







# Research Findings from Service Users and Service Providers

Building a Better GP and Primary Care Service





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## a) Background to Research

- The HSE is committed to achieving a decisive shift towards stronger, more integrated Primary Care services. To identify opportunities to enhance GP and Primary Care services, a series of consultations and engagements was undertaken to understand ‘what matters most’ to those who use and those who provide GP care, and to learn what they would most like to see developed in the future.
- Between November 2016 and March 2017, the HSE sought the input of both frequent and occasional GP service users, representatives of patient advocacy groups, current and future GPs, and as many categories of healthcare professionals working in or close to Primary Care as possible within the timeframe.
- Engagements were conducted by Coyne Research on behalf of the HSE and included one-to-one qualitative interviews, a nationally representative telephone survey, a variety of focus groups with stakeholders and a public consultation survey.
- Combined feedback from over 6,000 people made this one of the largest engagement initiatives undertaken by the HSE.
- Findings from the qualitative and quantitative stakeholder engagements are presented by Coyne Research in this report.

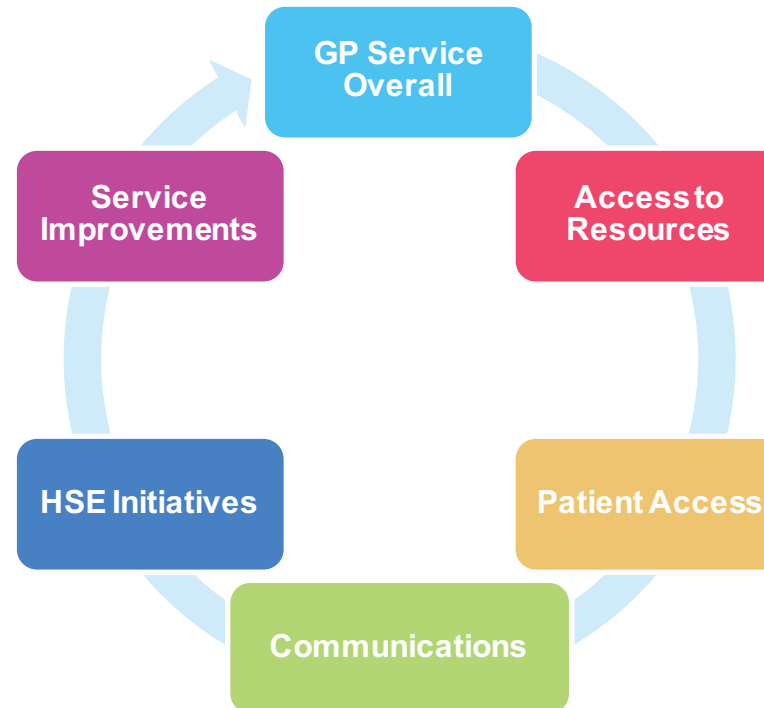
## b) Research Objectives



- The overall objective of the research was:

*“To provide the HSE with an insight into the current GP offering from the perspective of its service users and its stakeholders”.*

- More specifically, the research focused on the following key areas.



The following report will focus on the service users and service providers research.

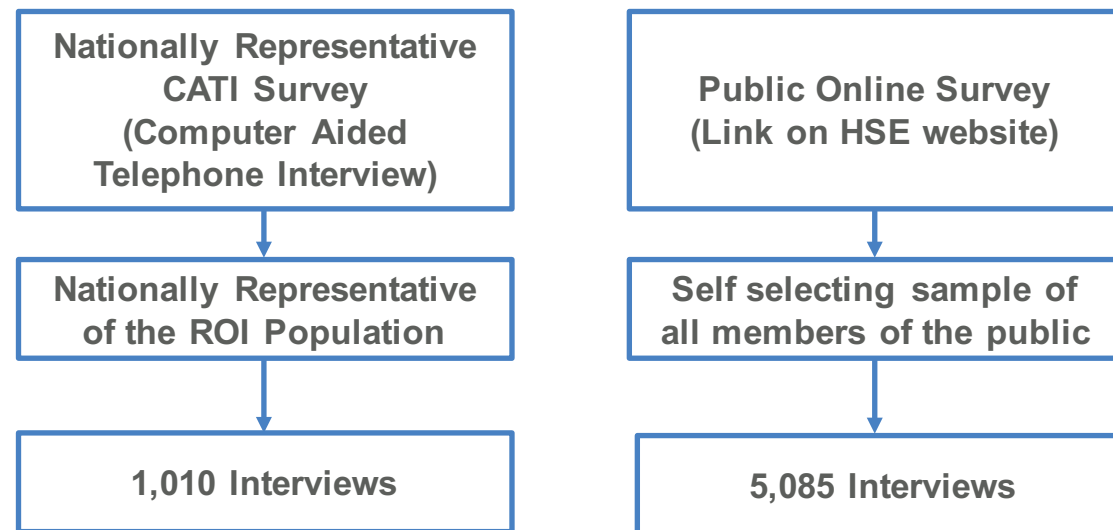


## c) Research Approach – Quantitative – Service Users



### Quantitative Stage

The quantitative research was split into two separate surveys. The first being a nationally representative survey conducted via telephone and the second survey being a public online survey open to all, hosted on the HSE's website.



N.B: Throughout the report the nationally representative survey is referenced as 'Nat Rep' whilst the public online survey is referenced as 'Public'. Question numbers corresponding to the questionnaire (Appendix 1) are shown on all relevant slides.

## c) Research Approach – Qualitative – Service Users



### Qualitative Stage

- The qualitative stage of the consumer research involved four focus groups conducted amongst those who had used the GP Service in the last 12 months.
- Groups were broken down as shown below, and in total 32 participants were included.

	Segment	Age	Gender	Social Class*	Location
1	Younger, No Children	20-35	Mixed	ABC1	Dublin
2	Young Family (Children Under 6)	30-45	Females	C1C2	Cork
3	Mix Children/ No Children	35-55	Males	C2DE	Dublin
4	Mix Children/ No Children	65+	Mixed	C2DE	Cork

\* Social class defined by occupation of the chief income earner.

ABC1 = Higher, intermediate, supervisory, clerical or junior managerial, administrative or professional.

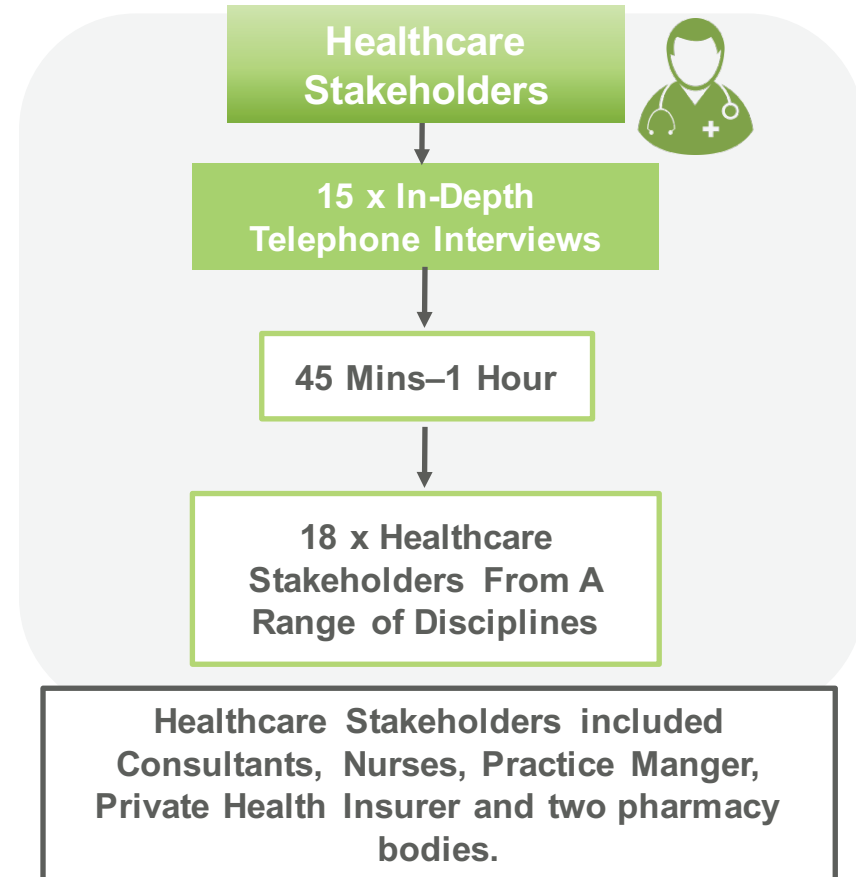
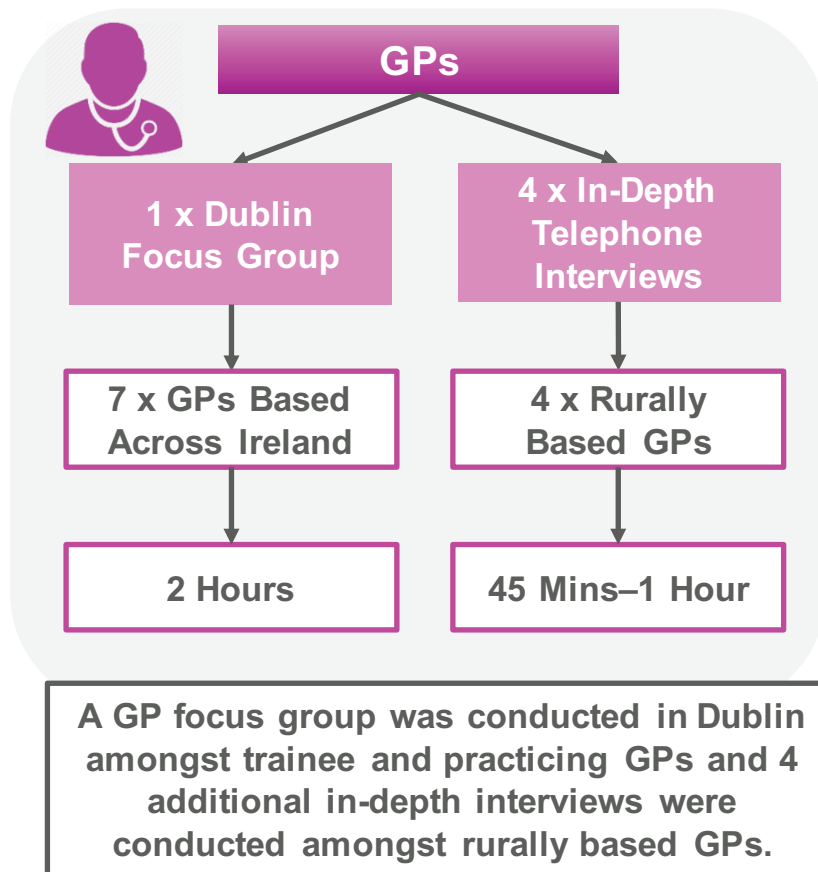
C1C2 = Supervisory, clerical or junior managerial, administrative or professional, or skilled manual workers.

C2DE = Skilled manual workers, semi-skilled and unskilled manual workers, casual or lowest grade workers, pensioners, and others who depend on the welfare state for their income.

**Focus groups were conducted on Tuesday December 13th, 2016.**

## c) Research Approach – Qualitative – Service Providers

- A number of methodologies were employed to capture feedback from GPs and healthcare stakeholders as outlined below;



## d) Acronym Glossary

Acronym	Meaning
<b>A&amp;E</b>	Accident and Emergency
<b>ARCH</b>	Applied Research for Connected Health
<b>COPD</b>	Chronic Obstructive Pulmonary Disease
<b>CPD</b>	Continuous Professional Development
<b>FEMPI</b>	Financial Emergency Measures in the Public Interest Act
<b>GMS</b>	General Medical Services
<b>GP</b>	General Practitioner
<b>GPIT</b>	The General Practice Information Technology Group
<b>HIQA</b>	Health Information and Quality Authority
<b>HSE</b>	Health Service Executive
<b>ICGP</b>	Irish College of General Practitioners
<b>IHI</b>	Individual Health Identifier
<b>NCCP</b>	National Cancer Control Programme
<b>NCHD</b>	Non Consultant Hospital Doctors
<b>NHS</b>	National Health Service (UK)
<b>PCRS</b>	Primary Care Reimbursement Service
<b>PCT</b>	Patient Care Technician
<b>PHN</b>	Public Health Nurse
<b>ROL</b>	Rest of Leinster
<b>STC</b>	Special Type Consultations
<b>STI</b>	Sexually Transmitted Infection



# Executive Summary



# Project Executive Summary (I)

## Public

- Overall current patient satisfaction is high, for quality of service received, access to services and value for money.

## GPs/Healthcare Stakeholders

- However, GP's own satisfaction levels within the industry are low, and it has been highlighted by them and other healthcare specialists, including private insurers that current resourcing issues are negatively impacting on the sustainability of current service and opportunities for improvement.
- It will be essential for contract negotiations to factor in maintenance of the current levels and quality of service to avoid any negative impact on patients, whilst also addressing the current shortfalls in the system.
- Evident crossover in keys areas of focus for both service users and service providers in terms of:
  - Maintenance of current access levels.
  - Flexibility of appointment length (and reflective payments).
  - Increased service provision at a primary care level to ensure continuity of care and avoid referral into secondary care.
- In addition addressing evident differences by region and practice also considered key for both service users and service providers.
  - A long term, joined up, national plan would be seen to address this.



# Project Executive Summary (II)



## Service Users

- Access – all access factors considered essential. Current levels of satisfaction are high, however, younger cohorts do preference longer access hours (evenings and weekends).
- Facilities – overall facilities of lower importance, with waiting times driving highest levels of dissatisfaction.
- Service Provision - overall majority of service users aware of main service offerings, however, notable differences by practice evident again. Interest in additional services to maintain care at a primary level, particularly; mental health services, practice nurses and diagnostics.
- Cost/ Value - Value mainly equated with time and quality of time spent with GP.
  - Notable variation in experience driven by relationships with GP and outcome.



## Service Providers

- Resource – current resourcing issues need to be addressed as part of contract negotiations including STC payment, grants/allowances and capitation payments. To ensure funding reflects long term primary care plans.
- Access - current access levels are considered to be putting unsustainable pressure on the primary health care system as is, therefore resource reallocation needed.
- Referrals/ Communication/ Administration – fragmented approach across GP practices, hospitals, Pharmacists, specialties and regions. Increases burden on healthcare professionals and drive inefficiencies.
  - Requires a joined up approach and investment in IT infrastructures at a national level to support a single system.
  - Take learning from successful local/ pilot schemes.



