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**DEVELOPING A PRIMARY CARE
STRATGEY**

Outcome Paper following 1st Workshop (26/09/2003)

(Prepared by Aidan Pender: 09/10/2003)

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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 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”. This work is being led by a Project Team within the Primary Care Directorate which has been tasked with guiding an inclusive and participative approach that will involve extensive consultation with all stakeholders in the Primary Care sector. In order to give practical expression to this consultative process, the first in a short series of workshops involving primary care practitioners was conducted on Friday 26th September 2003. This brief “outcome paper” summarises the main points of discussion on the day and attempts to synthesise the general tenor and direction of the debate.

1.2 The structure of the workshop was to a great extent driven by the requirement to provide for the fullest possible participation by stakeholders. In the event some 80 practitioners joined the workshop. These were sub-divided into five working groups which – apart from plenary sessions at the commencement and conclusion of the workshop – were retained as a working structure throughout the day.

1.3 The workshop agenda addressed three principal issues as follows:

- Session (1) Searching for a Definition of Primary Care
- Session (2) Identifying Key Issues/Concerns in Primary Care
- Session (3) How can these Issues/Concerns be Progressed in the future.

In respect of each session, participants were asked to address a particular task and were assisted in their discussions by a Facilitator who gathered feedback from the session.

1.4 The workshop agenda did not allow time for a detailed synthesis of the individual group discussions. While a brief summary comment was offered at the conclusion of the day, the purpose behind this paper is to try and “capture” and present an overview of the day, and a sense of conclusions reached.

2. Session 1 – Summary of Discussion

2.1 The purpose of this session was to assist the Project Team in developing a definition of Primary Care that would support the articulation of component services and associated care activities within a 20-year strategic framework. A Briefing Paper was prepared and distributed to workshop participants in advance in order to stimulate some preliminary reflection. This paper set out some definitions for Primary Care using references drawn from the international literature on the subject. The Project Team however remained mindful of the dangers and frustrations that could attend any attempt to use the workshop as a definition drafting or validation exercise. Such was the perceived complexity and diversity of the issue that any attempt to reach an agreed definition at the workshop seemed destined to meet with only the most limited success. Rather than attempt to pursue that objective, the Project Team instead requested the participants to consider in their working groups three linked questions:

- What do we understand by the term “Primary Care”?
- What Principles or Attributes should we expect to see embedded in Primary Care – Why are these important?
- What’s “definitely in” and “definitely out” in relation to Primary Care?

2.2 In relation to an understanding of Primary Care, the following commentary represents an amalgamation of the views that emerged across the groups:

- (a) Primary Care is an approach to care – it implies a concept rather than a specific service
- (b) Primary Care is holistic in its nature – it takes a broader view of well-being - at one interpretation this could extent to the involvement of education, sanitation and housing agencies
- (c) Primary Care involves all services outside of hospital
- (d) Primary Care represents the first point of contact – into a continuous and seamless service
- (e) Primary Care should be integrated and coordinated – it should be inter-

agency and multi-diagnostic

(f) Primary Care should mean people being cared for in the most appropriate

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settings, by the most appropriate people and the most appropriate means

(g) Primary Care should reflect an emphasis on working with local communities – service user involvement

(h) Primary Care must be properly resourced and recognised

(i) Primary Care should involve health promotion and disease prevention

(j) Primary Care should have effective interfaces with other health strategies (e.g.) Mental Health Strategy

2.3 The observation was made in some groups that the term “principle” was not perhaps the most appropriate one in the context of this discussion. It was suggested that a more appropriate term would be “characteristic” or “attribute”, as the session was primarily concerned with eliciting the views of participants in relation to the characteristics or attributes that they believed should inform any subsequent attempt to craft a definition of Primary care in a Northern Ireland context. The understanding at this point was that the Project Team would take away these insights and draw upon them as a principal input to the subsequent drafting of a definition. The following characteristics/attributes were identified:

Characteristic/Attribute	Why Important?
1. Client/Patient/Person Focused	To meet real needs of people – service should not seek “patient compliance”
2. Seamless & Integrated service	Avoid repetition – all patient needs cannot be met by one service
3. Accessible and Responsive	Service easily recognised and readily used
4. 1 st Point of Contact	Reflects closeness to community
5. Flexible & Innovative	Capacity in system to deal with change
6. Broad in its interpretation	In order to think outside of “silos”
7. Holistic	In order to build relationships across services
8. Looking outward to patient needs.	To avoid looking inward at structure

