would save time. This must be used throughout the entire primary care network.
- Sick notes: options such as self-certification for minor illnesses and/or HSCPs providing sick notes, eg. physiotherapist providing notes for patients with back pain, etc. Self-certification up to one week is allowed in the UK. Many GPs agree that people should not have to attend the GP just to obtain a sick note.
- Delegation of tasks: educating front-line staff to triage patients so that they can be managed by different PCT members is considered necessary. Training/in-services would be needed, and cover would have to be provided while this is carried out. It has been suggested that the local co-op could provide training in a given area on one half-day per month, for example, to facilitate continuing professional development (CPD) of staff on triage of patients and other problems. Patients would then receive a better service.
- Appointment reminders: the use of text message to remind patients of appointments is considered one effective solution to the problem of do-not-attends. A small penalty for missed appointments is a possibility; this would also help to reduce the number of patients who do not attend.
- Patient education: education of patients would prevent inappropriate use of primary care services. Patients should be taught how to manage simple problems at home. The effectiveness of leaflets/brochures was discussed (eg. in smoking cessation), and a wider range of these should be provided. Health literacy is also an issue that must be addressed at a national level.
- Telephone translation services: HSE-funded translators currently work mostly in acute hospitals. A similar system to that used in the NHS in the UK would be effective, whereby a free-phone number could be called and interpreters of various languages could be reached. It was suggested that the HSE could develop its own similar system or even 'piggyback' on the NHS system.

SUMMARY

The issue of patient overload is a composite of many problems. Each issue must be addressed individually, as well as the wider picture of an adequately funded and resourced primary care system.

Technology can play an important role in terms of managing patient overload and saving time and resources. Enhanced IT support is required. Electronic referrals would reduce time spent on written letters, while a text messaging service could be used to remind patients of appointments. A practice website with a dedicated patient portal would allow appointments to be booked online and/or repeat prescriptions to be issued without requiring a visit.

Funding for staff training and education is crucial; this would enable more effective triage of patients. This could be delivered by the local co-op on an ongoing basis. Additionally, health literacy must be addressed and patients must be educated and empowered about their own health.

Delegation of tasks would assist overworked and overburdened GPs and PCT members; training of healthcare assistants to carry out minor tasks would also alleviate workload pressure and is an option that must be explored.

Complex consultations, such as with patients of different nationalities, could be better managed if there was an effective interpreter service. This should be provided by the HSE.

With general practice and primary care under increasing pressure, steps must be taken to support GPs and all HSCPs in order to maintain practice viability and provide the best service possible to patients. Stress and burnout among GPs and other HSCPs must be addressed in order to maintain recruitment and retention levels.

The workshop was chaired by Dr Yvonne Williams and Dr Conor McGee

General practice/ambulatory care/emergency departments

INTRODUCTION

Emergency department (ED) overcrowding is an endemic problem within the Irish healthcare system. The establishment of the recent ED taskforce, which is co-chaired by HSE Director General, Tony O'Brien, marks the most recent attempt to solve the issue. Part of the solution is to ensure that only the most appropriate patients are seen in the ED. The establishment of medical assessment units (MAUs) and acute medical assessment units (AMAUs), through the National Acute Medicine Programme, forms a central part of this strategy. Of the total number of bed days in hospitals, 50 per cent relate to medicine. Treating medical patients, who are often frail and elderly, in AMAUs/MAUs is the best way of ensuring that only appropriate patients are seen in EDs. It is widely acknowledged that AMAUs, with the support of ambulatory care (a care process intended to get patients quickly and safely back into the community), have been a valuable addition to the healthcare landscape, even though their implementation has been uneven throughout the country. While certain AMAUs/MAUs, such as that located in St Luke's Hospital in Kilkenny, work very well, many others are not as well integrated with GPs. Although the units are intended to only treat medical patients, in some cases they are used to deal with inappropriate overflow from the ED. Patients referred from primary care are meant to be prioritised, yet the relationship of GPs with the units is variable. According to the *Report of the Acute Medicine Programme* (2010), "general practitioners will be supported by their hospital colleagues in the provision of clinical discussion, assessment and treatment for patients with acute medical problems about whom the GP is concerned." The document also states that the relationship between hospital staff and GPs will be a two-way process, based on mutual respect, and that GPs will have direct methods of communication with consultants, case managers, nurse managers and therapy leads, and be able to select the most appropriate patient pathway from a wider range of assessment, diagnostic and treatment options. The National Acute Medicine Programme also stated that GPs will have direct access to diagnostic services and that they will also be members of the governance structure for the AMAUs/MAUs. Many of these commitments have, however, failed to materialise, with the result that GPs feel isolated from their hospital colleagues. They also feel they can make a greater contribution to help hospital colleagues' deal with overcrowding but are hindered from doing so due to problems of communication and inappropriate referral pathways.