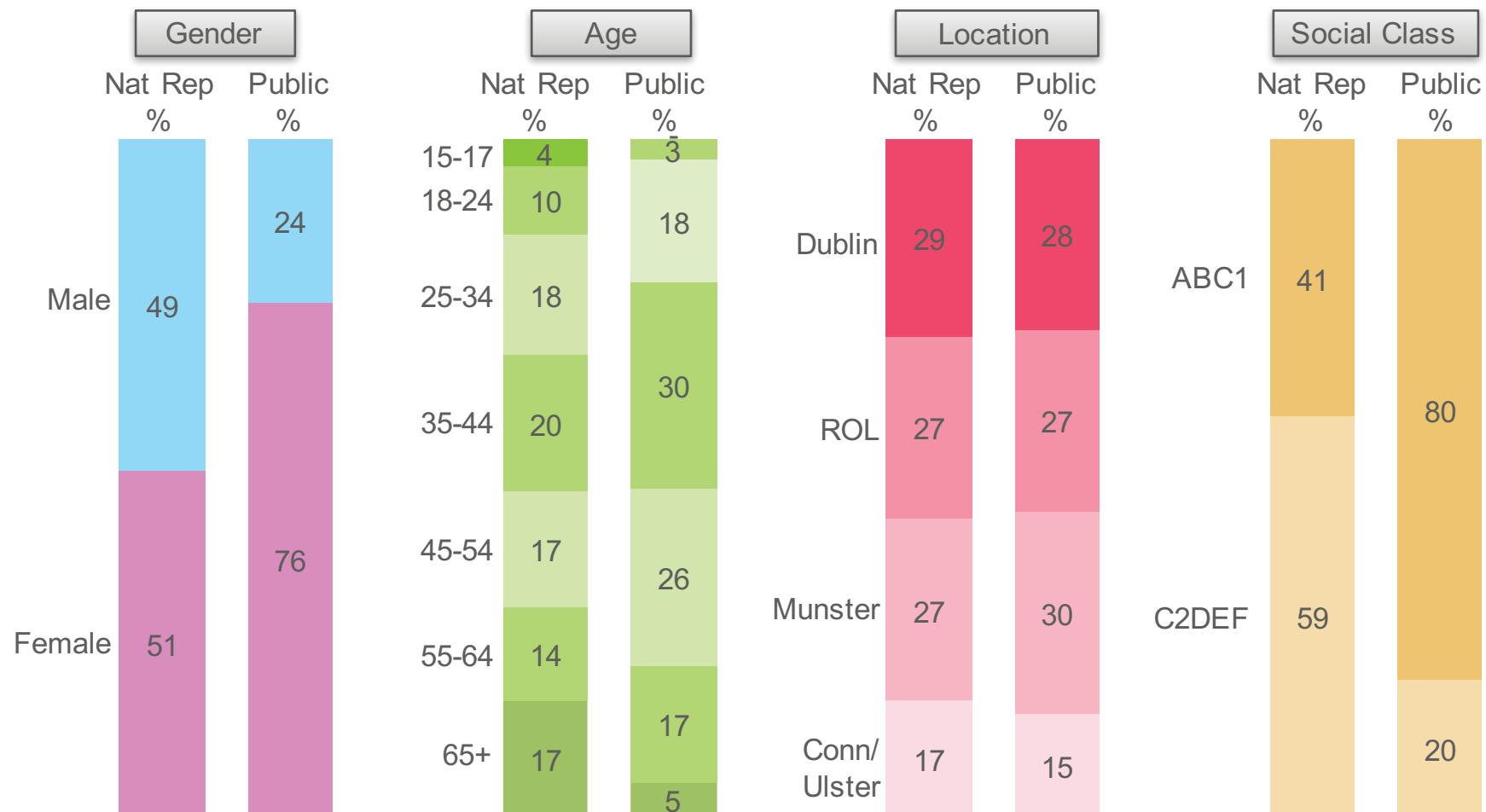
# SECTION 1: Service Users



## 1.1 Sample Profile

# Sample Profile - Demographics

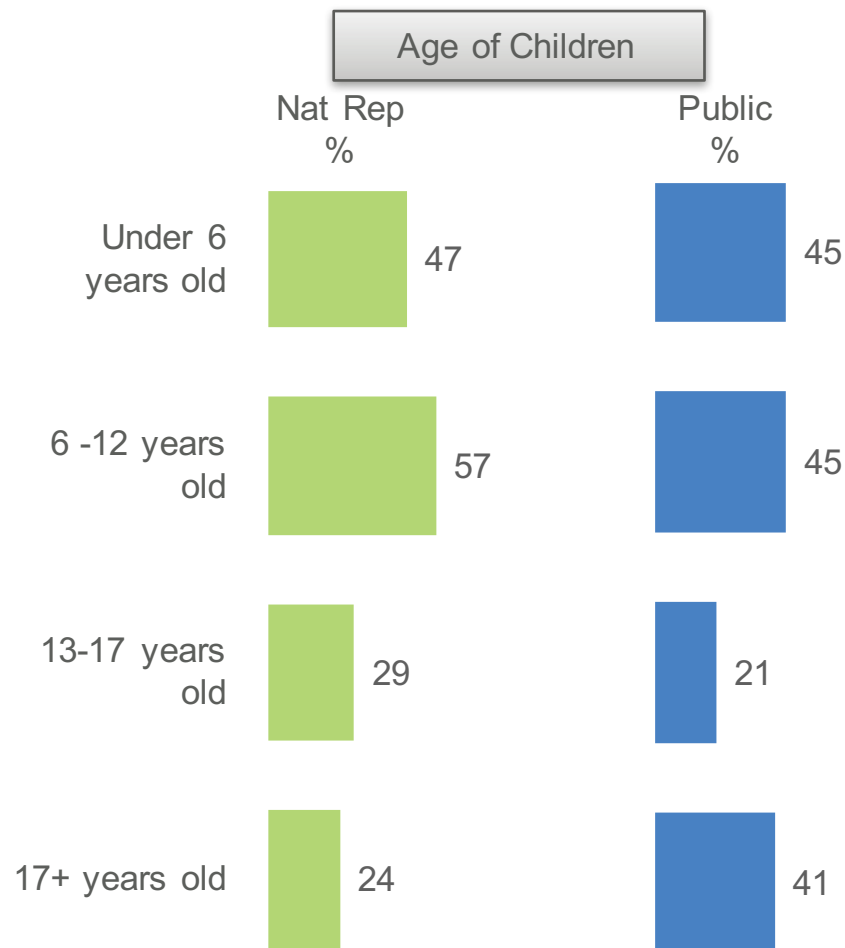
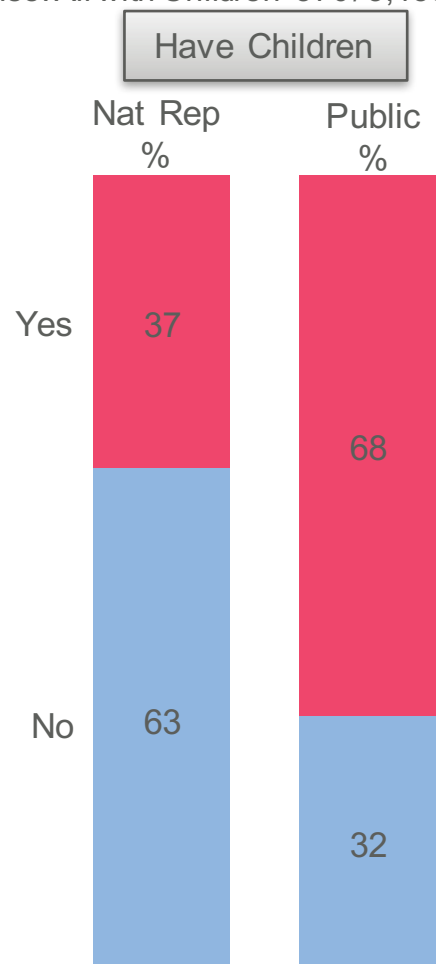
Base: All Nat Rep: 1,010/Public: 5,085



A noticeably higher proportion of older females, ABC1, completed the publicly accessible survey.

## Sample Profile - Children

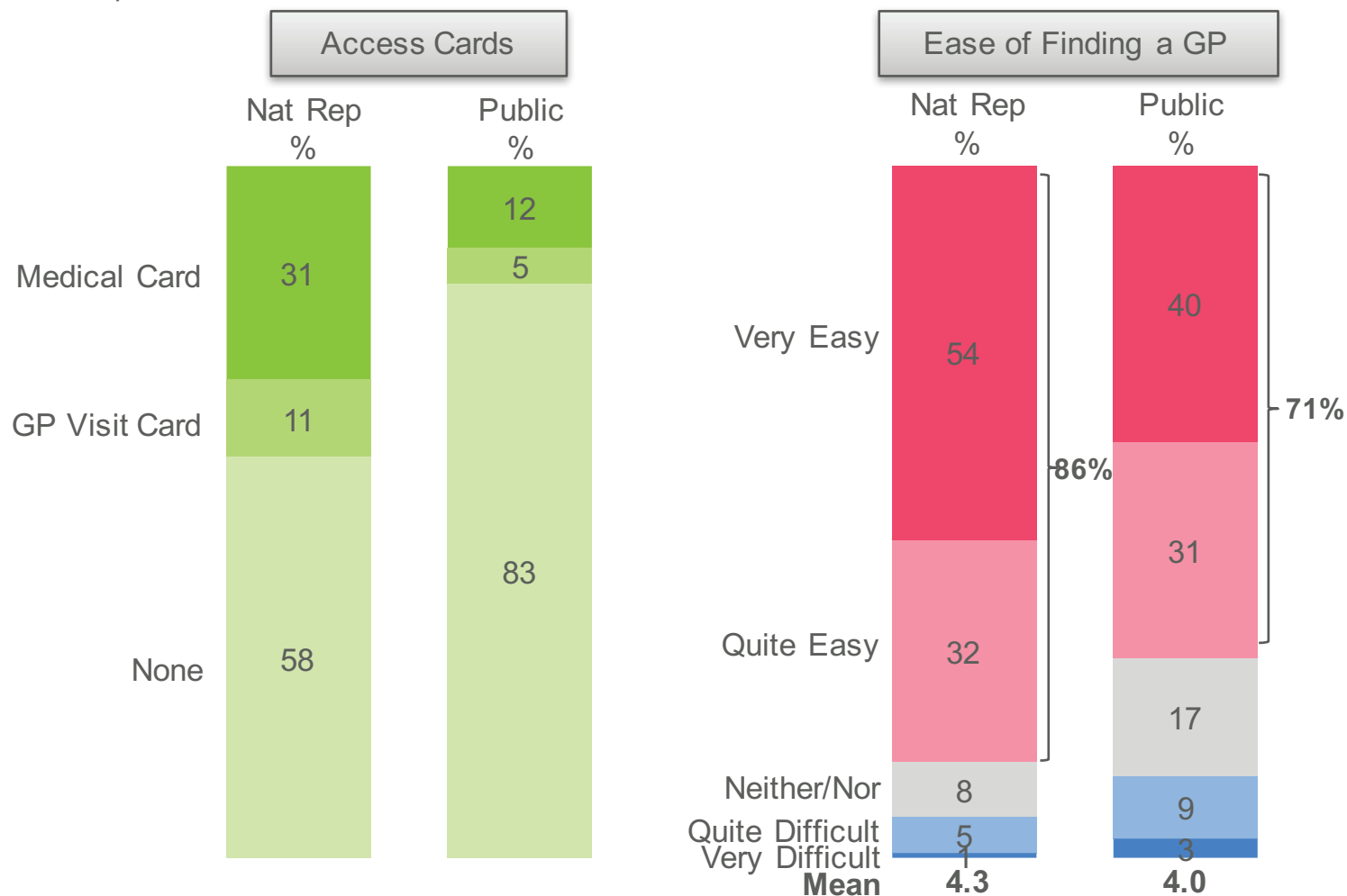
Base: All with Children- 370/3,453



Just over 1 in 3 of the total population have children, whilst over 2 in 3 within the public sample have children, with 2 in 5 having children under 6.

## Sample Profile - Access

Base: All NatRep: 1,010/Public: 5,085

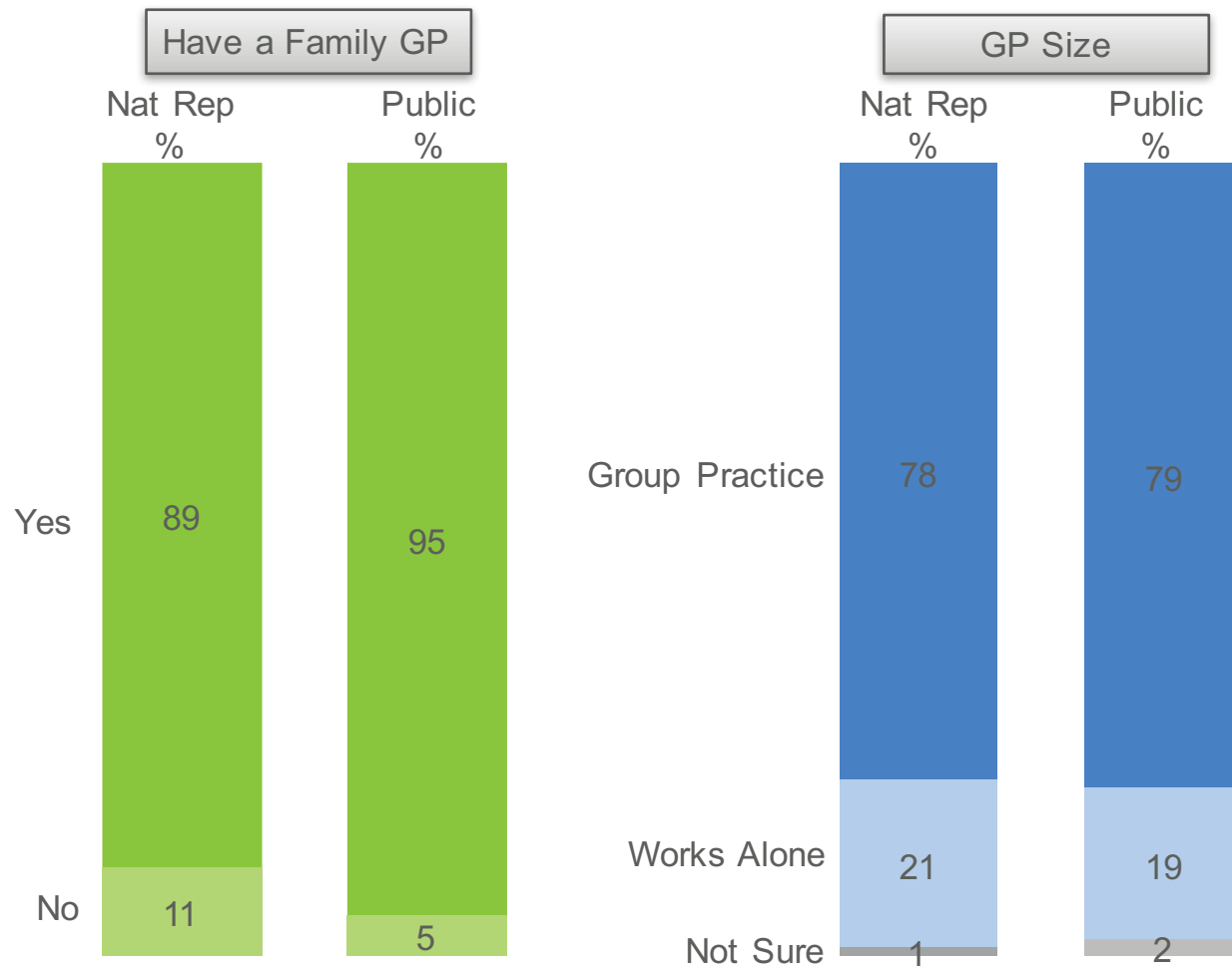


2 in 5 of the total population have access to their GP for free, whilst only 1 in 6 of the public sample have free access.