2.4 A further strand in this session was the review of “what was in” and “what was out” in relation to Primary Care. This discussion was prompted in the belief that

the “boundary lines” around Primary Care could be quite blurred, or indeed quite elastic depending on who was offering an interpretation of where it began and

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where it ended. Rather than allow this issue remain unspoken throughout the workshop, it was decided to invite participants to set out the boundaries to Primary Care – as they saw it. In order to facilitate this discussion, the supporting structure was couched in the rather stark terms of “What’s In” and “What’s Out”. The following Table summarises the conclusions reached across the five groups:

What’s In	What’s Out ?
1. Sign-posting the patient	1. Obsession with Activities & Inputs
2. Participation in decisions	2. Care provided in 2 nd /3 rd Setting
3. Combining health, social, community & public health services in the local community.	3. Narrow “medical model” of care
4. Long-term planning	4. Agencies outside of HPSS
5. Preventive medicine	5. Structural/Professional boundaries
6. Free at point of entry	6. Professional Protectionism
7. Multi-agency working	7. Short-term reactionism
8. Inclusive Process	8. Any acute care
9. Screening services	9. In-patient treatments
10. Linkage to Health Education	10. Very high-tech specialisms
11. Primary Care as a “mixed economy”	11. Regional services
12. 1 st point of contact	12. Day care services
13. Patient centred	13. Political footballs
14. Sharing of clinical information	14. Boundaries to sharing information

Much of this information was derived within the groups through participants “voting” by jotting ideas on “post-it” notes, and then sticking them up on the In/Out side of a flip chart as appropriate.

2.5 These notes revealed that although they worked separately, the five groups developed a number of ideas which recurred as linking themes across this first session. These included Primary Care as (a) a first point of service, (b) an integrated service drawing from a range of specialisms and disciplines, (c) a clear focus on the patient, not on structure or professional discipline, (d) an

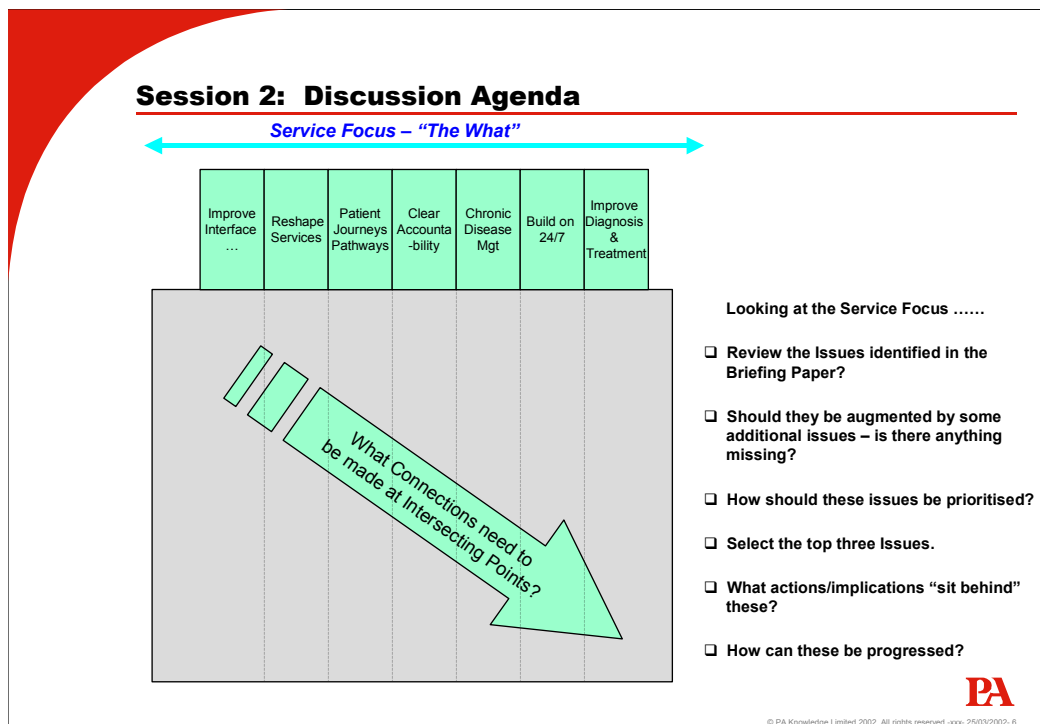
emphasis on health education and maintenance (and the responsibility of the individual in this respect), and (e) a readily accessible and responsive service.