THE PROBLEMS

- Lack of formal engagement between GPs and hospitals: fundamentally, GPs feel that consultants and hospital management are not listening to their views on ED overcrowding. There is a widespread perception that GPs are regarded as second-class citizens by many of the consultant body, and their opinions on hospital issues are not worth serious consideration. This perception is substantiated by the comment reportedly made recently by a prominent consultant with the Irish Association of Emergency Medicine (IAEM) that primary care had no role in inpatient hospital care. The isolation of GPs from the ED situation is reflected in the fact that, aside from HSE primary care personnel, there is no GP representation on the ED taskforce. There is also a lack of formal platforms or channels for GPs to meaningfully engage with their consultant colleagues, while the proposed GP membership of the governance structures of AMAUs/MAUs has failed to arise in many cases. Often, GPs themselves are reluctant to engage in a dialogue with consultants and management on the ED problem because they do not think their views would be taken on board and there is no structured, uniform and agreed forum to do so. As a result of the lack of formal national engagement between primary and secondary care, there is little standardisation in how AMAUs/MAUs and EDs deal with GPs. Regional variation means that some AMAUs/MAUs do not accept referral letters from GPs, even though it was intended that the units would prioritise patients referred from primary care.
- Inadequate communication and lack of appropriate direct care pathways between GPs and hospitals: GPs currently do not have universal direct access to AMAUs or MAUs and often have no option of referral for urgent cases other than EDs. Similarly, communication between GPs and the ED is a major issue. GPs often do not think their referral letters are taken seriously enough by their hospital colleagues. In many cases, the referral letter may be dismissed by a junior doctor, who has less experience than the referring GP. Continuity of care is also a problem as detailed discharge summaries from EDs may not be made available to GPs, meaning they are not informed of the diagnosis and treatment of patients they referred to the hospital in a timely manner. Discharge information provided by the AMAUs/MAUs is generally of a better standard but could also be improved. It can be difficult for GPs to contact the EDs and the AMAU/MAU to acquire basic information. As with the case of the discharge summaries, this problem is more pronounced in the ED, where calls frequently go unanswered and it is impossible to get hold of consultants. The lack of communication between GPs and hospitals results in the disruption of the continuity of care and referral pathways for patients. Urgent outpatient appointments can be extremely difficult to access, and long waiting lists are commonplace. The inability of GPs to have direct access to diagnostics puts a further burden on the hospital system. Recent data from the Irish College of General Practitioners (ICGP) showed that more than 20 per cent of GPs do not have direct access to either abdominal or pelvic ultrasound in the public system, while 70-80 per cent of GPs have no direct access to CT scans. Again, these tests are available to inexperienced junior doctors. As a result, GPs are sometimes forced to refer patients inappropriately to already overcrowded EDs in order to access essential diagnostic tests.
- Insufficient care pathways for ambulance staff: there is also potential for ambulance paramedics to make clinical decisions (in appropriate circumstances) and engage more

with their GP colleagues. Currently, ambulance personnel are required to bring all 999 calls to hospital EDs no matter the mildness or severity of the case. More sophisticated clinical pathways, where the paramedic could treat and discharge the patient, or engage with local GPs for advice, are not yet in place.

