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DHSSPS

**DEVELOPING A PRIMARY CARE
STRATEGY**

Outcome Paper following 2nd Workshop (05/11/2003)

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Appendix A: Circulated Text

Appendix B: Workshop Agenda

1. Context and Structure of the Workshop

1.1 The Department of Health, Social Services and Public Safety is currently in the process of developing a Regional Strategy for the delivery of health and social services in Northern Ireland over the medium to longer term. Linked to this work is an initiative being undertaken within the Primary Care Directorate to develop “a Primary Care Strategy as an overarching framework for the development of all primary care services over the next 20 years”.

1.2 This workshop was the second in a series of three designed to support the work of a Project Team tasked with guiding an inclusive and participative approach to developing the Primary Care Strategy. The immediate context for the day was the outcome of the first workshop event which explored some of the concepts and language surrounding primary care. This first event was deliberately tentative in its approach, and was concerned to open discussion on the subject rather than reach early conclusions. Having engaged in this exploratory dialogue however, it was decided that the second workshop should represent an incremental step forward in the process by presenting participants with some text and inviting them to comment on its appropriateness or otherwise.

1.3 In advance of the workshop therefore, participants were sent text on:

- A Statement of Core Purpose
- A Vision of Primary Care, and
- A Statement of High Level Goals.

This text, which was informed by discussions at the first Workshop, is appended as Appendix A. The principal focus of the workshop was to critique this text, and to consider whether or not it captured the essential messages that need to appear in a document mapping out the direction for Primary Care in Northern Ireland over the next twenty years.

1.4 After a short initial session on the Statement of Core Purpose and the Vision for Primary Care, participants then continued to work in groups for most of the day examining the High Level Goals. 42 participants representing a cross section of key stakeholders attended the workshop. An agenda for the day is attached as Appendix B.

2. Session 2 – Summary of Discussion

2.1 Following an introductory session in which the workshop chairman, Dr J.

Livingstone, outlined the purpose and expectations of the day, participants were divided into three working groups to consider previously circulated text relating to a Statement of Core Purpose and a Vision of Primary Care. The Table below presents some of the observations to arise at this point across the three groups.

Responses to Prepared Text
(01) Primary care should involve a partnership between the individual and the service, between the user and the provider
(02) The document as presented still forgets about social services. Social services are fundamental to the delivery of primary care.
(03) Some disputed the view immediately above, and believed we should be careful not to allow social care to “skew” primary care
(04) “Self Care” is still an important idea
(05) Service should be less paternalistic – should pay more attention to patient enabling – and in developing the concept of the “enabled patient”
(06) Though some felt that “patient” should not be used as a key word throughout the document.
(07) Language is particularly important – will people who wish to avail of primary care services be able to understand the document? – an example was given of women in a socially disadvantaged area who know what they need, but might use different language to express that need.
(08) People should be helped to use services appropriately – may be an educative need here – need to help people to think before they use the service.
(09) Document should speak of “supporting people to maintain their own health and well-being”
(10) Reference to “improving” health & well-being is inappropriate – should be about strengthening it.
(11) Should acknowledge the fact that primary care plays a leading-edge role
(12) A lot of work has moved out of 2 nd level care into primary care – but the money has not followed this work – we need to be mindful of budgets and resources
(13) Primary care is not on the political agenda - it doesn’t command the same high profile as other parts of the healthcare system.
(14) Document could be less risk-averse in its tone – the primary care system in general needs to be less risk-averse in tone.
(15) We need to be doing something <u>new</u> – the document appears silent on this – we need to be doing something today so that we won’t be engaged in “chronic disease management” tomorrow

This was a relatively brief session (45 minutes), and participants were encouraged to comment on the text as presented, rather than engage in a detailed re-drafting exercise. Equally participants were not invited to “sign-off” on the text, so the outcome of the session cannot in any sense be interpreted as an endorsement of the text as presented. Nevertheless, little if any commentary emerged in this discussion session suggesting a need for extensive or radical textual change. However, and as is usual in such situations, particular points of emphasis and presentation remain to be resolved. Most of this remaining work

involves finding the right nuances in the presentation of text, and in ensuring that the views expressed in this session are reflected as appropriate in a subsequent draft.

It is important to point out however, that these elements of the Strategy document are not now considered to be closed. They will be re-worked as necessary and participants at the next workshop will have another opportunity to consider a more developed draft paper.