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3. Session 2 – Summary of Discussion

3.1 The focus in this second session was on the Issues/Concerns that should be at the centre of Primary Care over the next twenty years. The session was therefore very much concerned with the “what” of Primary Care in the sense of the service activities that should characterise the sector in the future. As a “prompt” in this regard, the Briefing Paper made reference to a number of “issues consistently identified” in the series of regional consultations that had taken place over the earlier part of 2003. A number of these Service Development Areas were presented to participants (see diagram below), and they were then asked to do two things:

- Firstly, to validate or comment upon the service areas presented,
- Secondly, to augment this list by identifying further areas of service focus that they believe properly belong in Primary Care, but which were omitted from the given list.



The outcome of these discussions across the five groups is summarised

below.

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3.2 The Table below presents the response of the working groups to the seven Service Development Areas presented, and summarises the commentary in respect of each area:

Service Development Area	What is Important About It?
1. Improve Interface	Re-design within & between services – understand overlaps – avoid duplication – avoid confusion – reduces risk – speeds up care – better results for resources consumed – to achieve a “patient focus” – need to know what other professionals do – increase awareness across disciplines – best practice is important but not happening – prescribing/medicines management – relationships between GPs and consultants – poor communication leads to diminished patient experience
2. Re-shape/Reconfigure Services	Case Planning – Planning Strategies – appropriate use of skills – greater efficiency – value for money – but means huge change – people are overwhelmed by workload – need to “let go” sometimes – closing service gaps – LHSCGs are starting to make a difference locally – use of Champions – test new models (triage) – must identify win/win services – currently limited by existing roles, structures, capacities – need common culture – one stop shops – core and cluster
3. Patient Journey Pathways	More efficient – fitting the system to the needs of the patient – improving quality of life for the patient – empowerment of patient – holistic approach – better/shared information – helps to define need – should be seamless journey – clearly define pathway (e.g. cancer patient) – integrated working between professionals – aim for better outcomes (live longer) – eliminate anomalous interventions – think in terms of “client” not “patient”
4. Clear Accountability	Issues in Governance – risk of conflict with professional bodies – can be supportive – consistency of outcomes - a top priority issue – improved care governance – transparency around decisions – though could lead to risk averse situation – not entirely helpful – must tackle culture of defensive practice – about recognising risk

	and dealing with it – could mean more paperwork and less time with people – need to define better my actions – need to liaise with professional bodies that set codes of practice – shifting power – giving ownership – NI already too bureaucratic (too many tiers) – should be based on ministerial targets -
5. Chronic Disease Management	There is evidence of a growing need – link with prevention and health promotion – CD is at a very high level -
6. Build on 24/7	Important to define service scope under 24/7 – risk of creating unreal expectations – relieves pressure on informal carers – prevents unnecessary admissions and delayed discharges – more access – more choice – more convenient – staff needed to cover OOHs – great potential – driven by demands of consumer society – impacted by GMS contract -
7. Improve Diagnosis & Treatment	Care & Support – advice and information is key to avoiding inappropriate referrals – new ways of doing things – improved information – records do not always match -

This session generated a great deal of comment as is evident from the Table above. The consensus was that all seven service development areas were important, and there was effectively no comment to the effect that any of them should be deleted from the list. Furthermore when asked, most groups ranked the seven as being of high priority. There appeared to be a particular consensus around (1), (3), and (6) above as being high priority. One group highlighted in particular the inter-connectedness between these service areas, and observed that the linkages between each require more thought and attention.

- 3.3 Areas where the working groups suggested that the list should be augmented are set out below. This discussion attempted to capture a sense of other important areas of service development that were not referenced in the briefing paper.