THE SOLUTIONS

- Develop structured engagement between GPs and hospitals: a formal process of engagement should be established between GPs and consultants, both at local and national levels, to help resolve the issues outlined above. Such engagement is necessary to address the institutional disadvantage experienced by many GPs from their hospital colleagues. Building parity of esteem and trust between the groups would help foster the collaborative spirit needed to tackle the entrenched problems that face the health service. The engagement should take advantage of existing bodies and links that GPs and consultants can access, such as the training colleges (ICGP and Royal College of Physicians of Ireland [RCPI]) and other healthcare groups and organisations. At a local level, where engagement could be organised through local integrated care groups, it is important to foster personal relationships between consultants and GPs. Meetings establishing these relationships should not take place on hospital grounds, which would only reinforce the disconnect felt by GPs, but at a neutral venue. National engagement through the ICGP, for example, would help to standardise the relationships between hospitals and GPs, which, despite strong policy documents such as the *Report of the Acute Medicine Programme*, still have an unacceptable level of regional variability. Models of best practice, such as the Carlow-Kilkenny system, where GPs and consultants have developed strong business relationships, based on mutual trust, should be used as a template for other areas. The ICGP-St Luke's Liaison Committee has regular monthly business meetings that are formalised by agreement with the local ICGP faculties and medical board. Attendance is open to all GPs, consultants and management. This structure has helped to establish a number of new services for the hospital, improved access for GPs to diagnostics and reduced admissions during times of clinical surge. Developing the committee has improved morale for local clinicians/management and also strengthened ICGP faculty relevance and participation. It is a prime example of structured engagement facilitating improved delivery of care. Wider GP participation in hospital integration is urgently needed. A non-HSE GP representative should be placed on the current ED taskforce. GPs need to be part of the governance structure of all AMAUs/MAUs, and the appointment of GP leads, to develop local liaison and integration with the new hospital groups, should be a priority.
- Improve communication: by engaging consultants and GPs in a formal dialogue, many of the communication obstacles GPs face when dealing with hospitals can be overcome. GP referral letters need to be given greater attention and precedence than is currently the case. Contact between EDs/AMAUs/MAUs and GPs must be made easier, be it through the designation of existing staff member(s) for GP liaison, or by encouraging a culture change within hospital departments to make it easier for GPs to receive information from staff. Detailed discharge summaries should be routinely made available to GPs from EDs and AMAUs/MAUs.
- Develop improved referral pathways to hospital, including direct GP referrals to AMAU/MAU and hospital services other than ED and outpatient department (OPD): it is envisaged that through structured GP-hospital engagement and better communication, referral pathways can be improved. Regional disparities, where AMAUs/MAUs have differing admission criteria, must cease. AMAU/MAU access to GPs should be standardised and should be run in accordance with the protocols set down in the National Acute Medicine Programme document, which states that the units should accept direct referrals from GPs. AMAUs/MAUs should be used for the purpose for which they were established, which is to treat medical patients, and not as an overflow unit from the ED. GP access to diagnostics also needs to improve. As stated by the ICGP, increased access to diagnostics will lead to a reduction in diagnostic delay, a reduction in the number of referrals to both EDs and OPDs, a reduction in unnecessary admissions and an improvement in the quality of referrals overall. Ambulance personnel should be able to avail of different clinical pathways, and not bring all patients to the ED, as is the case currently. Depending on the clinical situation, these new pathways could allow ambulance crews (where appropriate and agreed) to treat and discharge the patient themselves; refer the patient to the GP within a two-hour period; refer the patient to the GP within 24 hours; or bring the patient to ED/AMAU/MAU.

SUMMARY

The need for integration between secondary and primary care is an acknowledged aim for all advanced healthcare services, as it is a move towards community-based care where patients can be treated at a lower level of complexity and at reduced cost to the State. The process of ambulatory care delivered by local AMAUs/MAUs through direct GP referral is good for patients, general practice and hospitals. The current situation that exists, where hospital consultants work at a remove from GPs, needs to change. This policy has been set out in successive healthcare strategies and clinical care programmes, but has failed to be realised at ground level. While additional resources and beds may be necessary to improve the health service, the problem of engagement and communication at the interface of primary and secondary care can be solved without major investment. Good communication costs nothing.

In opening up a structured and supported engagement between consultants and GPs, through building relationships as equal partners in care of a shared community, using local liaison committees, new referral pathways and services can be developed which will help patient care and begin to reduce the chronic pressure felt in hospital EDs across the country.

The workshop was chaired by Prof Garry Courtney and Dr Ronan Fawsitt

Improving patient care in rural Ireland

INTRODUCTION

The provision of healthcare in the community, where appropriate, has been widely acknowledged as optimal for effective patient care, however the sustainability of general practice in rural communities is under significant strain to the point where its viability is now in question. General practitioners welcome chronic care management models of care and agree that moving care from secondary to primary care will benefit patients. However, their support is contingent on appropriate supports and resources being put in place, which, thus far, has not happened.

The issues surrounding the viability of general practice in rural communities, along with associated factors such as staffing and funding requirements, are exacerbating an already difficult situation and have transformed rural general practice into a highly stressful occupation.

Fundamentally, there has been consistent underinvestment in general practice in recent years. Overall investment in primary care and general practice has, under the Financial Emergency Measures in the Public Interest (FEMPI), been cut by approximately 40 per cent since 2008, an approximate figure of €960 million over the past five years, while the number of patients with Medical Cards in the state has continued to rise. The funding cuts to rural general practice, in particular, have been highly disproportionate, with the specific rural allowances of the distance codes and the rural practice allowance (RPA) also being cut. Without the cushion of private practice in rural areas, there is no way that many rural general practices can remain viable.