3. Session 3 – Summary of Discussion

3.1 Session three invited participants to remain in their groups and to “identify the principal Service and Support Measures that will be required to give practical effect to the High Level Goals” (Appendix A). This was the principal session of the workshop, and was scheduled to take up most of the available time on the day. Using the template illustrated below, participants were asked to “look behind” the High Level Goals, and consider what each goal implied in terms of Service Measures and Support Measures. By “service measures”, it was intended to suggest the suite of service activities that would be required to translate the goal into a practical reality. In effect, these would be the visible services encountered by patients and service users. By “support measures”, it was intended to suggest the suite of resources or enabling activities that would be required to underpin the capacity of the front-line service providers to do their job.

Given the 20 year timeframe for the Primary Care Strategy, participants were also asked to consider the “near term” and “longer term” implications of delivering on each High Level Goal. It was expected that this could be particularly important, as a service activity that may appear infeasible in the near term, could be realistically pursued over a longer timeframe, (albeit with some preliminary actions taken in the near term to support such an initiative).

**Looking behind the High Level Goals –
Service & Support Measures (HLG 1)**

To build a primary care infrastructure which allows for people to be treated and cared for in the most appropriate settings, by the most appropriate people, and by the most appropriate means.	Service Measures			Support Measures					Desired Outcome
				People & Skills	Technology	Training	Budget	Other Support	
	Near Term Implications								
	Longer term Implications								

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- 3.2 In practice, each of the three groups approached this task in somewhat different ways. No group managed to work through each of the 12 High Level Goals in detail. Instead groups concentrated on particular goals that they considered to be of greater importance than others, or alternatively they reconsidered the coherence of the goals and assessed whether they might benefit from some degree of amalgamation and/or refinement.

Each group worked with a Facilitator and a Note-taker. The latter worked on a laptop computer and attempted to catch the essence of the debate as it took place. This has resulted in a set of notes for each of the three discussion group sessions which convey a strong sense of the discussion and of the issues that were considered. When reading these notes, it is important to remember that they were prepared in “real time”, and that the person preparing the notes had no opportunity to pause and reflect on what was said, or on the nature of language used. Consequently, the notes are somewhat akin to a “thinking aloud” piece, where a flow of ideas can be observed in fairly quick succession. They are best read as such, and certainly not as the carefully worked and re-worked text that we normally find in the printed word.

Nevertheless, the notes represent the best insight to the discussion that took place on the day. It has been decided therefore not to editorialise them, but to present them as they emerged.

- 3.3 These notes are set out in the following sections, along with a brief note summarising the work of each group in turn.

4. Session 3 – Summary of Discussion (Group A)

This group examined High Level Goals (1), (7), (11), and (12). This was done on the basis that the Group considered these HLGs to be particularly important, and they believed therefore that their time would be best spent considering the implications sitting behind these goals. The general tenor of the discussion is presented in the comments below:

4.1

High Level Goal (1):

To build a primary care infrastructure which allows for people to be treated and cared for in the most appropriate settings, by the most appropriate people, and by the most appropriate means.

HLG (1)

1) To build a primary care infrastructure which allows for people to be treated and cared for in the most appropriate settings, by the most appropriate people, and by the most appropriate means.

Preliminary comments arising from group discussion – Key Points

- 1) Include all 11 high level goals
- 2) Re-educating change in acute hospital culture (public, politicians)
- 3) Re-branding primary care
- 4) Building capacity in community care (investment in care at home, intermediate care, Rehabilitation)
- 5) Rehabilitation)
- 6) Need to focus diagnosis in the community (GPs, pharmacists)
- 7) Diagnostic equipment and staff availability outside acute sector
- 8) Development of telemedicine
- 9) Attracting cutting edge technology to primary care?
- 10) Flexibility important
- 11) GPs access to consultants
- 12) Shared care pathways

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Looking behind the High Level Goals – Service & Support Measures (HLG 1)

To build a primary care infrastructure which allows for people to be treated and cared for in the most appropriate settings, by the most appropriate people, and by the most appropriate means.	Service Measures	Support Measures					Desired Outcome
		People & Skills	Technology	Training	Budget	Other Support	
	Building community confidence in primary care. Diagnosis and diagnostic equipment in the community.	Investment in CPD. Reappraisal and validation. Group to engage with communities. Resourcing LHSCGs.		Compulsory exchange programmes for GPs and consultants	YES		
	Near Term Implications	Chronic disease management in the community/intermediate care management model. Identify other services/groups of need which could be provided for in a primary care setting.					
	Longer term Implications	Legislative and professional regulations implications in terms of moving services from acute to primary care.					