## Sample Profile - GP Profile

Base: All Nat Rep: 1,010/Public: 5,085



The majority of the population have a family GP that they would usually visit with circa 4 in 5 visiting a group practice and 1 in 5 using a solo practitioner.

## Sample Profile – Recent Visits

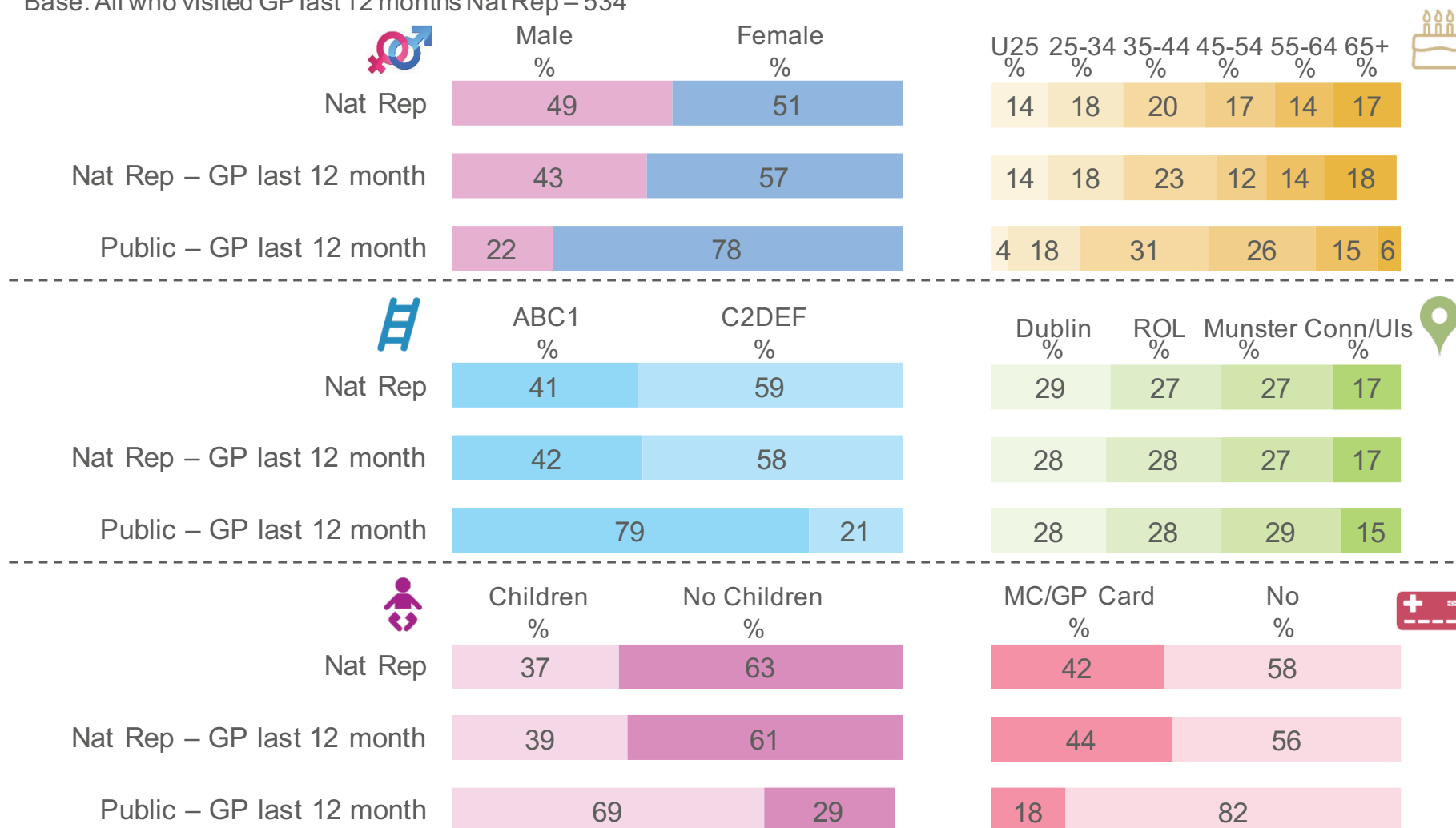
Base: All NatRep: 1,010/Public: 5,085



Within the public survey, 3 in 4 had been to the GP in the past 12 months versus a lower proportion of circa 1 in 2 of the total population. The majority had the recent appointment for themselves, however circa 1 in 5 of the public sample were visiting with their child.

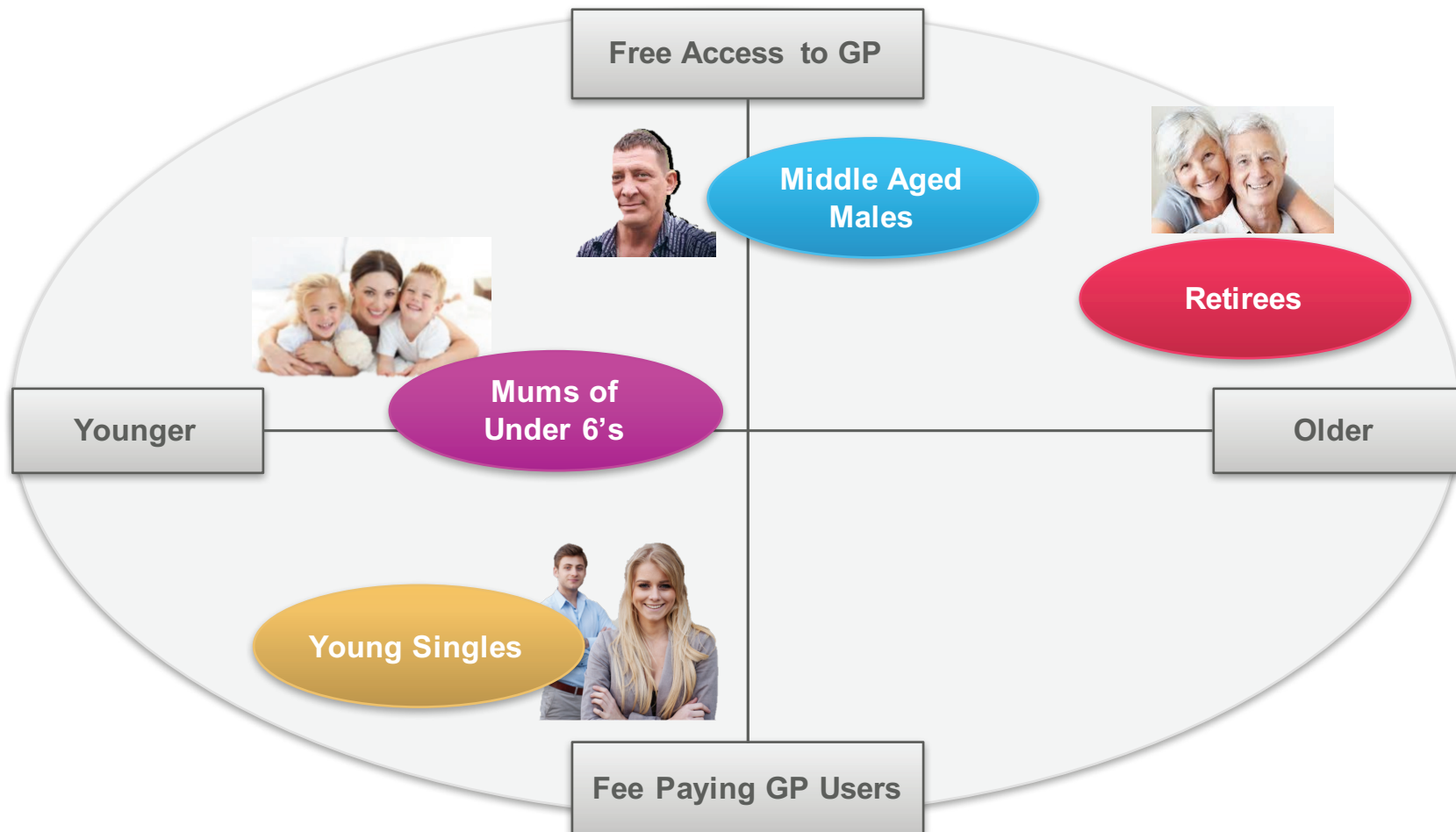
# Profile of Those Who Have Used GP in Last 12 Months

Base: All who visited GP last 12 months Nat Rep – 534



Those who have visited their GP in the past 12 months within the public sample are more likely to be female, ABC1 with children with no medical or GP card.

# Profile of GP Service Users (Qualitative)



# GP Service Users – I (Qualitative)

## Demographics

## GP Profile

### Young Singles



- 20-35 year olds, ABC1.
  - No children.
  - Majority living away from home with friends/partners for studies or work.
  - None currently in receipt of free access to the GP.
- 
- Infrequent GP usage.
  - Majority with new GP since leaving home.
    - Some using 2 GPs depending on their location (i.e. family home GP and Dublin GP).
  - Limited, transient relationship with GP.

### Mums of Under 6's



- Mums aged 30-45.
  - All with children under 6, some with children over 6 as well.
  - Mix of those with/without free access to the GP and the whole family.
- 
- Frequent GP users; majority visiting every 1-2 months.
  - Established relationships with GPs - prefer to visit the same GP but visit others within practice as well.

# GP Service Users – I (Qualitative)

## Demographics

## GP Profile

### Middle Aged Men



- Males, 35-55.
  - Majority with children, living at home.
  - All with either a GP visit or a medical card.
- 
- Majority have long term relationship with GP/GP Surgery.
  - Frequency varies, every 2-3 months.
    - More frequent amongst those with young children.
    - Majority of males visiting for regular check ups; every 6-12 months.

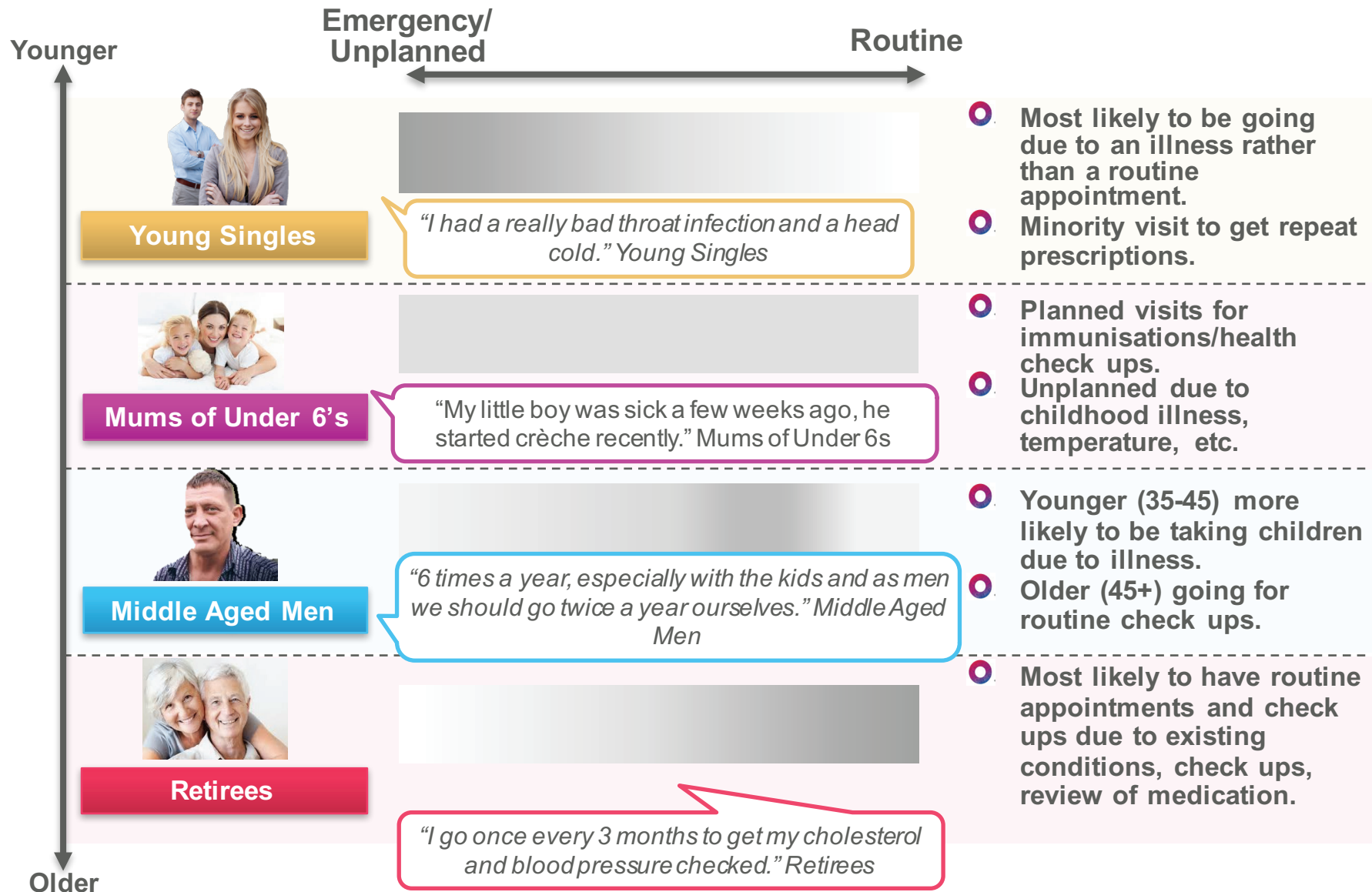
### Retirees



- Aged 65+, mix of gender.
  - Majority in receipt of free GP access – over 70 or in procession of a medical or GP visit card.
- 
- All have long term relationship with GP practice 10 – 20 years or more.
  - Have established relationship with a particular GP - prefer to visit the same GP who knows their history.