This has had a significant effect on manpower and morale, with recent research by the Irish College of General Practitioners (ICGP) indicating that almost half of GPs now describe their morale as poor or very poor, while over 70 per cent admit their morale has worsened over the past five years. Furthermore, while almost two-thirds of GPs support the principle of primary care teams (PCTs), only 13 per cent feel they are currently working in a well-functioning PCT. Less than one-quarter of GPs indicated a preference for co-location with a PCT.

THE PROBLEMS

- Loss of financial viability in the delivery of primary care in rural areas is an inescapable and absolute reality. It is simply not economically viable for GPs to operate sustainable practices that offer the patient an optimum level of service. The historic model for the delivery of primary care in Ireland was based on balancing a mix of public and private patients, which no longer exists in rural areas where private income often makes up only 10-20 per cent of overall income. In its absence, GPs are expected to maintain properly equipped, technologically-enhanced premises, employ expert staff in sufficient numbers and manage a range of expenses – a combination of demands which simply cannot be met. It is now impossible to establish or maintain a viable primary care service in rural areas. The frustrations and stress that result from this threat to rural general practice were a key factor in driving the 'No Doctor, No Village' campaign.
- GPs are finding it more and more difficult to recruit a locum or sessional doctor. According to recent ICGP research, over half of surveyed GPs who tried to recruit a sessional doctor or assistant in the preceding year were not able to do so. A total of 44 per cent of GPs overall who tried to recruit a locum in the past year were unable to do so on more than half of the occasions that they tried. Significantly, the research indicated that rural GPs, specifically, were less successful than GPs generally in recruiting sessional/assistant or locum cover.
- Warnings of manpower shortages and risks to the viability of the profession have been issued for several years to no avail, as large numbers of trainees and graduates have been attracted by better opportunities outside Ireland. Young GPs are highly qualified, their medical expertise is highly transferrable into other health systems and so they are eminently employable overseas. The loss of this highly skilled cohort to opportunities abroad represents an existential threat to the future supply of adequate GP resources to rural Ireland.
- There is a lack of cohesion in the organisation, management and provision of the skills/expertise infrastructure needed to support the delivery of GP services in rural Ireland. Specifically, there is a lack of prompt and efficient access to health and social care professionals (HSCPs), such as occupational therapists and physiotherapists, as well as to vital services such as outpatients and diagnostics. The strategic impetus to centralise services goes against all international evidence in rural healthcare delivery where the most effective and cost-effective method is the creation, development and support of small community-based GP-led teams. This is exactly the service that exists currently and is being actively undermined. Patient conditions and their treatments are constantly increasing in complexity, further underlining the need for the strengthening of these services. Compounding a lack of service infrastructure is a scarcity of physical resources, with GPs reporting serious difficulties in sourcing appropriate fit-for-purpose facilities to serve patient needs.

THE SOLUTIONS

- Financial incentives are essential to make rural general practice viable. The introduction of measures to ensure stability of income stream, allied to the establishment of clearly articulated career paths for rural GPs, is vital. This will by necessity include a 'salaried' option, which is already operational in certain remote and rural sites currently. Financial support to enable substantial investment in IT is needed to enable rural GPs to refine data collection procedures and metrics measurement with a view to increasing practice efficiencies. Overall, policy makers need to create a framework for rural practice that reduces the overwhelming uncertainty that currently characterises the inadequate supports that have developed, haphazardly, over the years, which is typified by the lack of clarity surrounding the application of the

rural practice allowance.

- A framework which supports and promotes students and trainees with a rural community background to follow a career in rural general practice is required. Measures suggested include proactive encouragement and incentivisation of the rural student intake to medicine through the provision of scholarships and attractive loan repayment arrangements.
- Regionally-based training: evidence from abroad supports that training young GPs in their local communities increases the likelihood that they will go on to practise in those communities subsequently. Policy measures should be introduced that will facilitate practical steps to involve medical trainees in locally-based training initiatives.
- The establishment of a specific rural GP training 'school' to cater for those who have self-identified as being interested in rural general practice: this would establish, at an early stage, a cohort with an acknowledged commitment to rural general practice and facilitate the promotion of an informed rural general practice ethos, ensuring it has parity of attention, esteem and commitment from all stakeholders in the Irish healthcare system.
- More flexible and family-friendly contracts need to be developed to match the lifestyle and work/life balance requirements of the latest generation of GPs, many of whom would have limited (20-30 hours per week) availability. Options such as looking at the feasibility of sharing a General Medical Services (GMS) contract need to be explored. The introduction of contracts that recognise 21st century realities would help to increase the size of the talent pool available to rural general practice.
- A commitment is needed at government level to provide substantial investment in a diverse range of appropriately skilled and resourced health professionals to provide optimum patient care.
- Discussions should take place with the Health Service Executive (HSE) to identify opportunities to utilise appropriate, fit-for-purpose 'spaces' in HSE buildings for rural general practice needs. Discussions should also be initiated with local authorities around the country to explore the potential to seek provision of physical infrastructure, where the local authorities may have fit-for-purpose building spaces available.
- Taxation incentives should be devised to encourage the development of physical infrastructure. Ideally, these incentives need to be preferentially targeted towards locally-based rural GP teams seeking to establish facilities in the communities they serve.