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High Level Goal (7):

To enhance and expand the roles of those involved in delivering primary care.

HLG (7) 7) To enhance and expand the roles of those involved in delivering primary care

Preliminary comments arising from group discussion – Key Points

- 1) Proper workforce planning
 - 2) Long term planning
 - 3) Flexible workforce
 - 4) Retaining generic skills/balancing specialisation
 - 5) Competence based career development
 - 6) What do patients want? Least number of steps to access care and treatment.
 - 7) Development of primary care worker (pharmacy role?)
 - 8) Technology
 - 9) Fitting for purpose
 - 10) Expanding the range of people included in PC (including carers, patients, community)
- 1) Opportunities to development new roles
 - 2) Creating care pathways – access facilitators



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Looking behind the High Level Goals – Service & Support Measures (HLG 7)

To enhance and expand the roles of those involved in delivering primary care	Service Measures	Support Measures					Desired Outcome
	Flexible workforce (within and across professions)	People & Skills	Technology	Training	Budget	Other Support	
	Fit for purpose taskforce (targeting areas which need development) at regional and local level. Piloting innovative roles (health visitor/social worker, rehab assistants, OT Assistant). Scoping exercise on current developments. User driven.		E.g. electronic Access to information/information sharing	Cross professional training on a more formal basis – face to face contacts.		Linking in to GMS contract, consultant contract, social services, nursing strategy, dental strategy, clinical networks etc	A workforce which fits the needs of patients and service users.

Near Term Implications	Series of projects to be established within the next few years
Longer term Implications	A workforce which meets the changing needs of the population



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High Level Goal (11):

To invest in primary care research and development.

HLG (11)

11) To invest in primary care research and development

Preliminary comments arising from group discussion – Key Points

- 1) Create a research and development group for PC
- 2) Developing a culture for basic science research for PC
- 3) Promotion, dissemination and quality assurance of R&D within primary care
- 4) Promoting innovation through pilot projects
- 5) Developing infrastructure
- 6) Enabling development to be researched
- 7) Creating a primary care identity



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Looking behind the High Level Goals – Service & Support Measures (HLG 11)

To invest in primary care research and development	Service Measures			Support Measures					Desired Outcome
				People & Skills	Technology	Training	Budget	Other Support	
	Developing infrastructure			Involve R&D group Establish a search group, identify regional champion (from PC background with networking skills)	As appropriate	Teaching PCT NHS university/jj oined up training	Pump priming funding from R&D office. Longer term funding for res projects	More opportunity to present and disseminate research. PC research website. Protected time for staff	To create, assure, disseminate evidence based practice. Balancing acute care/

Near Term Implications	Target and fund protected time. R&D recognition of PC.
Longer term Implications	Creating and supporting innovative development within primary care.



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High Level Goal (12):

To improve and expand information and communications technology.

HLG (12)

12) To improve and expand information and communications technology

Preliminary comments arising from group discussion – Key Points

- 1) Personal Control over Personal Card
- 2) PCIS needs to be fully integrated including referral
- 3) Rationalising systems and linking databases
- 4) Communication Technology
- 5) Information from data
- 6) Every professional to have access to PCIS



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Looking behind the High Level Goals – Service & Support Measures (HLG 12)

	Service Measures			Support Measures					Desired Outcome
				People & Skills	Technology	Training	Budget	Other Support	
To improve and expand information and communications technology	Personal Control over Personal Card			Everybody	Levels of Access for Staff, Patients, Professionals, Carers.	National Curriculum, Education of Users, Community Dimension of training. Tailored to fit the client group.	Long term planning prioritisation.	Education Budget. Legislative Requirement.	To achieve fully integrated information which facilitates evidence based decision making.
	Rationalising System and Databases			Partnership with Education					
						Comprehensive staff training	As above	Keeping up to date on technological developments	As above

Near Term Implications	Building on PCIS work, making internet accessible to all professionals Regional leadership
Longer term Implications	Legislative Requirements, Ethics, Funding



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4.2 Summary Comment: It is interesting to note the particular HLGs selected by the Group for discussion, and the Near/Long Term implications they identified.