# GP Service Users – Service Usage

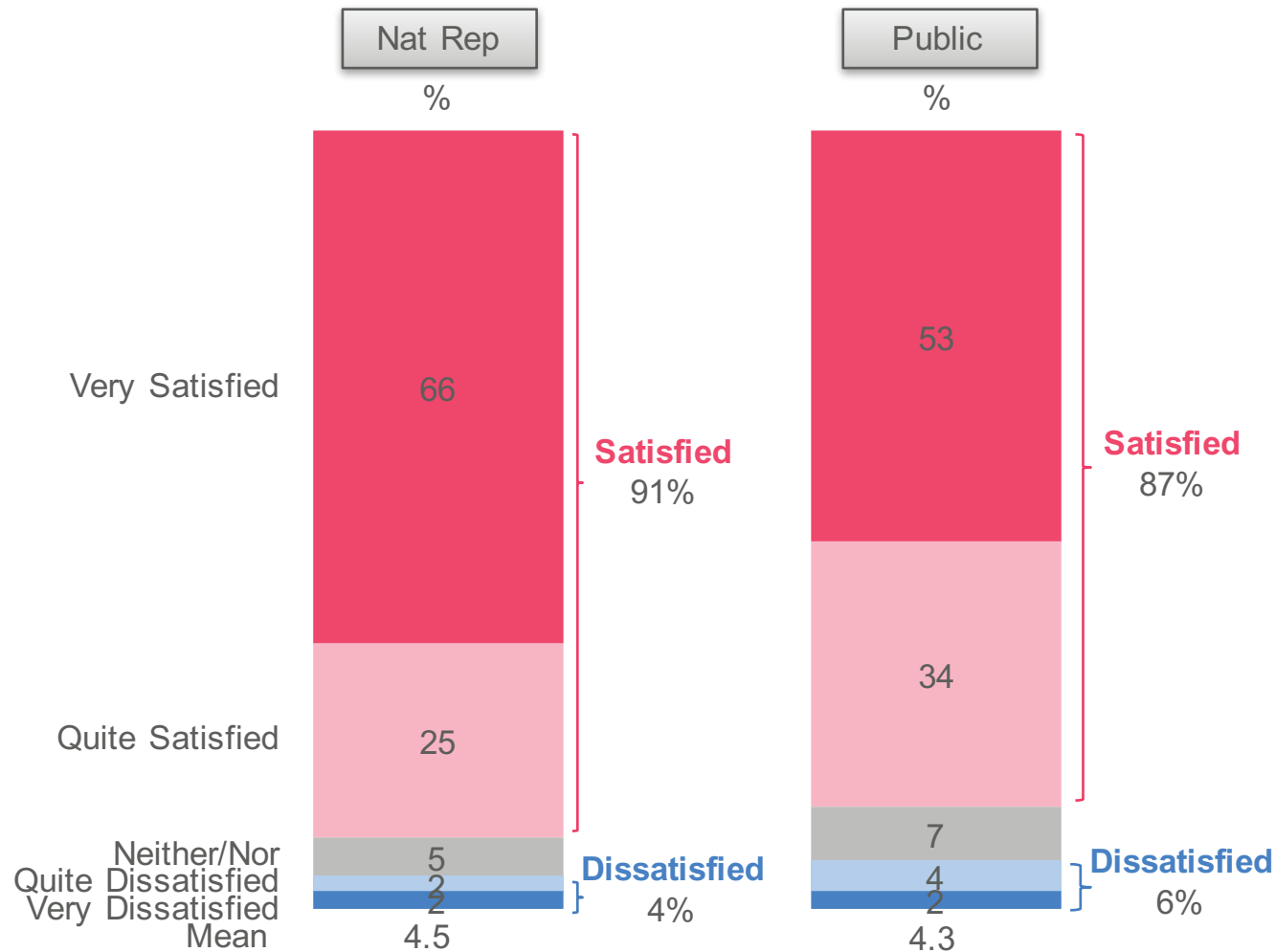




## 1.2 Overall Satisfaction with GP

# Overall Satisfaction With Most Recent Experience

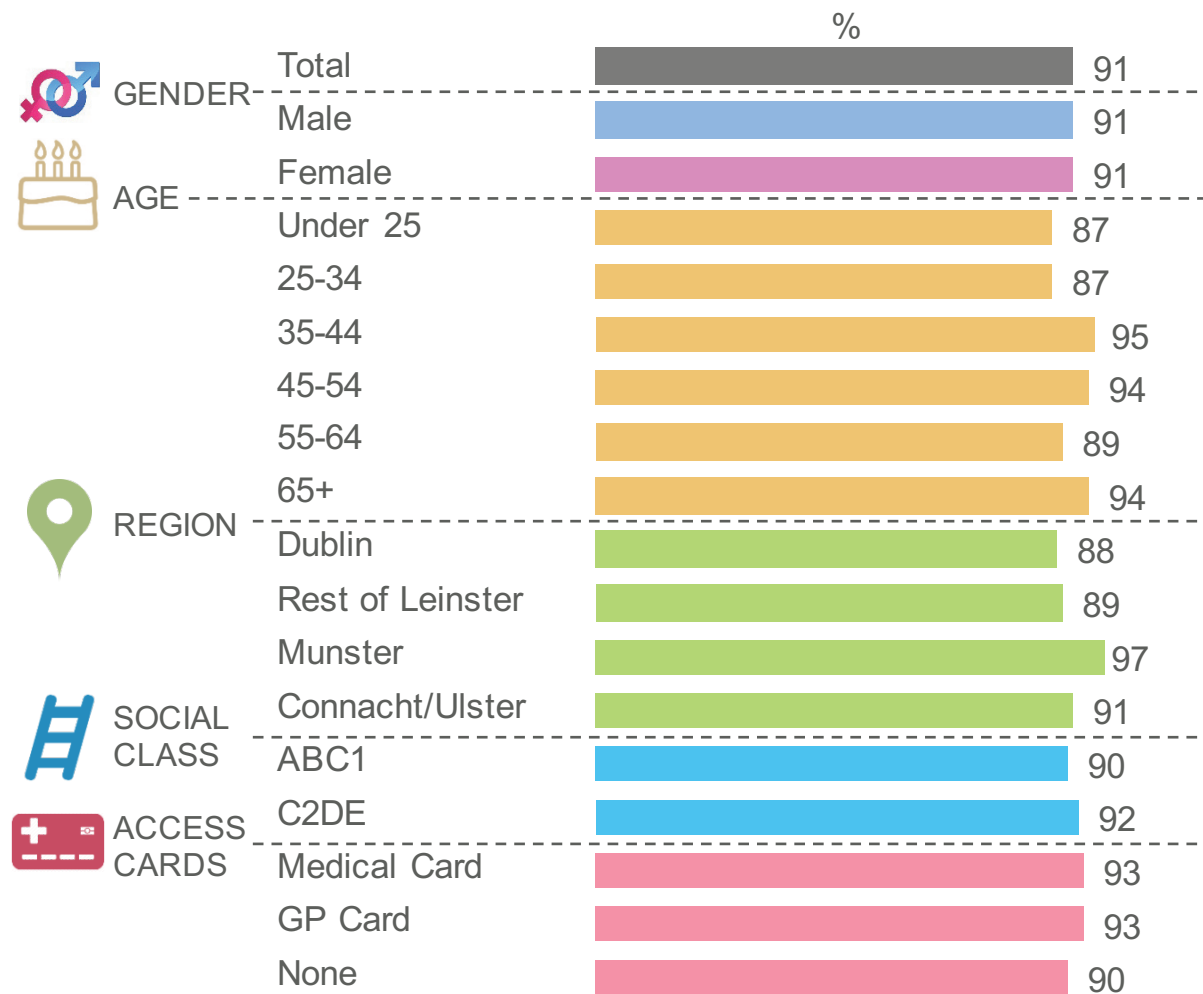
Base: All visited GP in last 12 months - 534 NatRep/3,877 Public



Overall, circa 9 in 10 claim to have been satisfied with their last GP visit with 2 in 3 from the total population claiming to be very satisfied.

# Satisfaction With Most Recent Experience By Subgroups - I

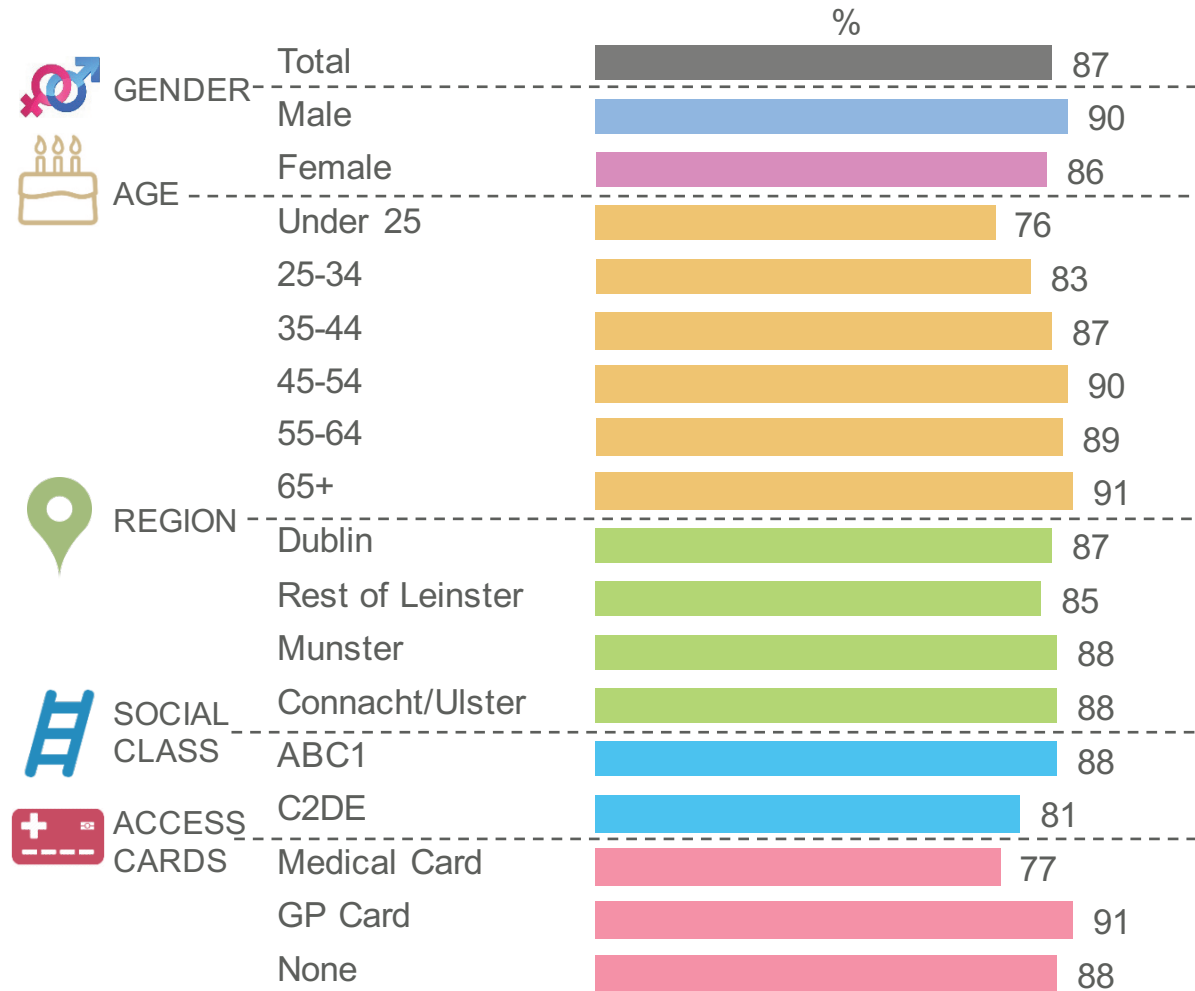
Base: All visited GP in last 12 months – Nat Rep - 534



Satisfaction marginally lower amongst younger age groups, those in Dublin and those without a medical card.

# Satisfaction With Most Recent Experience By Subgroups - II

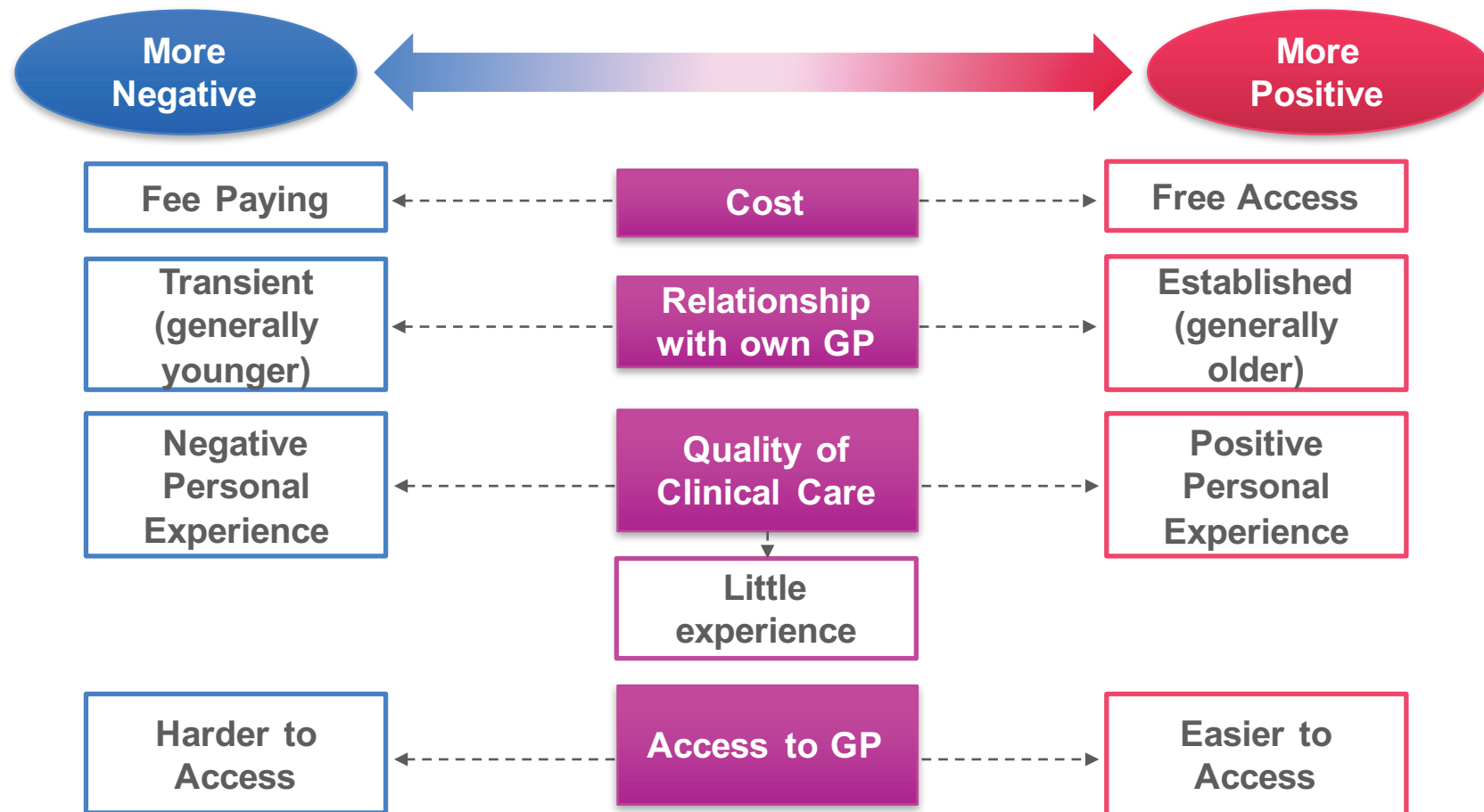
Base: All visited GP in last 12 months – Public - 3,877



Within the public survey the same trend amongst younger service users is evident. However, C2DE, medical card users within this sample are notably less satisfied.