SUMMARY

The importance of primary care in the community is widely acknowledged and there is a consensus on the central role of rural general practice services in ensuring that such care is delivered effectively and optimally to the patient. However, rural general practice is facing crippling constraints in relation to its fundamental financial viability and in attracting young GPs to rural areas, as well as in the provision of vital back-up services from associated HSCPs such as occupational therapists (OTs) and physiotherapists. In addition, there is a need for a better-resourced and more effectively integrated service infrastructure, including outpatient and emergency services.

A suite of solutions needs to be explored urgently to address these existential threats to the future of rural general practice in Ireland. There are successful models for rural general practice in countries ranging from the US to Australia that can be studied and adapted, as appropriate, to the Irish experience. A range of initiatives, from national to local level, must be implemented to provide a coherent career path for young rural GPs in Ireland in order to save rural practice and ensure that, at the very least, an adequate level of primary care is provided to rural communities across the country.

The workshop was chaired by Dr Liam Glynn and Mr Kieran Ryan

Improving patient care in an urban deprived environment

INTRODUCTION

Gandhi's observation, that the true measure of any society can be found in how it treats its most vulnerable members, is felt most keenly by those who live in areas of urban deprivation in Ireland. General practice is underfunded across the whole country, but this inevitably means that those people who live in marginalised communities – especially marginalised urban communities – are destined to suffer most when, in fact, they are most in need.

There are many similarities in the difficulties faced by general practice in rural communities and urban deprived communities. The overriding factor is that both types of practice are finding it increasingly difficult to be financially viable. General practitioners who work in these areas of need know that they could earn more money if they located their practices in geographical regions of higher income, but they choose to practise medicine where they do, and are frustrated that they cannot provide an adequate service because they are under-resourced.

Other key similarities in the difficulties faced by general practice in rural communities and urban deprived communities are that both have difficulty recruiting and keeping younger GPs; there is a critical lack of infrastructural support in terms of the services that patients need; out-of-hours work is onerous and the lack of locum availability creates a hugely stressful lifestyle.

According to the Department of Health, 3.6 per cent of the total health spend of €13.2bn in 2014 was to general practices. The equivalent spend in the UK was 9 per cent – where GPs say they need 11 per cent in order to provide a proper service! This chronic under-funding, allied to the devastating effects of the Financial Emergency Measures in the Public Interest (FEMPI), have been felt particularly hard in urban deprived general practice.

On average, there is one GP to every 1,600 patients nationally. However, in deprived areas, the number of patients per GP rises significantly. In north Dublin, it is estimated to be as high as 2,500 patients per GP.

The Irish College of General Practitioners (ICGP) study, *Irish General Practice: Working With Deprivation* (Osborne 2015), revealed that almost all services are used more by those on the lower rungs of the income ladder, and that those people have the greatest need. Most observers accept that patients with Medical Cards visit the GP more frequently than fee-paying patients – up to three times as often. The ICGP report says that it is estimated that 5,400 people could be saved from a premature death on the island of Ireland each year by tackling deprivation and inequality.

For GPs working in these deprived environments, it is extremely stressful. The challenges involve multiple morbidities and health issues, with many patients presenting with HIV, hepatitis C, drug issues and homelessness. The effects of deprivation create not just health problems but behavioural problems too, and the supports to deal with these issues are not readily available.

A real problem is that it has become very difficult to recruit young GPs to work in urban deprived practices because they don't have the requisite skills. However, it should be noted that the North Dublin City GP Training Scheme is having a small but effective impact on training GPs to tackle these specialised problems.

THE PROBLEMS

Multiple problems have been identified in this difficult area. These may be summarised in three groups, as follows.

- Urban deprived general practice is the poor relation of the impoverished family that is general practice in Ireland. There is huge inequity in resources – most particularly in manpower, and in the physical structures that are the clinic buildings and facilities. The cohort of GPs that currently work in the area are ageing and not being followed by a younger generation of GPs, for obvious reasons. Income levels for GPs are erratic, and career paths for younger GPs are uncertain.