5. Session 3 – Summary of Discussion (Group B)

- 5.1 This Group considered High Level Goals (1), (2) and (4). It then went on to examine the remaining HLGs as a group, and presented a series of thoughts on these remaining goals. The general tenor of this discussion is presented in the comments below:

High Level Goal 1.

In general, connections not emphasised in HLGs. No strategy for connectivity.

In HLG1 infrastructure needs to specified (funding, physical). Connectivity already described in practice but needs to be shaped by strategy. Strategy also should facilitate innovation.

Goal doesn't empower.

Multiple points of access not emphasised. Doesn't have to be GP (internet, other profs). Patient identifier should do this and also provide data base.

Starting from scratch when moving to next point of treatment. Multiple telling of the problem can sometimes be beneficial. Patient pathways important. One point of access could also solve this – create consistency, coherence but will it create delays. Instead, multiple points of access should send them to one centre. Rurality dictates that user should have multiple points of contact. NHSdirect should in principle provide single point of contact. Multiple points of contact reflect different needs and sharing workload. Technology is an enable for this.

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High Level Goal 2

Services about people not buildings but premises are important esp. with connectivity.

Value the workforce and patient by providing modern premises.

Single point of contact esp. in rural setting can be connected up to network by IT ? Presence of multi-disciplinary team important. One-stop shops are happening in practice and evolving into community HSS (health,diagnostics,DSD etc.) focal points ("Health village"). But must be connected into network –regional specialist centres. Does everything have to be provided in one centre ? Geography might dictate – one stop shops more appropriate in urban centres, community clinics in rural setting (relaxation, surestart). Facilities will be defined by the community enabled by IT & premises & connectivity).

Team building, team training, team working – all equals, shared leadership - will provide connectivity. Role definitions are a barrier. Team working should be reflected at all levels of hierarchy and institutionally (unified funding flows-GP contracts obstacle, management teams, POCs etc.). Produce p.c organizations bringing all disciplines together. Strategy should open up discussion about this connectivity. Accountability model needs to be thought about. Are roles going to change over the next 20 years – PC advocate (triage person) attached to community clinics ?

LHSCGs role & funding & vision not defined clearly enough by DHSSPS. These could potentially have a large role. They demonstrate the potential for connectivity. Innovation should be allowed for in structures. Statutory duties of LHSCGs will constrain their activities. They have been disempowered by Dept, senior mgmt but they have the potential to provide coherent management. They are no better model to deliver the vision we discussed. RPA do not look at LHSCGs.

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High level Goal 4

We need to recognise existence of inequalities linked to poverty, differential spend per capita by trusts. Easier to provide some services centrally (eg translation service).

Accessibility – appropriate PEOPLE & PLACE (ideally at home)

Accessibility – geography, waiting time, see appropriate person, physical access, education on standards of services provided and systems of measurement, access to methods of communication (language used by professionals is a barrier), patient often doesn't know the service they need to access

HLG should indicate the direction the strategy should take to tackle ineqs and expand accessibility. Inequalities should be a separate HLG - major issue. Funding should be skewed towards areas with poor health outcomes? "Improve and expand" should be replaced by trying to achieve a highly accessible service. Reducing inequalities about more than accessibility.

Obstacles to accessibility – lack of centralised standards, lack of signposting, ways of working, lack of 24/7 and long waiting times, personnel resources, primary/secondary care interface, complexity of referral processes (service providers define due to resource constraints)

No access to info about how they will be treated or that they can access system.

Rolling out good practice should also be a goal.



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Other HLGs

Health promotion and self-care must be balanced by need of vulnerable people

HLG6&7

Governance issues need to be addressed when roles are broadly defined

People at grass roots need to be able to influence administrators

Profs, admins, and community should have input to planning process.

What's not working? Lack of integration for example in breastfeeding promotion. Management structures resist innovation. Professional protection inhibits integration.

Does partnership mean unification of decision making. Private and voluntary sectors should be involved. Aims and objectives of different sectors should be aligned even though not exactly the same. Partnership should be more than a contractual relationship. Need to develop culture of recognition of different points of view of partners.

Goals should reflect actuality – links between administrators and frontline profs should be utilised.

Duplication of services and lack of coordination to prevent this. Role for users to advocate. Diabetic patient experience an example or champion of best practice.



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Other HLGs - Continued

Professionals concept of partnership also necessary.