Augmenting the Service Development Areas – What else should be included?
1. Promotion and Prevention
2. Research and Development – Dissemination
3. Needs Assessment

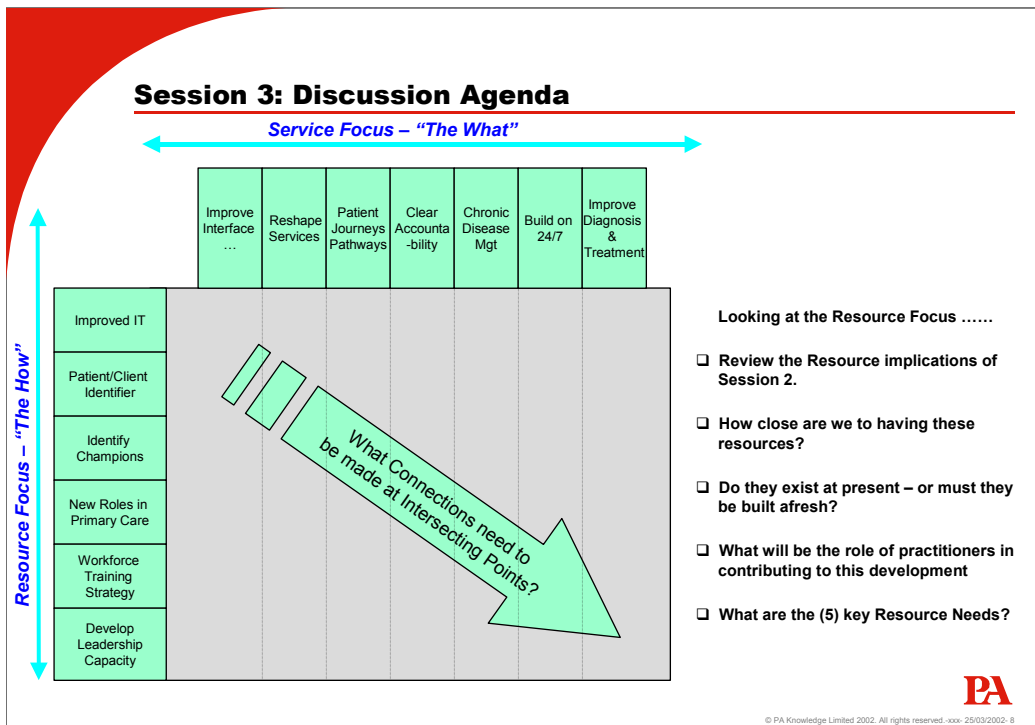
4. Improved PR and Communication
5. Engagement with the Voluntary and Independent Sectors
6. Improved Community Involvement
7. Further Development of Outcome Measures

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Some of these might indeed be interpreted as representing a service development focus, (i.e. Needs Assessment, and Promotion and Prevention). Some others however (i.e. Improved PR, and Engagement with the voluntary or independent sectors) could perhaps more strictly be interpreted as enablers of improved service rather than representing an extension of an outward looking service focus. This observation is revisited at the conclusion of this paper.

4. Session 3 – Summary of Discussion

4.1 The third principal session in the workshop explored the enablers that would be required to support the service development focus previously considered. This session therefore was concerned with the “how” aspect of developing a strategy – in other words how the seven service focused themes (as augmented by the additional themes identified in earlier group work) could be resourced. A number of resource/enabler themes were also referenced within the Briefing Paper as “issues consistently identified” in the regional consultation process. These are reflected in the diagram below:



4.2 Within this session, participants were asked to consider the resource implications of supporting the service lines identified at Session 2, and to highlight in particular the key resource needs that would be implied by the model of Primary Care they had been considering through the day. Where appropriate, they were also asked

to describe why they attached a particular importance to a resource/enabler.

4.3 The outcome of this discussion is summarised overleaf. Once again there was considerable overlap in the commentary emerging from the groups. This suggests that there is a considerable unanimity of view across the six resource/enablers identified, and an endorsement of all six as being essential to

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the future delivery of an effective primary care system.