# Overview of Factors Impacting Overall View of GP Service in Ireland

- Within the qualitative research it was evident that feelings towards the current GP offering in Ireland were notably impacted by two factors.





# Overall View of GP Service - I

## Young Singles



- Disparate responses from the young single cohort regarding their current opinion of the GP offering.

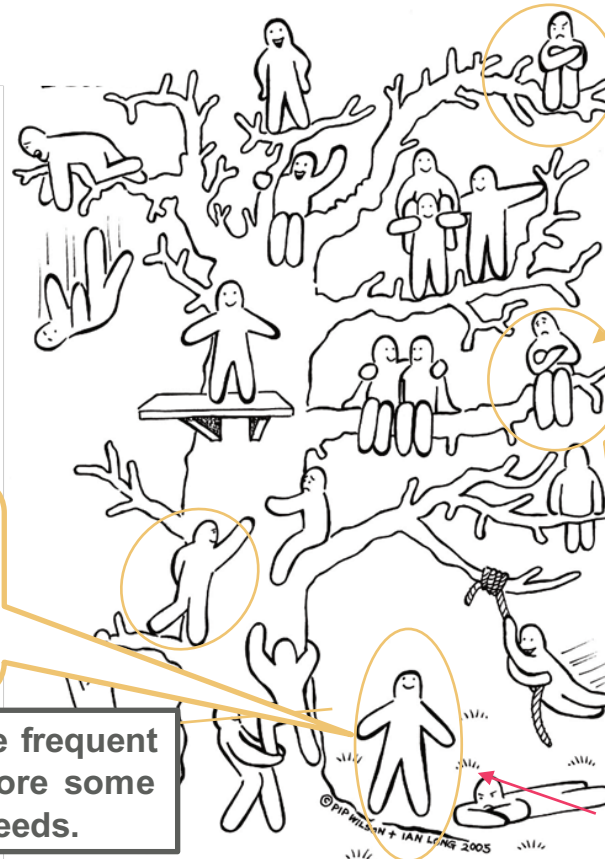
*"It just cuts the frustrated figure of someone waiting in the GP office like myself, about 20 kids running around shouting or crying and all you want to do is to get in and get out."*  
Young Singles

*"I am not a very good patient. My GP is really good and I never feel under pressure, I would be in there for twenty minutes, he does not rush me out the door."* Young Singles

**Others had positive personal experiences with their own GP driving overall satisfaction.**

*"I picked this guy smiling up at everyone. I guess it is because touch wood nothing too serious has ever happened so it is kind of like you should be OK because you are this age or whatever."* Young Singles

**This cohort are the least likely to have frequent or complex needs from the GP, therefore some felt service meets their current needs.**



**Many associated with images looking despondent and on the edge – driven by frustration over wait times and lack of time dedicated to consultation that has been paid for.**

*"It is contrasting experiences, between my GP at home and the free college service, I think this is a common perception among students, they feel the GP will rush you because they know it is a free service."* Young Singles

# Overall View of GP Service - II

## Mums of Under 6's



- Overall very positive experiences with their GP driven by personal relationships with GP, attentiveness and access.

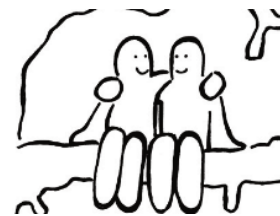
- Any dissatisfaction driven by waiting times and lack of access to same GP for each appointment.



*"I'm very happy, I've been with them years, and they'd always accommodate me."*

Mums of Under 6s

*"She talks and listens to you like a friend, I'm very happy with the service."* Mums of Under 6s



*"I'm very happy with my GP. She is based in two places it's very handy. She's always available."* Mums of Under 6s

*"I see it as a friendship. My baby was premature and my doctor was great, she was on standby all the time to help."* Mums of Under 6s

*"I find it frustrating that they're so busy. You could be easily waiting an hour. I find it hard to get an appointment with who I consider my own GP too. But the standard of care there is good."* Mums of Under 6s

*"I see my GP as giving me a helping hand and I trusted them so much, they really helped me."* Mums of Under 6s



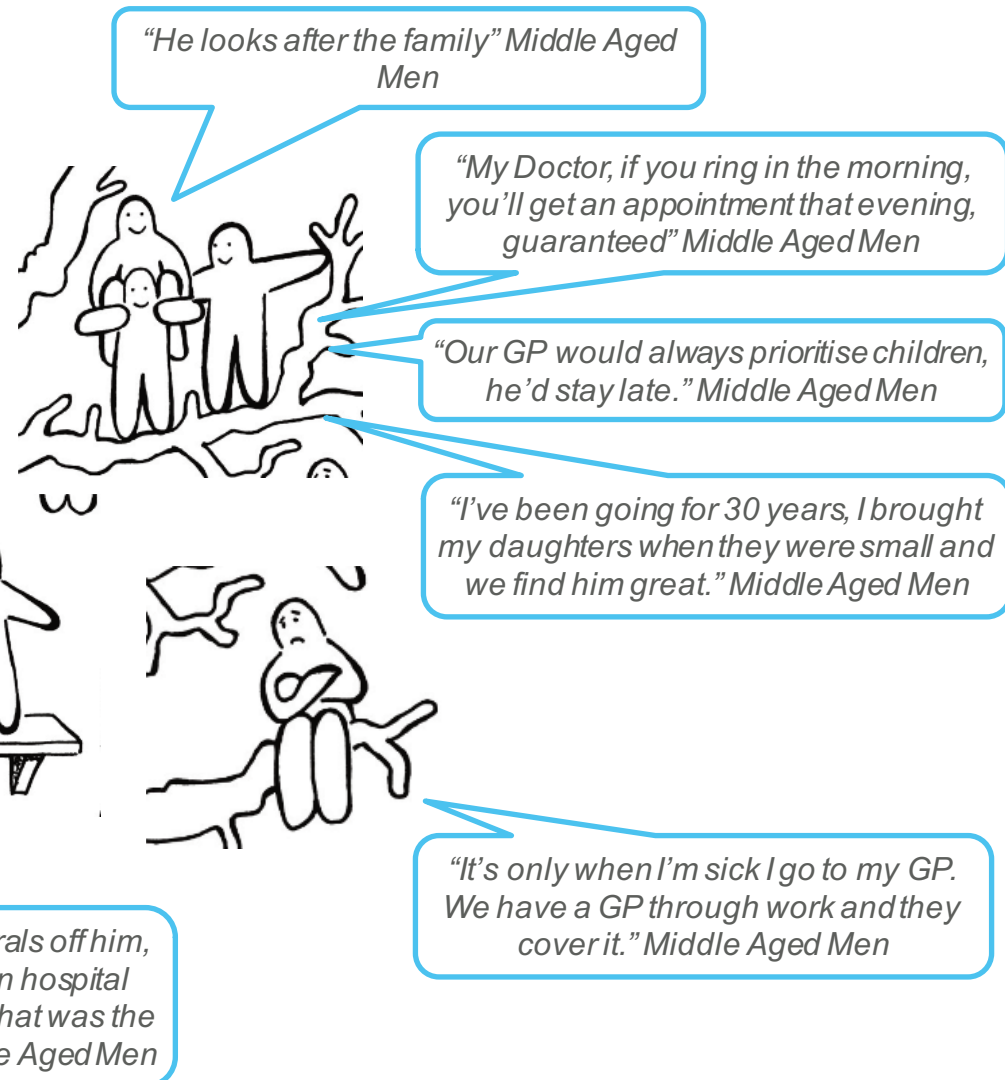
*"I went on a recommendation and they'd be brilliant. They'd always call you and fit you in. I'd have faith in all of them."* Mums of Under 6s

# Overall View of GP Service - III

## Middle Aged Men



- Universal, positive feelings towards GP service provision overall.
- The vast majority associated with the image of the family, feeling it represented the service they receive from the GP for all members of their family.



# Overall View of GP Service - IV

## Retirees



- All had a positive opinion of GP service they received.
- Again driven by personal relationships and trust established over time with the GP in dealing with all family members.

*Our children go and our grandchildren go and we're all very happy." Retirees*

*Myself and my wife go to the same GP practice and we're quite happy with the service". Retirees*



*"I'm the only one that goes to him, he's brilliant, I've no faults" Retirees*



*"We both go to the same GP, we're both very happy with him, he's very good". Retirees*

*As a family, we'd find him great. My daughter had trouble after pregnancy with bloods and that, the doctor looked after us very well..". Retirees*