Service breaks down in handover – need for protocols/shared management structures. Someone must be accountable for outcome for partnerships to work. Role of coordinators - Find, manage, treat ,check on outcome. Diabetic treatment good example of partnership between client and service deliverers. Audit procedure for measuring quality of teamwork – outcome sufficient ? Trust, commitment etc. Mental Health provides a different type of model but accountability an underlying theme. Midwives – conflict between patient choice vs accountability. Structure needs to facilitate change to remove threat to professional position. Culture of litigation, financial rewards, lack of clarity over terms & conditions contributing to this. Dept undertakes many reviews but no review of its own administrative structures.

PC team with management structure – practice size units, critical mass – hard to organize a team around small practice or on the other hand a LHSCG. Around 30000 people perhaps ideal size to bring in sufficient different disciplines. Enough flexibility within GP contract to provide all services.

Need to agree on the necessity of teams-advantages, doesn't threaten their position, must agree on resources and size. What structure sits over these teams – need to agree on what services should be managed at what level. Equity issues would have

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Other HLGs - Continued

to be managed at a higher level. Overarching strategic framework needed to allow these new partnerships to develop - structure should follow strategy. Structures necessary for outsiders to see pathways. Teams then above LHSCGs then department (training,funding)? Need to decide the services provided by LHSCGs. Funding on practice size or geographical basis – can be done different ways for diff services but most can be provided by practice.

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- 5.2 Summary Comment – interesting to note the opening comment about the inadequacy of connectivity between the HLGs. This was a theme which recurred across the three groups, and perhaps helps to explain why the Groups adopted different approaches to the task. There was a general sense on the day that the twelve HLGs as presented, need to be reconsidered and tested in terms of their connectivity, coherence, and distinctiveness.

6. Session 3 – Summary of Discussion (Group C)

- 6.1 This Group reached the view that the High Level Goals offered in the text were characterised by a high degree of overlap and inter-connectedness. After some discussion, it was also felt that the HLGs contained some elements that were more about supporting (enabling) actions, rather than outward facing service activities. Based on this preliminary discussion, the Group decided that it could usefully spend the available time on a more considered discussion of the HLGs, and the more specific actions that might be associated with these goals. The tenor and direction of this discussion is presented in the notes below:

We should have Five HIGH LEVEL GOALS based around the following themes:

- (1) HIGH QUALITY (CONTINUOUSLY IMPROVING OUTCOMES)**
- (2) RANGE**
- (3) ACCESSIBILITY AND OPTIONS**
- (4) RESPONSIVENESS**
- (5) INTEGRATION**

Associated with these five High level Goals should be six Objectives.

Objectives

- 1. Modernise/upgrade premises**
- 2. Clinical & Social Care Governance**
- 3. Better information all round (internal and external)**
- 4. Partnership working/integration (to include users)**
- 5. Workforce development & planning (Training of staff/ expanding roles)**
- 6. Research and Development**
- 7. Effective/efficient management of resources**
- 8. Expand capacity and role of PC (alternatives to SC)**
- 9. Localising PC services**

This list is not exhaustive It could also be reduced/merged.

Objective 1: Modernise/Upgrade Premises

Service Measures Activities

- Evaluate and roll out community treatment & care centres (if appropriate)
- Local community hospitals (DBS)

- (above should work in collaboration with each other)
- Developing PC premises to a specified/agreed standard e.g. (in line with GMS contract and Pharmacy strategy)
- PC team being housed together (workforce planning)

Support Measures

- Private finance (explore)?
- To develop the specified/agreed standards (interface with HSSRIA) – (Care Standards Unit).
- Modernisation fund.
- ICT strategy, networking, interfacing, NHS Direct, telemedicine

Objective 8: Expand Capacity & Role of Primary Care (Alternatives to Secondary Care)

Service Measures Activities

- Set up a PC task group to determine the full remit of PC and scope of services
- The outcome of above will inform the development of PC roles (commission a workforce plan)
- Support the current development of PC specialist roles (incentivise and motivate workforce)
- Put conditions for change in place in overall health service (seek the co-operation of other sectors e.g. SC, PC, CC)
- Management support for development planning
- Recognition of early successes
- Phased implementation
- Evaluation

Support Measures

- Multi-disciplinary training – under graduate and postgraduate to be informed re. Multi-disciplinary issues and Specialist training and extended role training
- ICT strategy (PCIS)
- Appraisals, mentoring and support
- Additional funding and resources

Objective 4: Partnership Working/Integration (to include Service Users)

Service Measures Activities

- LHSCGs, HAZ, IFH Partnerships, Community Pharmacy Partnership, Local strategy partnerships – (need to be joined up/coordinated)
- Clinical and care pathways must include PC dimension (seamless service)

- Expert patient self-care programme – ICT Strategy
- Multi-disciplinary training
- Developing of guidelines/protocols
- Establish links with professional training establishments to inform curriculum development

Support Measures

- Professional support and cooperation
- Departmental leadership and commitment
- Good communication ICT
- Establishment of task groups to take activities forward
- Need SC support
- Community Development approach.