  Timely and equitable access to diagnostics – especially x-ray, ultrasound, MRI and CT scans – is a real problem. There is virtually no direct access to CT or MRI scans for public patients covered by Medical Cards.

  Another issue that significantly affects urban deprived general practice is that Medical Card eligibility is decided by accountants, not by examining the overall need and circumstances of the family. For example, costs such as childcare, mortgage, and medications for chronic diseases like asthma, should be factored in.

  All of the issues that affect GPs everywhere in Ireland, such as securing properly funded out-of-hours cover, sick leave and holiday relief, are magnified for the urban deprived GP.
- The second major issue for urban deprived general practice is that deprivation is simply not recognised as an issue. There is a fundamental disconnect between the GP's vision for primary care, and the vision that the Health Service Executive (HSE) and Government have. This disconnect results in unrealistic expectations from Government about what primary care should and can deliver in urban deprived areas.
- There is a severe lack of infrastructure to deliver a service to patients in deprived urban areas. The GP working in these areas is often the only contact that his patients have with the total healthcare system. The GP must deal with their medical, physical, psychological and social problems. This makes consultations very long, complex and multi-faceted. GPs have to help their patients negotiate the public healthcare labyrinth where waiting lists for ultrasounds or consultant appointments are measured in years, not months.

THE SOLUTIONS

- Inequity in resources: all GPs working in urban deprived areas acknowledge that they need some 'positive discrimination' towards their area of primary care. They require more certainty about their income levels. They require more certainty about their career path. They are flexible about the solution; for example, there might be a part-time guaranteed salary arrangement; or a not-

for-profit system where profits could be reinvested in the practice.
Acknowledging the difficulty of recruiting young GPs to urban deprived practice, GPs in urban deprived areas would like to see more flexible contracts for young GPs, with properly funded out-of-hours cover, sick leave and holiday relief. A solution might involve a deprived area allowance, or a deprivation weighting on the GMS payment linked to a deprived patient.
There is a requirement for more structured further education in order to retain and empower young GPs. The skills that are being passed on in the North Dublin City GP Training Scheme need to be more widely distributed.
One of the major issues faced by GPs in an urban deprived setting is coping with the behavioural issues that arise in their practices, as they can feel intimidated as well as ill-equipped to deal with these problems.
The serious damage caused by FEMPI has to be reversed, and a weighted average capitation payment introduced. FEMPI has been particularly hard on the urban deprived segment of general practice.
There needs to be timely access to diagnostics for public patients covered by Medical Cards – x-rays, ultrasounds, CT scans and MRI need to be made readily available.

- Deprivation not recognised: there have been several attempts to define and measure deprivation in Ireland, including, notably, the maps produced by Pobal. However, these statistical analyses, while valuable, fail to take account of the individual person. Treating patients, particularly in a deprived environment, requires knowledge of not just their medical condition, but their mental health, their family and social circumstances. We need a model that defines the person according to their level and type of deprivation so that the right resources can be allocated. Work has been developed in this area in the US at the Centers for Medicare and Medicaid Services.
- Lack of infrastructure and supports: deprived areas need more supports and more integrated services than general practice in other socioeconomic areas of the country. As patient care becomes more complex, there is a greater need for a team approach and the development of particular expertise in a range of sub-specialties or paramedical areas to deal with a range of interlinked problems. There is a need to have core practice teams that are adequately resourced to handle the specific patient needs. One idea that has been introduced in the UK in deprived areas is to have 'link workers' who act as a link between GPs and patients. So, for example, if a GP has many patients with addiction issues who never attend the surgery, the link worker will visit them at home.
Other jurisdictions have faced similar problems and devised workable solutions. For example, in Alaska they have centred primary care around small community-based team units and have successfully reduced hospitalisation rates by more than 50 per cent. This model could be replicated anywhere.
We need a flexible approach to the structure that delivers primary care. Solutions should be explored that involve using not-for-profit organisations owned by the community, or some sort of public private partnerships which incentivise GPs and other primary care team members to invest in their own delivery system.
In this deprived environment patients don't just need medical care; they need help to get housing, to apply for disability welfare, to receive mental health supports and more. There is a requirement for more community workers who are part of the primary care infrastructure.
Infrastructural reform is fundamental to ensure that those patients who are most in need have timely access to diagnostics and emergency care.
It would be desirable for the HSE to make infrastructure, including buildings, available for use by GPs in some urban deprived areas at a nominal rent. This would provide substantial economies. Many GPs feel that they shouldn't pay council rates when the building next door used by the HSE is exempt. There is a perceived inequity in the system – either nobody should pay or everybody should pay. On the issue of co-location, there is a consensus that in certain areas, where GPs have invested in infrastructure, the HSE could avail of space in those buildings to provide services and pay an appropriate rent.