Key Resource	What is Important About It?
1. Improved IT	Aid decisions – improve appointment system – helps interface – sharing information – better access to information for both patient and professional – improve care and safety – facilitate audit - reduce duplication – patient centred planning – critical issue and Dept lagging behind on IT
2. Patient/Client Identifier	Efficient care – better outcomes – patient safety – speed – need integrated information system – issues of gaining consent to information sharing – common coding structures – PCIS needs extended
3. Identify Champions	Will mean changes – not confined to individual or professional groups – community and service user involvement important here – accelerates improvement – disseminate best practice – who do we consider champions (“top people”?, LHSCGs?, natural teams in PC?) – knit together expertise – targeted funding needed or “champions” will not work – champions needed to make things happen
4. New Roles in Primary Care	Release capacity of others to specialise – career path – improve morale, recruitment & retention – supports 24/7 concept – utilising skills – avoiding skill loss – addressing governance requirements – change happening in individual professions, need to come together and integrate this – need to look at team structures and accountability – new GMS contract will drive change – collaboration between GP practices to access greater expertise and secure success – structure must complement change not hinder it
5. Workforce Training Strategy	Equity in training - joint training helps mutual respect and professional signposting – better performance – improve morale – confidence – better team development – promotes understanding across disciplines – user input to education – shrinking pool of people for 24/7 – competition from private sector -
6. Develop Leadership Capacity	Resource it – professional role v leadership – pressures of time to exercise leadership – vehicle to draw disparate groups together -

4.4 In addition to examining the six resource themes offered, some additional themes were also put forward in the context of this discussion. These included:

- ❑ Premises (which were seen as “just adequate”, frequently low quality, and non-standard across the service)
- ❑ Funding Research & Development
- ❑ Optimising teams
- ❑ Patient empowerment

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- ❑ Barriers to resources moving with the patient – in terms of costing/budgetary structures that tended to prevent such movement

Given the time limitations towards the conclusion of the workshop, there was however little opportunity to consider these additional themes in any depth.

4.5 Equally, given the nature of the workshop as a consultative forum, the discussion on resources/enablers was to some extent tentative and preliminary. It was not the purpose of the workshop to reach final conclusions in this respect, nor to drill down to levels of operational detail where more precise resource deployment options could be considered. Consequently, much of the discussion tended to affirm the resource/enablers offered, and to suggest a limited number of additional ones. The question of resource “trade-offs” was not therefore addressed, nor were the resource/enablers prioritised to any significant extent, in terms of considering what choices might need to be made in a resource constrained operating environment. It was not envisaged that these questions would be addressed in this session. The purpose of making reference to them at this point is simply to log them, and to note that they remain as issues that will require consideration at a later point in the development of the Primary Care Strategy.

5 Conclusions and Implications

- 5.1 The workshop generated quite a strong consensus on “what Primary Care should be about”, and on the attributes and characteristics that should inform any attempt to define it. This consensus appeared to lean unmistakably toward an interpretation of Primary Care that was very broad and inclusive, that focused exclusively on the patient/client’s needs, that was local, recognisable and readily accessible, and that represented a first point of contact into a seamless and integrated care system driven by a holistic concern for patient/client well-being irrespective of professional discipline or structure. This interpretation also rejected any attempt to see primary care in terms of a “narrow medical model” and sought instead to present primary care as a “mixed economy”, presumably drawing from the expertise, insights and skills of a diverse range of contributors.
- 5.2 In terms of crafting a Primary Care Strategy, this interpretation gives rise to some immediate implications. What is enunciated in the preceding paragraph as a consensus view is undoubtedly benign, positive, and patient/client centred. In a published document, it will be important to find language that does not appear simply noble or pious, or that reads as a ritualistic rehearsal of a vision that is more aspirational than achievable. Clumsy drafting could reduce a strong and purposeful depiction of primary care into a vacuous and flaccid statement of the obvious. The realisation of the broad and inclusive primary care system set out in Section of 2 of this document, will presumably require some reconsideration of structure and practice across relevant organisations and professions. Where it is believed that significant change is required, it cannot be expected that such change will in all cases be ushered in on an accelerated basis. On the other hand, the Primary Care Strategy is quite deliberately being designed as a framework for thinking over the next

twenty years. In that context and over that timeframe, it would be surprising if the document (at least in some respects) did not set out a vision of primary care that appeared to challenge contemporary understanding. This issue will require a careful and balanced treatment in the strategy document – acknowledging the challenge represented by the vision while taking care also to illustrate the developmental path that makes that vision realisable.