6.2 Summary Comment – interesting to note the suggested re-structuring of the High Level Goals across five separate themes. These themes were arrived at by the Group as a more coherent and generic suite of ideas, behind which would sit a set of Objectives, encompassing a more targeted set of activities. This was the first occasion in the workshop discussions that a clear distinction was made between higher-order goals and lower-order objectives. The fact that the Group felt it necessary to re-group and re-think in this way, tends to support the idea that some further editing of the twelve High Level Goals (as presented), will be necessary as this planning process moves forward to the stage of creating a first draft of the Strategic Plan.

7.1 At this wrap-up session, the Facilitators from each of the three Groups made a brief presentation highlighting the main points of discussion to emerge through the day in their respective groups. This feedback was made in plenary session, although time constraints prevented any further discussion on the issues raised at that point.

7.2 As a prelude to bringing the workshop to a close, the Chairman invited participants to voice any particular issues that remained of concern to them. These might have been issues that participants believed had remained neglected through the day, or they could have been points that individuals wished to reiterate or stress before the proceedings were brought to a close. The following issues were raised:

- We need to elevate Primary Care from its current status as a “Cinderella Service”.
- We need to consider “connectivity” more – how will everything in this Strategic Plan connect to everything else?
- We need to consider innovation, experimentation, and the adoption of best practice. How do you actually do these things – not just espouse them?
- We need to think about switching around from R&D to D&R – (i.e.) developing initiatives firstly through practice, and then considering getting some supporting (or validating) research underway.
- How will we take the services forward – for example, how will certain statutory functions (e.g. Children’s Services) sit within this Strategic Plan?

8 Conclusions and Implications

8.1 A considerable amount of work was achieved through this day. Unlike the first workshop where the tone was deliberately exploratory, this workshop presented some ideas and some text, and invited a reaction. The progression in Workshop (2) therefore was to move from the exploratory to the confirmatory. While participants were not necessarily asked to “confirm” any of the ideas in the circulated text, they were asked to respond and comment as they considered appropriate.

8.2 A number of conclusions emerged quite clearly on the day:

- The twelve High level Goals need to be re-visited and edited (most likely downward)
- Some “design principles” behind the HLGs should be considered
- The inter-connectedness between the HLGs (and the activities they will generate) need to be considered – in terms of document design, the Strategic Plan will need to demonstrate that it has examined this inter-connectedness, and that it has adequately addressed the point.
- Whilst the workshop affirmed (once again) the *inclusive, integrated, seamless, user-focused* language that emerged from the first workshop, it did not (in its consideration of Purpose and Vision) reach any final conclusions on how this language should best be presented, or (more importantly) on how the actuality of this vocabulary will be realised. Indeed, “turning fine words into practical realities” arose as an issue requiring further thought at the close of the workshop.
- Within a twenty-year time frame, “near term” and “longer term” issues need to be carefully distinguished.

8.3 The implication emerging at the end of the workshop was that many of the ideas considered through the day require further testing and refinement. Responding to a circulated text appeared to work well, in that it provided participants with a focus for their discussion. A further implication arising from the day was that while the text associated with Purpose and Vision will need some further thought, it nevertheless appeared to strike the correct note. However the High Level Goals need to be re-considered with a view to some re-ordering and synthesis that will eliminate unhelpful areas of overlap.