SUMMARY

There is no single solution, no magic bullet to the problems faced by urban deprived general practice. Any solution will be multifaceted, and must combine staffing, infrastructure, technology, remuneration, workplace organisation, the GP's professional environment and social family and community support. It must provide for treating the patient in a holistic way.
There is a need for undergraduate and postgraduate training courses specifically developed for the urban deprived environment.
The issue of remuneration must be reviewed; there ought to be some kind of financial incentive programmes to encourage and motivate GPs. This model might include loan repayment schemes, grants, and salaried or part-salaried posts.
We need to develop a system of rotating assistantships between urban and rural practices, and look at more flexible General Medical Services (GMS) contracts. We need to develop better locum supports to cover continuing medical education (CME), holidays and illness – the idea of a state-provided locum agency should be considered. There needs to be a national standard for out-of-hours work.
Patient care and treatment has become more complex and requires a major shift in the way we think about staffing and the necessary skill sets. We need to establish core practice teams and then resource the team according to the specific community needs. Infrastructural reform is fundamental to ensure that those patients who are most in need have timely access to diagnostics and emergency care.

The workshop was chaired by Dr Andrew Jordan and Dr Paul Grundy

Primary care – a vision for the future

INTRODUCTION

There is agreement from all stakeholders that general practice is central to the operation of the healthcare system as a whole. Its value in terms of cost-efficiency and patient care is repeatedly acknowledged. The critical role of primary care in reducing demands on secondary care services has never been more important than it is today, given the current difficulties facing the healthcare system.

THE PROBLEMS

- Relationship between the Health Service Executive (HSE)/ Department of Health (DOH) and primary care: while there was acknowledgement that the Primary Care Partnership conference is a step towards creating a functional relationship, past methods of communications and policies have led to hurt and almost anger among primary care providers (PCPs) as a result of measures that have been introduced over the past number of years. Acknowledging this past and moving on is the essential first step in the process of repairing that relationship.
- While acknowledging the necessity for the Financial Emergency Measures in the Public Interest (FEMPI) Act, there is a belief that general practitioners were disproportionately affected by FEMPI measures and that the method in which the cuts were communicated and applied was less than ideal.
  Furthermore, GPs are uncertain as to their position as contractors or employees. While technically contracted providers, GPs are often subject to the obligations of an employee but without the associated benefits. Similarly, having signed a contract with the HSE, there is little support from the HSE to allow GPs to deliver on the provisions of that contract.
- Consensus and collaboration: fragmentation within the sector has created a situation where primary care means different things to different people, depending on their own role within the system. If we are to develop a future vision for primary care and a roadmap to achieve it, we must first find agreement on what primary care is.
  Similarly, there is a lack of clear vision and consensus on what PCPs want to deliver, and the sector's vision for its own future. There is a lack of understanding among the public of what it is that primary care can deliver, and the focus is largely on secondary care.
  Agreement on the definition and future of general practice will foster the partnership and collaboration which is essential to deliver on that vision. There is a need to develop a GP-led team approach throughout primary care. This should not be confused with the creation of teams within primary care but, rather, an environment of collegiality between and within all primary care professions. 'What you need from me' is as important as 'what I need from you'. Local relationships also need to be strengthened. At present, primary care teams (PCTs) are, to a large extent, non-functional. PCTs have not been given the resources necessary to deliver what was initially envisaged. This has left PCT members dispirited and has fuelled a lack of enthusiasm for the concept. If participation in PCTs is to be maintained and augmented, the teams must be made functional.
- Morale: PCPs feel over-worked and under-valued, which has a considerable impact on morale and work-life balance. Creating a functional PCT network and a collaborative primary care vision would have benefits in both regards.
  A significant source of frustration at present is the difficulty PCPs face in delivering, or accessing, appropriate, timely care for patients. Long waiting lists, lack of access to diagnostic and other services, and difficulties referring patients, are having a substantial effect on job satisfaction, contributing to the increasing number of professionals choosing to leave the public system. If a patient requires urgent, but not emergency, investigation, it serves nobody's best interest if the only option available is to refer to an emergency department (ED). Patient demographics are changing and there is a growing focus on chronic disease management in primary care. This drive is not reflected in remuneration or resource allocation.
- There is a lack of resources and funding, staff shortages throughout much of the sector, a lack of infrastructure, poor access to diagnostics, poor information-sharing practices, obstacles to continuing professional development (CPD), and uncertainty in relation to care pathways to and from different settings. The repercussions of these issues for PCPs and their patients are not fully acknowledged or appreciated.