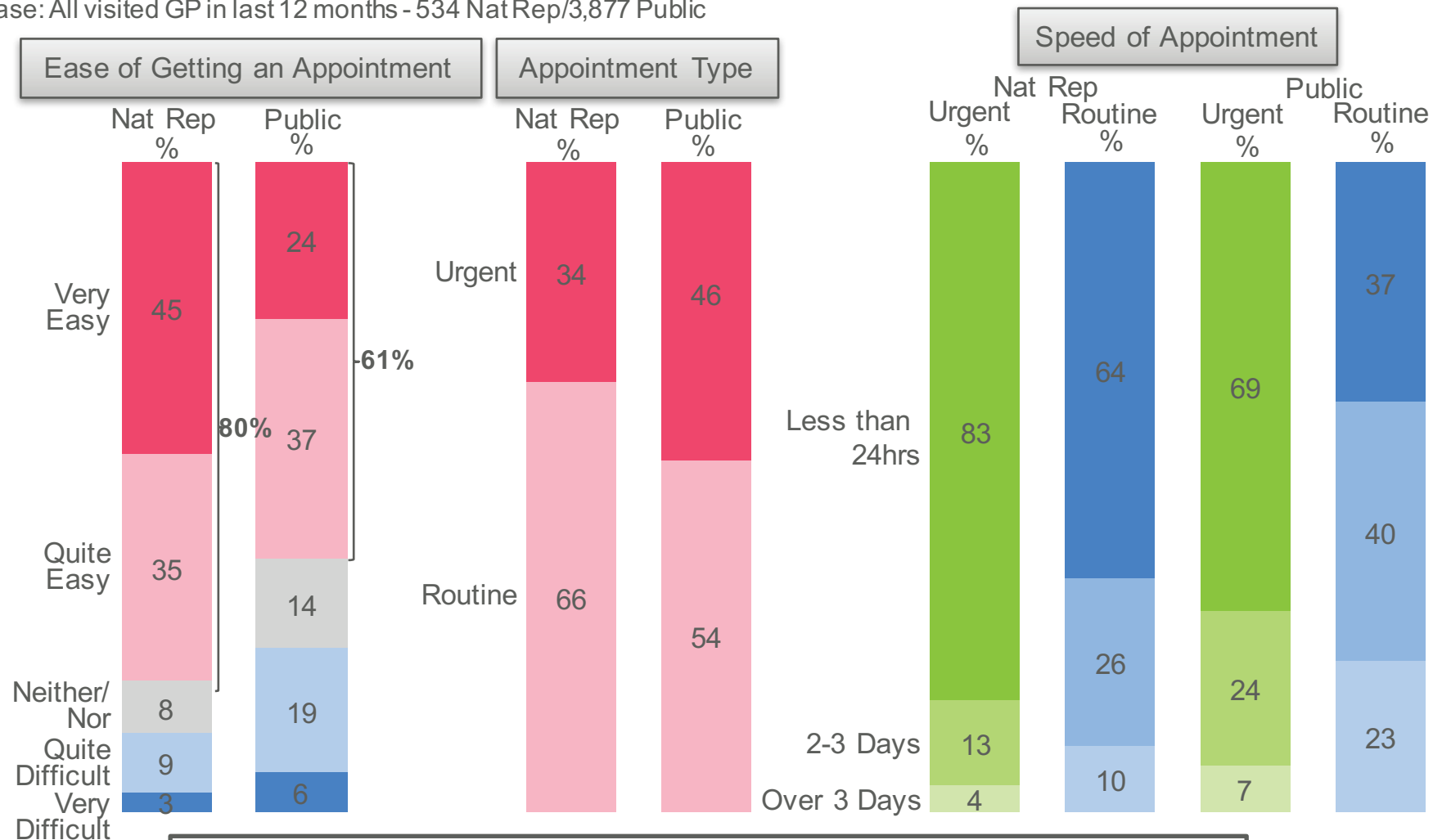


## 1.3 Access to GP



# Access to GP Appointment

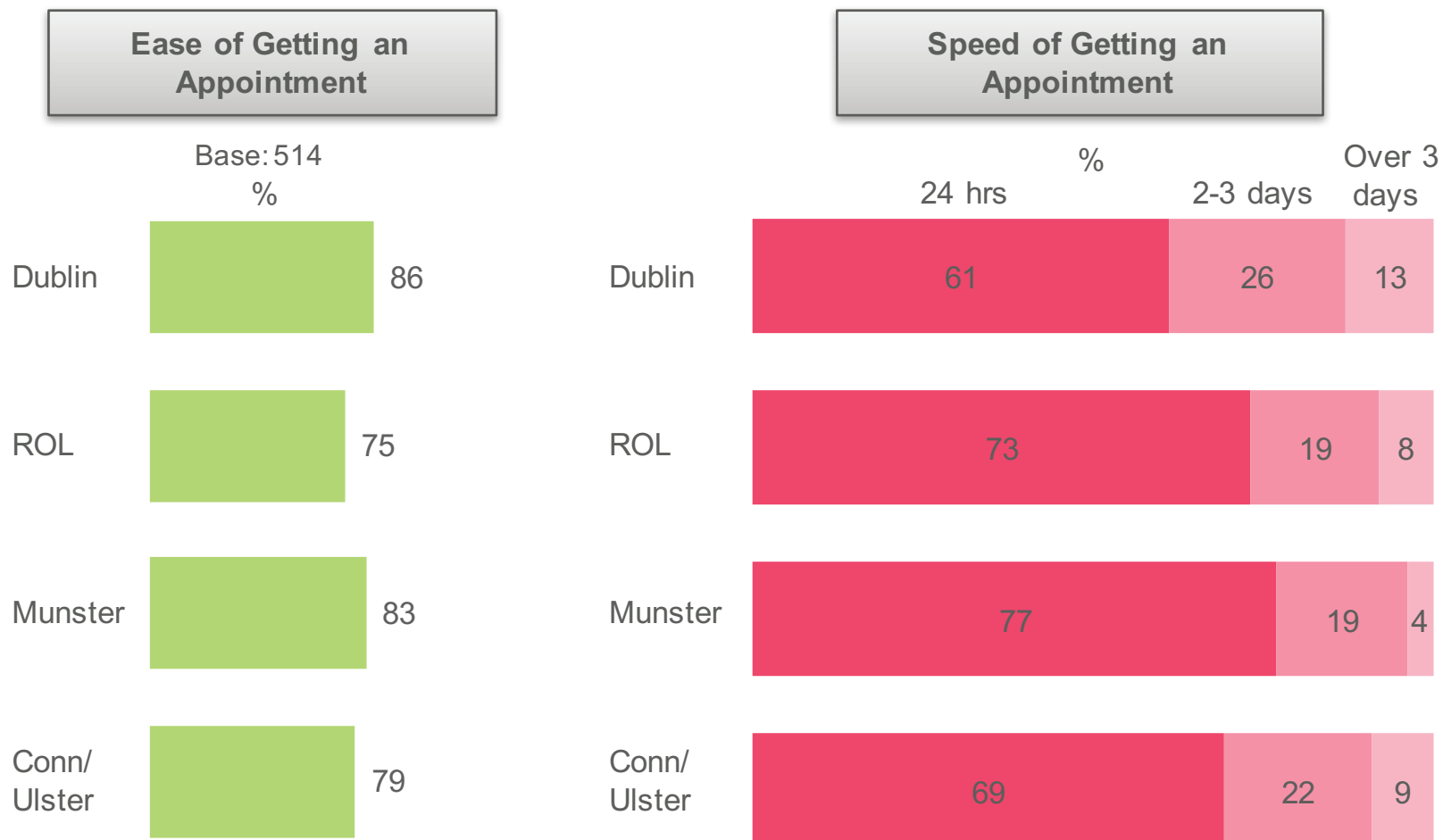
Base: All visited GP in last 12 months - 534 NatRep/3,877 Public



4 in 5 of the total population who have visited a GP in the last 12 months found it easy to get an appointment, with over 4 in 5 of urgent appointments accessed within 24 hours – down to 7 in 10 amongst the public survey population.

# Access to GP Appointment By Region (Nat Rep)

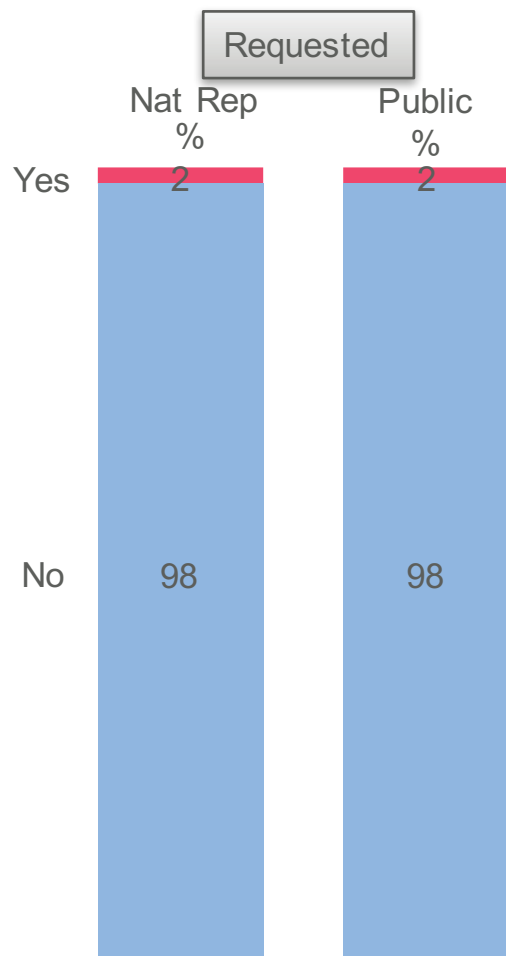
Base: All NatRep visited a GP in last 12 months – NatRep - 534



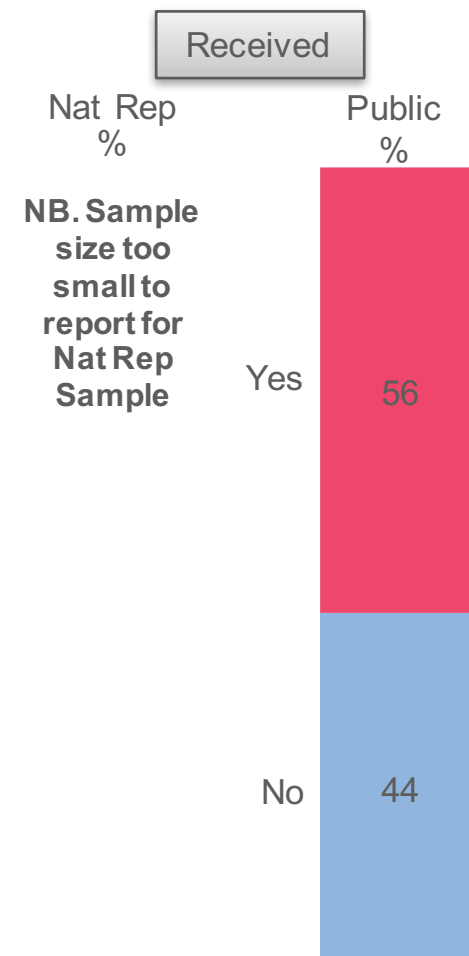
Those living in Dublin are most likely to claim that access to appointments is easy, however, those in Munster were most likely to get an appointment within 24 hours.

# Access to GP Appointment – Home Visits

Base: All visited GP in last 12 months - 534 Nat Rep/3,877 Public



Base: All requested home visit - 63

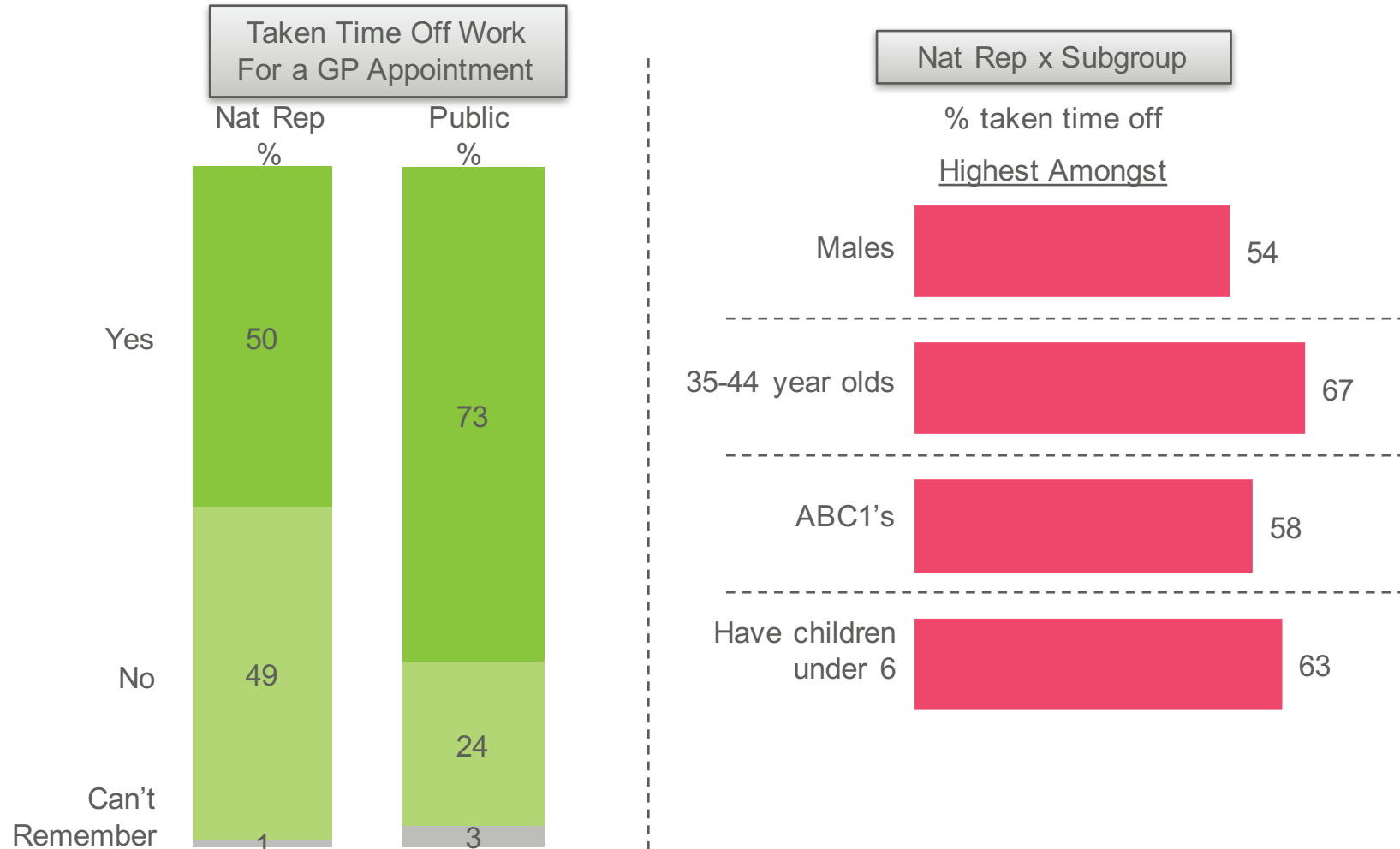


A small proportion requested a home visit for their most recent appointment, with 3 in 5 of the public sample receiving one.



# Access to GP Appointment – Opening Hours

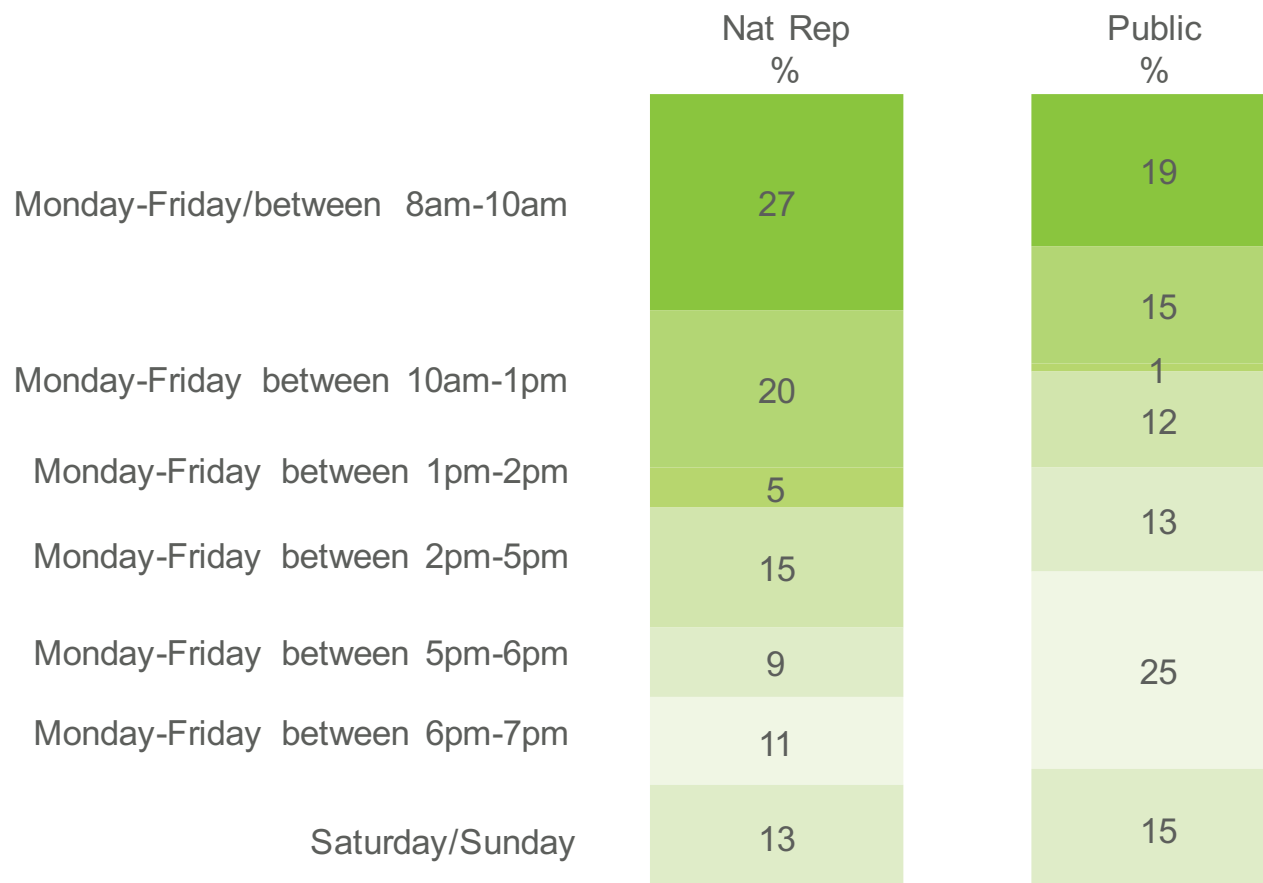
Base: All NatRep: 1,010/Public: 5,085



1 in 2 of the total population and 3 in 4 of the public survey have taken time off to visit the GP in the past. Again the public survey displays more access issues than the nationally representative sample.