9. Next Steps

- 9.1 A third and final workshop in this planning process is scheduled for 1st and 2nd December 2003. Whilst it is not expected that this workshop will bring the consultative process to an absolute and final close, it is hoped that the discussion over these two days will enable the Department to proceed to the preparation of a substantially advanced First Draft of the Strategic Plan.
- 9.2 The format of this final workshop will follow much of the earlier pattern. There will be a considerable emphasis on group work, and a particular focus on taking the discussion another incremental step forward from Workshop (2). A somewhat different feature of the third workshop will be the participation of a limited number of invited speakers, who will be asked to present some thoughts on aspects of primary care delivery, and on the central messages and issues that might be expected to form the spine of a Strategic Plan. The purpose of these inputs will be to support and provoke dialogue over the two days.
- 9.3 A further element in the “next steps” will be the preparation of a document to support dialogue at the workshop. On the basis that it is more purposeful to circulate a document to which participants can respond (rather than invite people to a final event unsupported by any documentation), it is intended to prepare and circulate a preliminary sketch of the Primary Care strategy framework early on the week commencing 24 November. It is important to stress that this document will not be a first draft of the Strategic Plan. Such a first draft cannot be prepared until the workshop process has been concluded and the full implications of the issues emerging have been considered and analysed. Rather the document to be circulated in advance of the final workshop should be regarded as a sketch or a “skeleton” of the Strategic framework. The purpose of this document will simply be to stimulate debate, and to provide a focus for discussion around what the shape, structure and content of the final document should look like.
- 9.4 The objective of this final workshop therefore will be to facilitate and guide the further drafting process, not to conclude it.

Appendix A: Circulated Text

PRIMARY CARE

What is Primary Care?

Primary care represents a very broad and inclusive approach to the care of people. It involves a wide range of trained health and social care professionals delivering health, social, community and public health services in the local community. It is holistic in nature encompassing treatment, health education, promotion and disease prevention. Its key feature is that it is “first contact” care which is local, responsive and accessible by self-referral.

Purpose

To deliver convenient, safe, efficient and effective high quality primary care services, based on sound clinical practice, using highly skilled and motivated staff.

Vision for the next 20 years

A vision for Primary Care over the next 20 years is that it will play a central role in improving the overall health and well being of the people of Northern Ireland by:

- providing a seamless and integrated service which offers high quality treatment and care based on evidence of effectiveness;
- providing equity of access to services which are capable of responding quickly and appropriately to the needs of individuals, and communities;
- being appropriately resourced;
- being client, patient and person centred;
- actively involving local communities and individuals;
- adopting a locality based approach to needs assessment and service delivery;
- sharing information and working in partnership with other parts of the Health and Social Services;

- working closely with other sectors, such as education, housing and employment, which have an impact upon health and well-being;
- operating in modern well equipped premises fit for their purpose;
- fully utilising information and communications technology;
- placing emphasis on prevention of ill-health and the active promotion of good health and well-being;
- promoting and supporting self care & responsible service use;
- extending the range of primary care services and, where appropriate, tailoring them to meet the needs of all population groups;
- targeting of resources to reflect the special needs of specific parts of the community;
- sharing experience to further enhance quality and expand the range and capacity of services; and
- having a well-trained and knowledgeable workforce, capable of taking on new and expanding roles including chronic disease management.

High Level Goals

- 1) To build a primary care infrastructure which allows for people to be treated and cared for in the most appropriate settings, by the most appropriate people and by the most appropriate means.
- 2) To upgrade and modernise primary care premises to ensure that they are fit for purpose.
- 3) To improve and expand the range of primary care services available to local communities.
- 4) To improve and expand accessibility to primary care and reduce inequalities.
- 5) To provide more and better information allied with greater choice for patients and more responsive services.
- 6) To promote partnership working between primary care professionals, administrators and the community.
- 7) To enhance and expand the roles of those involved in delivering primary care.

- 8) To improve interfaces between primary care and other parts of the Health and Social Services.
- 9) To minimise the necessity for hospital admissions.
- 10) To help to reduce the length of stay in hospitals and facilitate timely discharges.
- 11) To invest in primary care research and development.
- 12) To improve and expand information and communications technology.

Appendix B: Workshop Agenda

Developing a Primary Care Strategy – Workshop (2) Agenda

09.15		Registration & Coffee
09.30	Session 1	Welcome , Introduction, & Update
10.00	Session 2	Working Groups review Prepared Text (a) Statement of Core Purpose (b) Vision of Primary Care (c) Statement of High Level Goals
10.45		Coffee
11.00	Session 3	Working Groups identify principal Service and Support Measures that will be required to give practical effect to the High Level Goals.
12.45		Lunch
13.30	Session 3 (Contd.)	Working Groups reconvene to conclude Session 3.
14.30	Session 4	Plenary Session - Feedback & Review
15.30	Session 5	Where does the process go next?
15.45		Workshop Close