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- 5.3 Of its nature, a first workshop opens dialogue and debate rather than concludes it. This was true of the discussion that took place around the “Service Development Areas” which attempted to explore the types of activities that one should properly expect to find within a primary care system. The workshop affirmed the service areas offered, which were themselves culled from views emerging at the regional consultation exercise. For the most part also, these services were ranked as being of high importance, and relatively little effort was made to discriminate between them. Equally there was little opportunity to discuss alternative or competing service lines that could legitimately challenge those already affirmed for resources. Once again however, it must be acknowledged that this simply reflects the time-constrained nature of a workshop setting. In the context of this first workshop, participants got through a substantial amount of work in delivering a comprehensive assessment of the seven items listed.
- 5.4 An implication arising in this respect is that the affirmation of the seven service lines cannot be taken as a sufficient or definitive statement on service focus. The second session in the workshop asked participants to work in a somewhat “context free” setting, in that they did not have in front of them an agreed and common overview statement (or vision) of what the primary care system sought to achieve. Consequently, it was impossible for participants at that point to consider whether the service lines offered represented a comprehensive translation of corporate ambition into practical service activity. This task might perhaps usefully form an element within the second workshop.
- 5.5 Unsurprisingly, there was considerable consensus at the third session on the contribution that could be made by expanded or improved ICT applications.

This was felt to be most immediately applicable for example in relation to the development of a patient/client identifier system that could be used to track all episodes in an individual's care history. There was a sense that the Department needed to accentuate this emphasis on ICT systems development. The view also emerged that all the enablers were inter-linked, and that attempts to progress them should be understood in that light. Again,

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there was little (if any) dissension in relation to the enabling factors offered. It was acknowledged that all were important, although time prevented any more exhaustive examination of whether other enablers might be required and if so, how they might be resourced.

- 5.6 It is interesting to note in passing that although participants affirmed the resource/enablers presented, they did not believe that these enablers necessarily existed at present nor that they could be developed without some significant effort. One group suggested that IT was a critical resource factor and that the Department was lagging behind in this respect. Another discussed the significant “consent” issues that they believed surround the sharing of information required for a Patient/Client Identifier system. Equally it was considered that “champions” will not necessarily spontaneously emerge – they require funding and support. In terms of developing new roles in Primary Care, the observation was made that structures must complement change and not hinder it. The implication of these comments therefore is to suggest that further thought is required in relation to whether the enablers discussed at the workshop are sufficient or whether they need to be expanded, and in relation to the actions that may be required to secure these enablers and make them available to primary care practitioners.
- 5.7 By way of a concluding thought, reference can be made to the conventional wisdom which suggests that strategy, structure, and system must always follow each other in that strict sequence. In a sense the first workshop paralleled this thinking by attempting to thread together a discussion on our prevailing understanding of Primary Care (now and in the future), a depiction of the service lines that flow from this understanding, and a sense of the resources or enabling factors that must be in place to support the delivery of

those services. Assuming that this sequencing is broadly appropriate, then clarity on the first element will inevitably facilitate the development of an equivalent clarity on those that follow. This first workshop generated a valuable insight to the first of these in particular (our understanding of the core purpose of Primary Care), and this in turn will facilitate the further development of thinking in respect of the other two elements in the remaining workshops scheduled in October and November.

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6. Next Steps

- 6.1 Two further workshops in the consultation process are scheduled for October and November. It would seem purposeful to use these events as opportunities to extend the thinking around service lines and enabling factors. For this to happen, some text could be prepared around a definition of Primary Care or a statement of core purpose. From this a vision of Primary Care in Northern Ireland over the twenty-year time horizon associated with the framework could be presented. This could in turn lead to the articulation of some High Level Goals which derive explicitly from the statement of core purpose and vision.
- 6.2 The presentation of such text at the next workshop event would provide a context for subsequent discussions. In the first instance, it would stand either to be affirmed or refuted by the workshop participants. If affirmed, it would represent a basis for a more context specific discussion around those service lines that emanate from the High Level Goals, and a description in turn of the enablers that will be required to support that service delivery. If refuted, it will prompt a sharper debate around core purpose and vision, which should then lead to a similar discussion on services and enablers.
- 6.3 This incremental progression in the debate could usefully serve as the concern of a workshop in October. A further refinement of the conclusions reached that day might then be taken forward as the task for the November workshop.