## Access to GP Appointment – Most Suitable Appointment Time

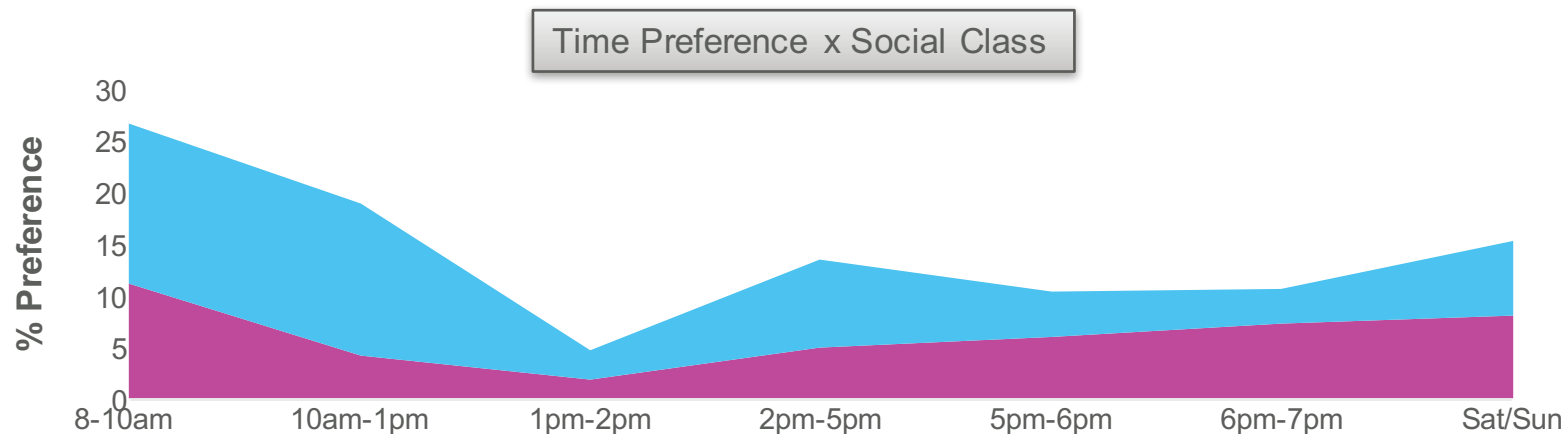
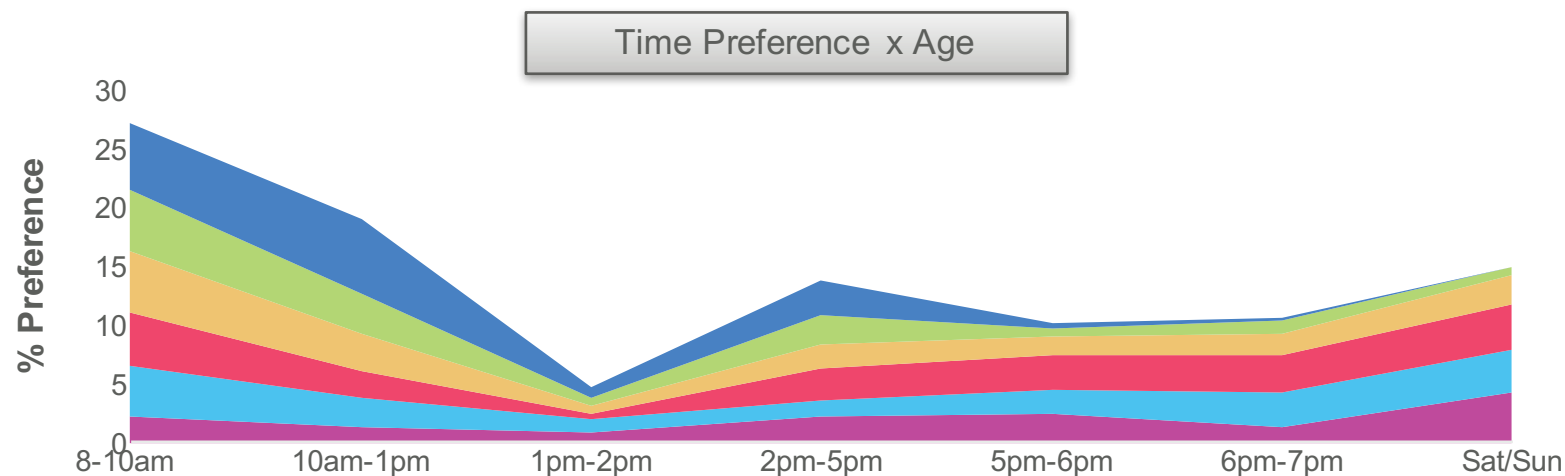
Base: All Nat Rep: 1,010/Public: 5,085



Amongst the total population, over 1 in 4 prefer early morning appointments with circa 1 in 10 opting for an appointment after 6pm. However, amongst the public survey population, a higher proportion prefer later appointments.

# Most Suitable Appointment Time x Sub Group

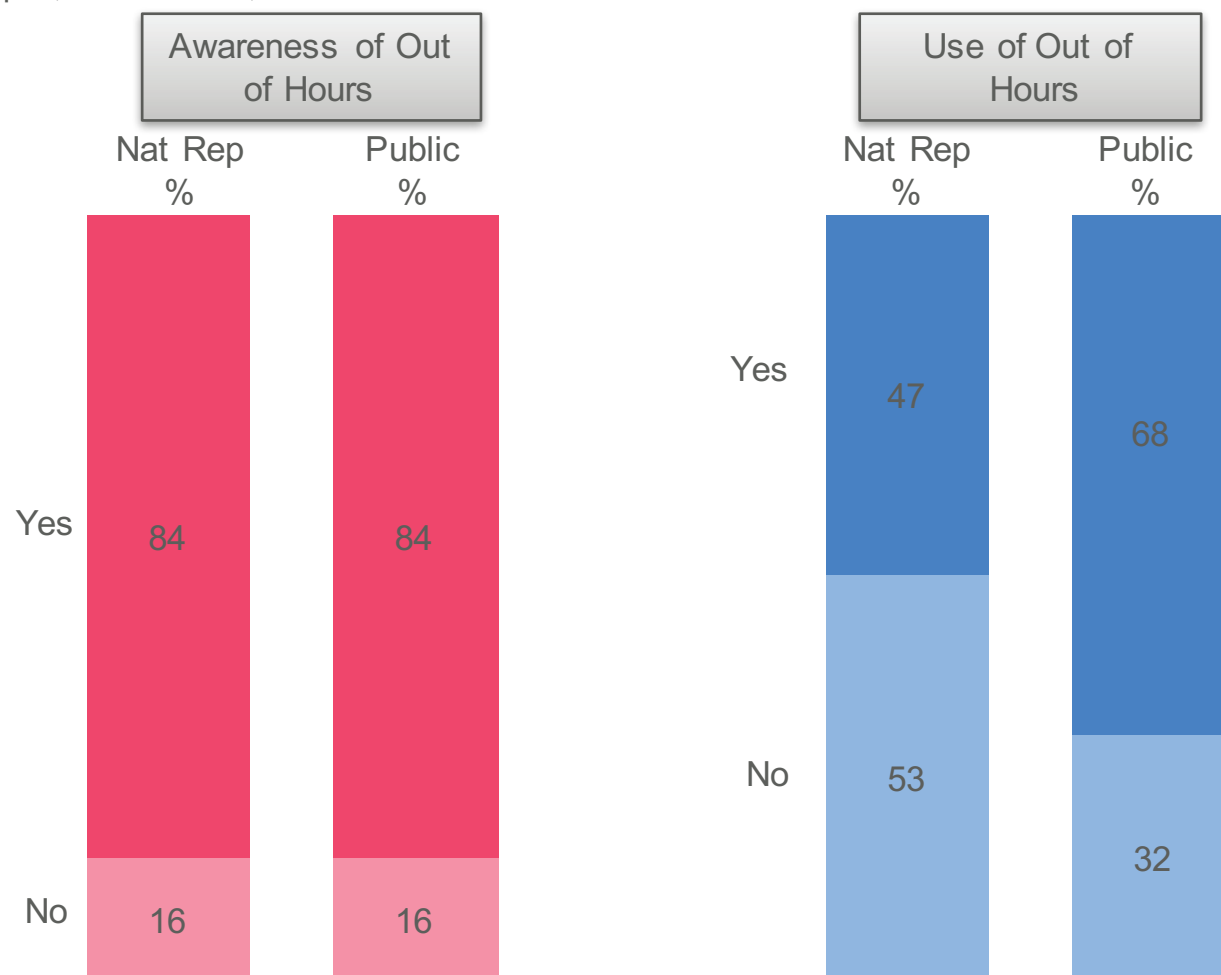
Base: All NatRep: 1,010



Older age cohorts and C2DE's most likely to preference morning appointments, whereas those under 35 and ABC1s drive the later evening and weekend preference.

# Out of Hours Service – Awareness and Usage

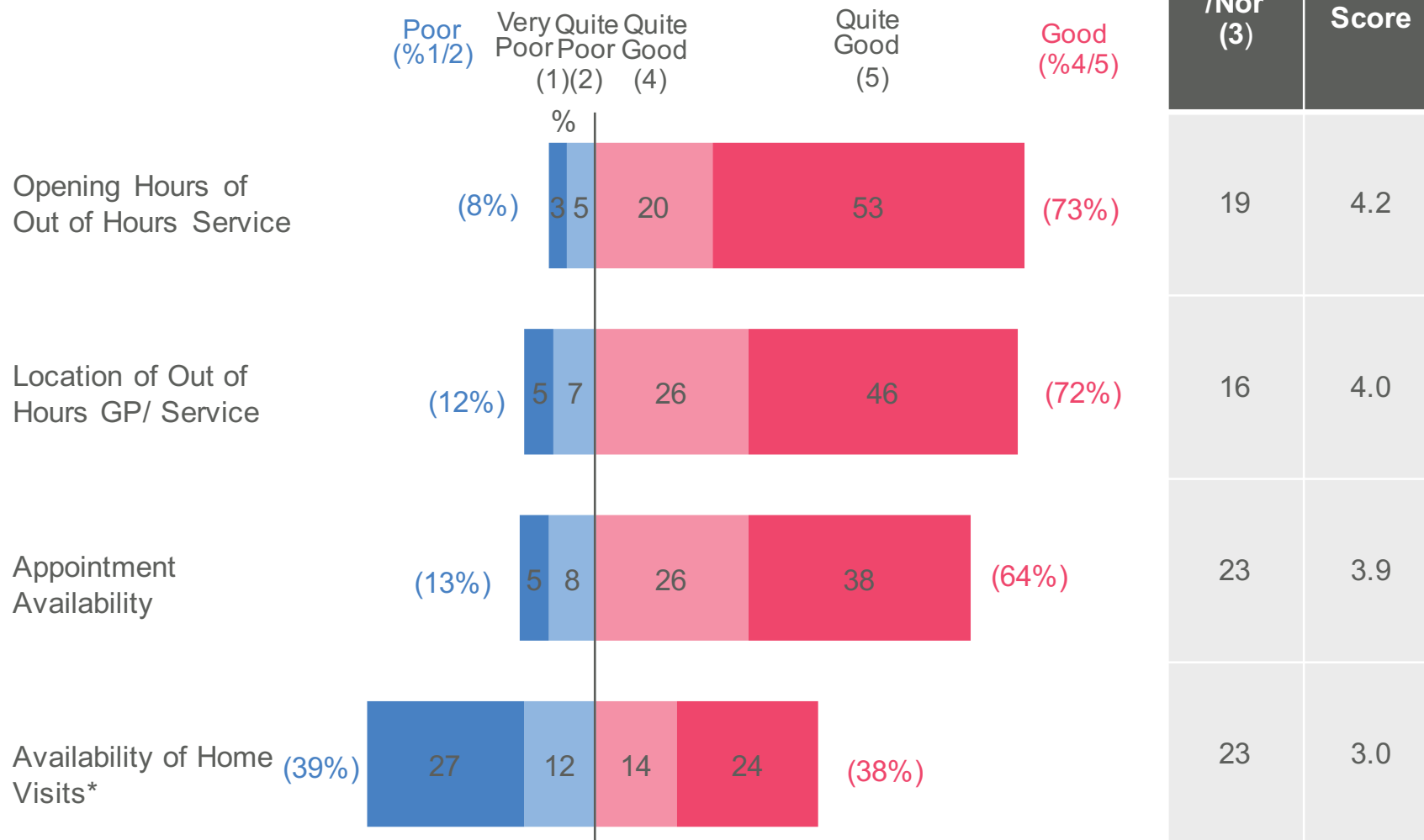
Base: All Nat Rep: 1,010/Public: 5,085



4 in 5 of both samples were aware of the out of hours service available from GP's with circa half of the total population and 7 in 10 of the public survey sample having ever used the service.