THE SOLUTIONS

- Rebuilding relationships: re-establishing trust between PCPs and the HSE/DOH is essential in order to facilitate all of the following suggestions. This can only be achieved when PCPs feel that their services and insights are valued and respected by funders and policy makers.
  Decision makers and funding providers must ensure that what has been planned and promised can be delivered on the ground.
  Clear processes which drive interdisciplinary liaison are needed.
  A culture of professional respect and partnership should be fostered, and the Carlow-Kilkenny situation may serve as a learning point on this.
  Better two-way communication channels between PCPs and the HSE, and between primary and secondary care, would be valuable.
  Regular local meetings (eg. half-day/month) between all PCPs and HSE management would nurture local relationships. All PCPs should be accommodated and encouraged to attend and participate in these meetings, which would require that the loss of income incurred by GPs in attending during practice hours is compensated.
  The exclusion of the National Association of General Practitioners (NAGP) – which is the chosen representative organisation of more than 1,500 GPs – from negotiations on general practice, is an extremely divisive issue.

- Creating a strategy: the existing primary care strategy should be reviewed to identify what items have not been delivered and why, in order to fully consider such issues in future strategies.
  A national forum of grass-roots PCPs should be established to agree a national consensus on what primary care is, what services it provides, what the sector could achieve if supported to do so, and how to enable primary care to achieve its full potential. The consensus should be informed by a consultation process which is open to all PCPs and other relevant stakeholders, and informed by grass-roots PCPs.
  The national consensus should be compatible with other branches of the health service but should allow flexibility at local level, within a defined framework.
- Vision: this has to be collaborative with integration of the Irish College of General Practitioners (ICGP), DOH, HSE, NAGP and health and social care professionals (HSCPs), with a suggestion of a media campaign, such as a video on what your GP can do for you, to inform the public, and growing roles in the community to ultimately take pressure off EDs. To achieve a vision we have to resolve contradictions such as a Government policy to introduce free GP care without supporting general practice to function. A new service cannot be delivered on a non-functional platform.
- Primary care teams: PCTs must be GP-led. In order to reflect the loss of income and additional costs (eg. locum cover) incurred by GPs in attending PCT meetings, a service-leave arrangement is necessary to ensure that GPs are not financially disadvantaged by their involvement in PCTs. There needs to be flexibility to allow for local initiatives or pilot programmes that reflect local needs and services.
  PCTs should be holistic and synchronised with defined targets (agreed by the team) and outcome reporting.
  Outcomes should be measured against agreed targets.
  A community health co-ordinator would be central to the network. This individual should have both a clinical and business skill-set, and would work with a senior appointed GP.
  Local governance structures must be in place.
  PCTs must have stability of staff numbers, resources, and mix of professionals.
- Funding: the current stance of funding not being allocated to general practice goes against the widely promoted activity-based funding. If general practice does not receive funding it cannot get to the level of achieving any activity in the first place. There has to be a dramatic change in health budget allocation to restore functionality. Ireland should mirror international practice in health funding, eg. Denmark provides 14 per cent of the health budget to general practice, compared to 3.6 per cent of the health spend to general practices in Ireland (according to Department of Health figures for 2014). Funding should reflect the complexity of managing patients in light of changing patient demographics where more patients are presenting with comorbidities and chronic diseases.
  Financial incentives should be put in place to support/reward PCPs who provide additional services, be they in general practice or physiotherapy, etc.
  Co-payment by patients warrants consideration in order to reduce unnecessary demand and create a sense of value for primary care in the public mindset.
  A comprehensive analysis of cost-wasting should be carried out to determine the amount of health funding wasted by patients not attending unnecessary diagnostics.
  Data should be leveraged to inform efficiencies.
  Local initiatives that deliver improvements in patient care and value for money should be better captured and implemented nationally, where appropriate.
  An employee contract should be considered for GPs, particularly in light of the growing number of areas without a GP service due to financial viability.

SUMMARY

Primary care remains under-utilised and under-valued. The sector has lost its identity, largely due to concern and confusion regarding the future of primary care. It is now time to create a vision for that future, and empower PCPs to legitimately contribute to the design and implementation of that vision. If the poor morale that pervades the sector at present is to be addressed, PCPs must believe that the future of primary care is brighter than the recent past. There is a willingness and energy for healthcare reform to be primary care-based and GP-led. This is a proven model by functional health systems around the world.

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

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