# Out of Hours Service – Rating (I)

Base: All used out of hours service - Nat Rep 477

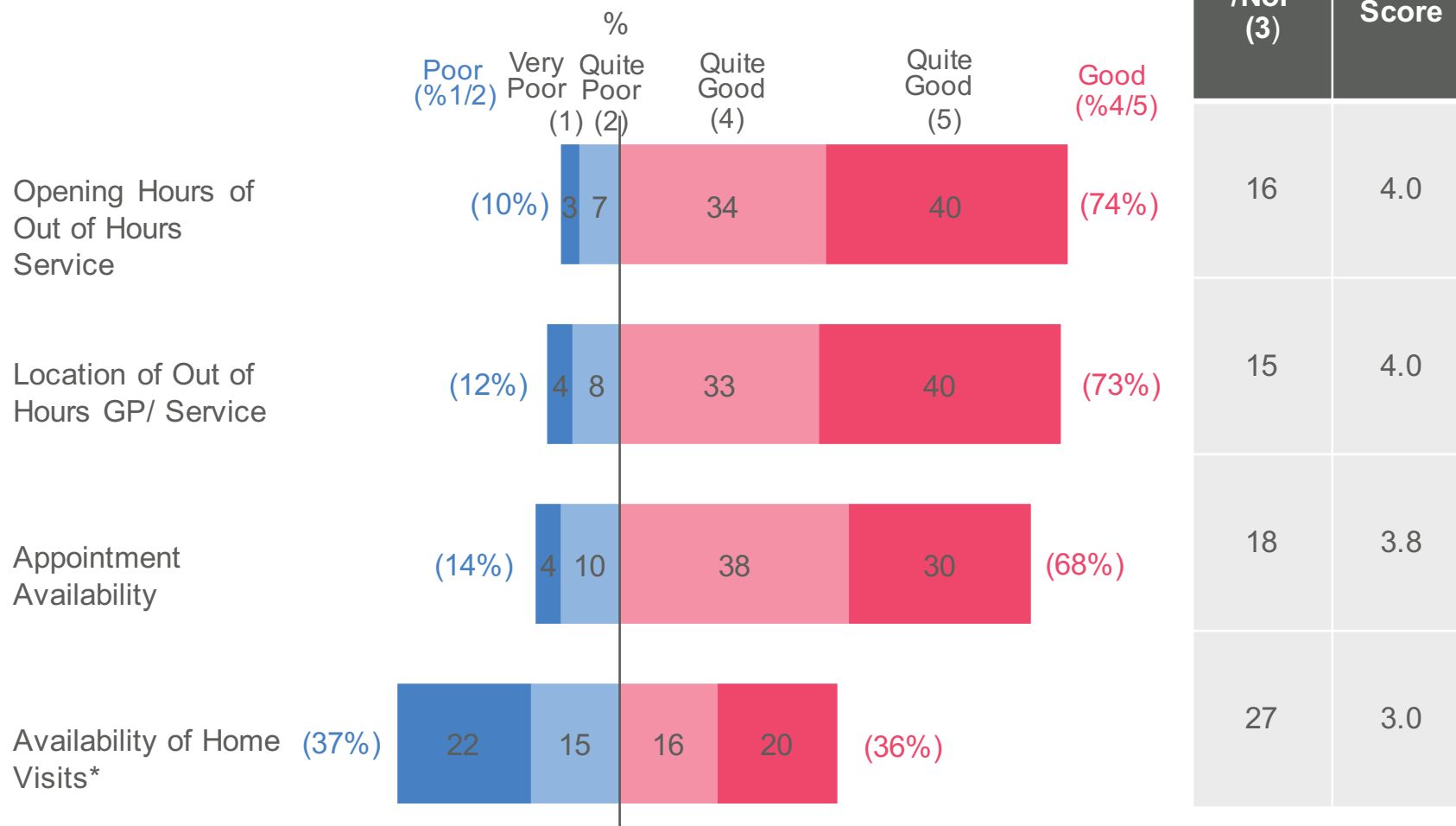


\* Base excludes N/A - 294

Accessibility of the out of hours service is positively rated, with 1 in 2 of the total population stating that opening hours are very good.

## Out of Hours Service – Rating (II)

Base: All used out of hours service – 3,439 Public

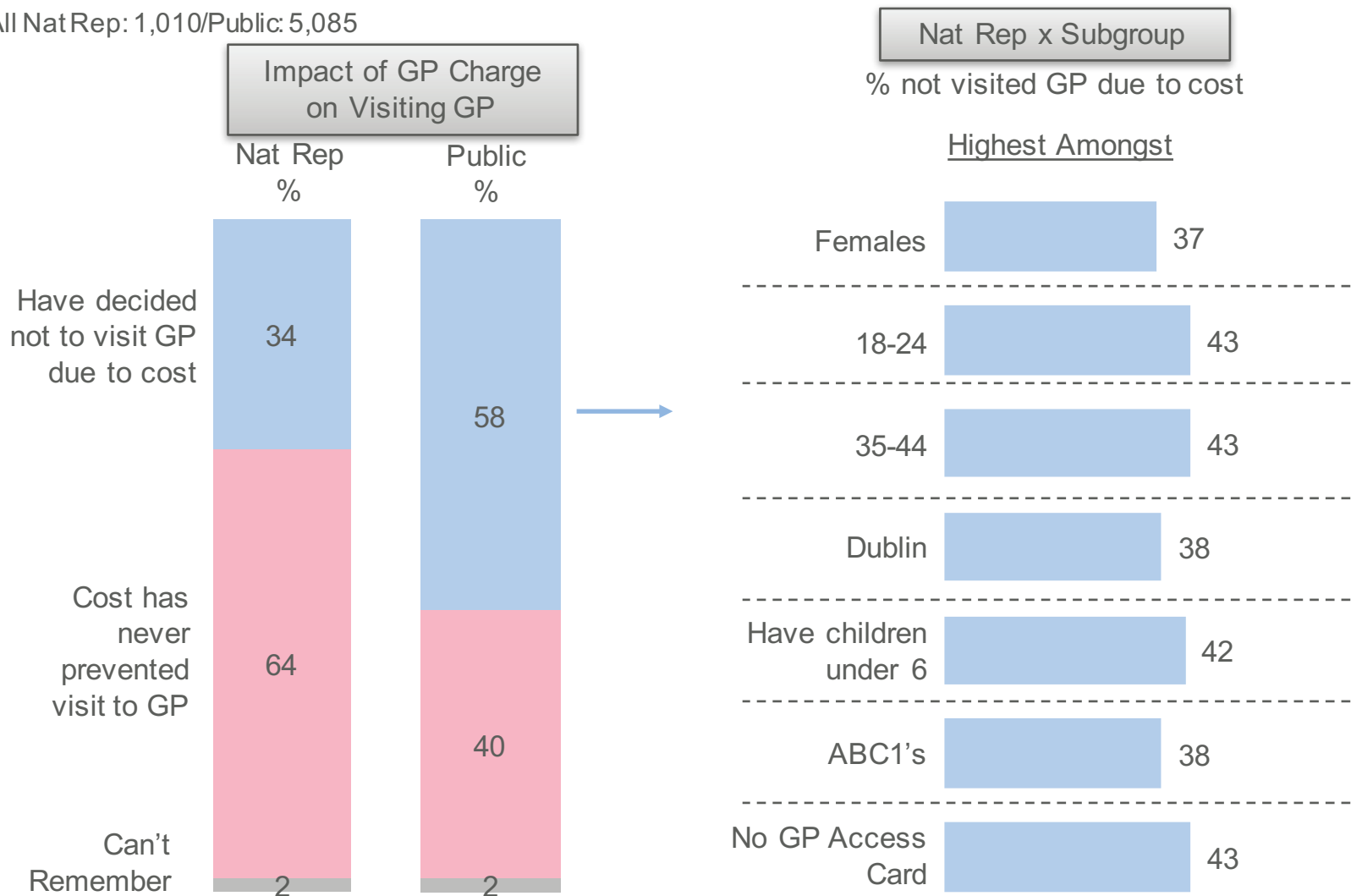


\* Base excludes N/A – 1,922

Satisfaction with out of hours accessibility is also high amongst users from the public survey sample. Availability of home visits as part of the out of hours services has the lowest rating, with over 1 in 3 rating this as poor.

# Access to GP Appointment - Cost

Base: All Nat Rep: 1,010/Public: 5,085



1 in 3 of the total population have previously decided not to go to the GP due to cost, higher amongst those paying for the service and younger age cohorts.

# Overview of GP Accessibility Rating (Qualitative)



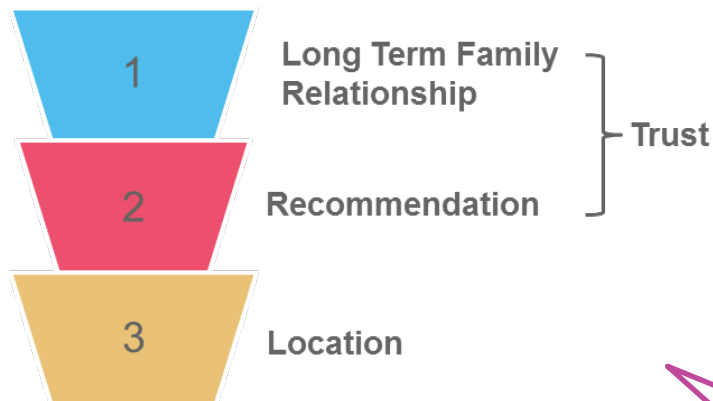


# GP Accessibility – I

## Finding a GP



- The majority find it easy to find a GP.
  - Minority referenced going on a waiting list to get into a GP that had been recommended to them, but alternative were available.
- Key facts impacting GP choice are:



- Young Singles who are living away from home are more likely to have chosen a GP based on recommendation and location. Whilst older age cohorts use their GP due to the established relationship.

*"Location as well. I was with a doctor in Patrick street but when I had Amelia there was no way I could drag her into town." Mums of Under 6s*

*"35-40 years, with the family doctor". Retirees*

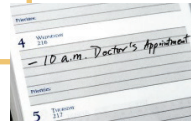
## Location & Access



- Overall satisfaction with the location of GP clinics is high. With GP practices accessed either by car or public transport.
  - Majority have been with their GP for a long time period so are familiar with the location.
- Diverse experiences regarding access to buildings.
  - Purpose built clinics praised for ease of access.
  - Those in older buildings (both Dublin and Cork) less accessible: stairs, smaller rooms, less parking.

# GP Accessibility – II

## Appointments



- Overall extremely positive experiences regarding access to appointments with the GP.
  - Those with children referenced being given priority treatment for urgent appointments.
  - Same day appointments available for majority.
  - Young Singles more likely to utilise the walk-in clinics. Visits are unplanned service considered to be accessible.

*"My Doctor, if you ring in the morning, you'll get an appointment that evening, guaranteed" Middle Aged Men*

*"I think it's essential, especially for kids. You need to know that if you ring up on a day you'll get an appointment." Mums of Under 6s*

*"Mine is a walk-in, it is Monday Wednesday and Friday up until 2 it is walk in." Young Singles*

## Opening Hours



- Current opening hours of the GP considered accessible by majority.
  - 8:30 or 9am – 5 or 6pm.
- Younger age cohort more likely to want longer opening hours to fit around work and childcare arrangements.
  - Spontaneous references to wanting later evening/and or appointments on a Saturday.
- In addition many referenced flexibility of individual doctors in seeing them if needed e.g. staying past 6pm or fitting them in first thing.

*"I would have to get an appointment for either Thursday or Friday in the evening after work" Young Singles*

*"Walk in services are great you can make appointments too, he'd stay on if he had to." Retirees*

*"You can't expect them to be open 24/7" Middle Aged Men*

# GP Accessibility – III

## Home Visits



- Younger age cohorts less likely to have awareness or experience of this service offering.
- Considered more important amongst older age cohorts.
- Varied experiences of availability and use of home visits.
  - Niche minority have used regularly and were extremely positive about their experiences.

*"Home visits, ring in the morning they'll be down 12.30/1 in the day.." Middle Aged Men*

*"Southdoc is a bit of a disaster, it's a different doctor every time". Retirees*

*"I wouldn't say they're brilliant. I wouldn't feel 100% confident that they've fixed my problem when I come out." Mums of Under 6s*

## Out of Hours Service



- Vast majority aware of the out of hours service – D-Doc and South Doc.
- Majority of older age cohorts have some experience of the out of hours service.
- Again differing experiences from individuals within the groups regarding service provisions.
  - Majority would avoid using the service if at all possible due to:
    - Lack of consistency of service.
    - Use of locums causes uncertainty.
  - All would expect some form of out of hours service, however, overall understanding that access to your own GP and clinic is unlikely to be feasible at all times.

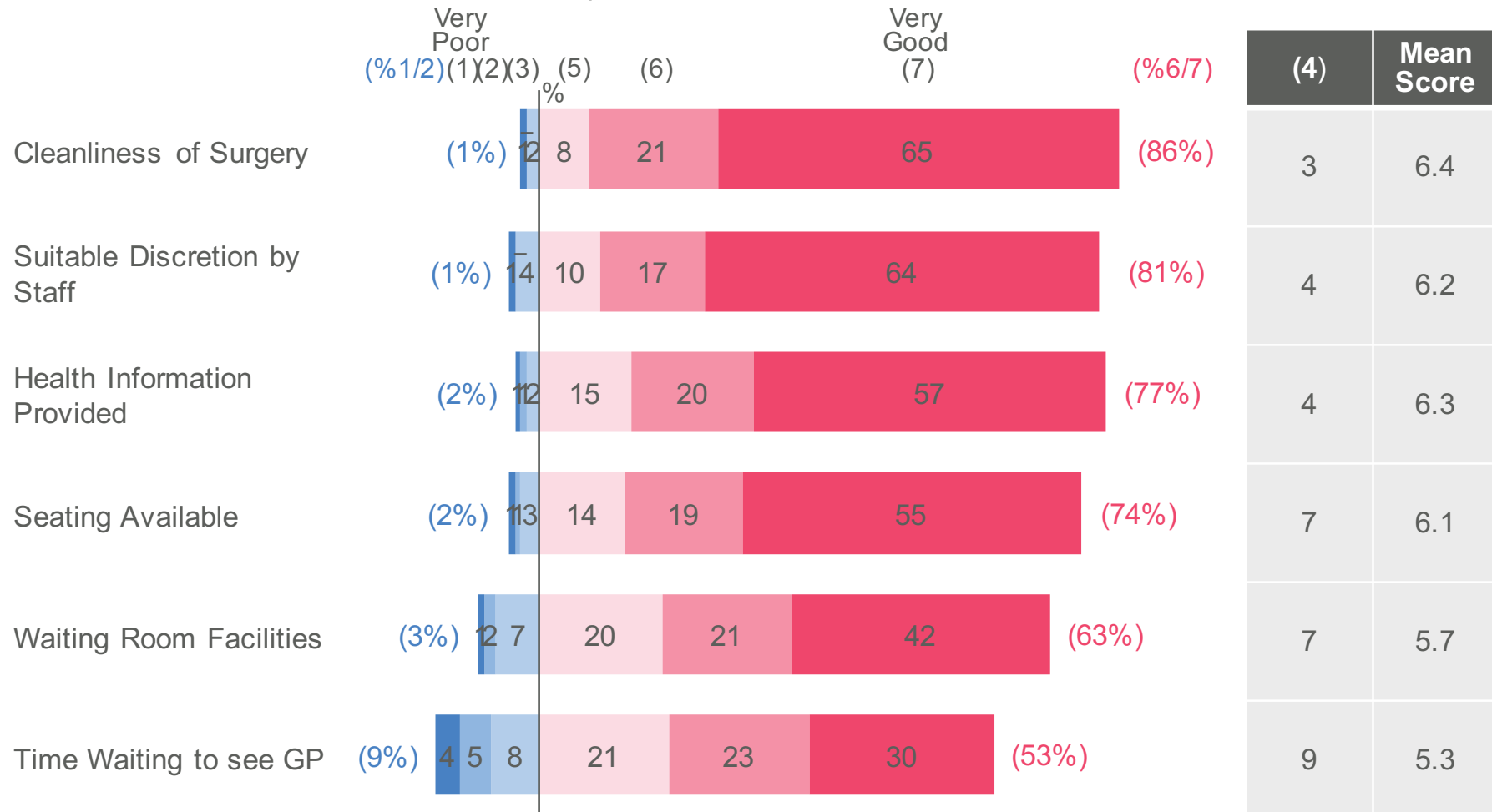
*"D doc is a super service." Middle Aged Men*



## 1.4 GP Facilities

## Rating of Experience – Facilities (Nat Rep)

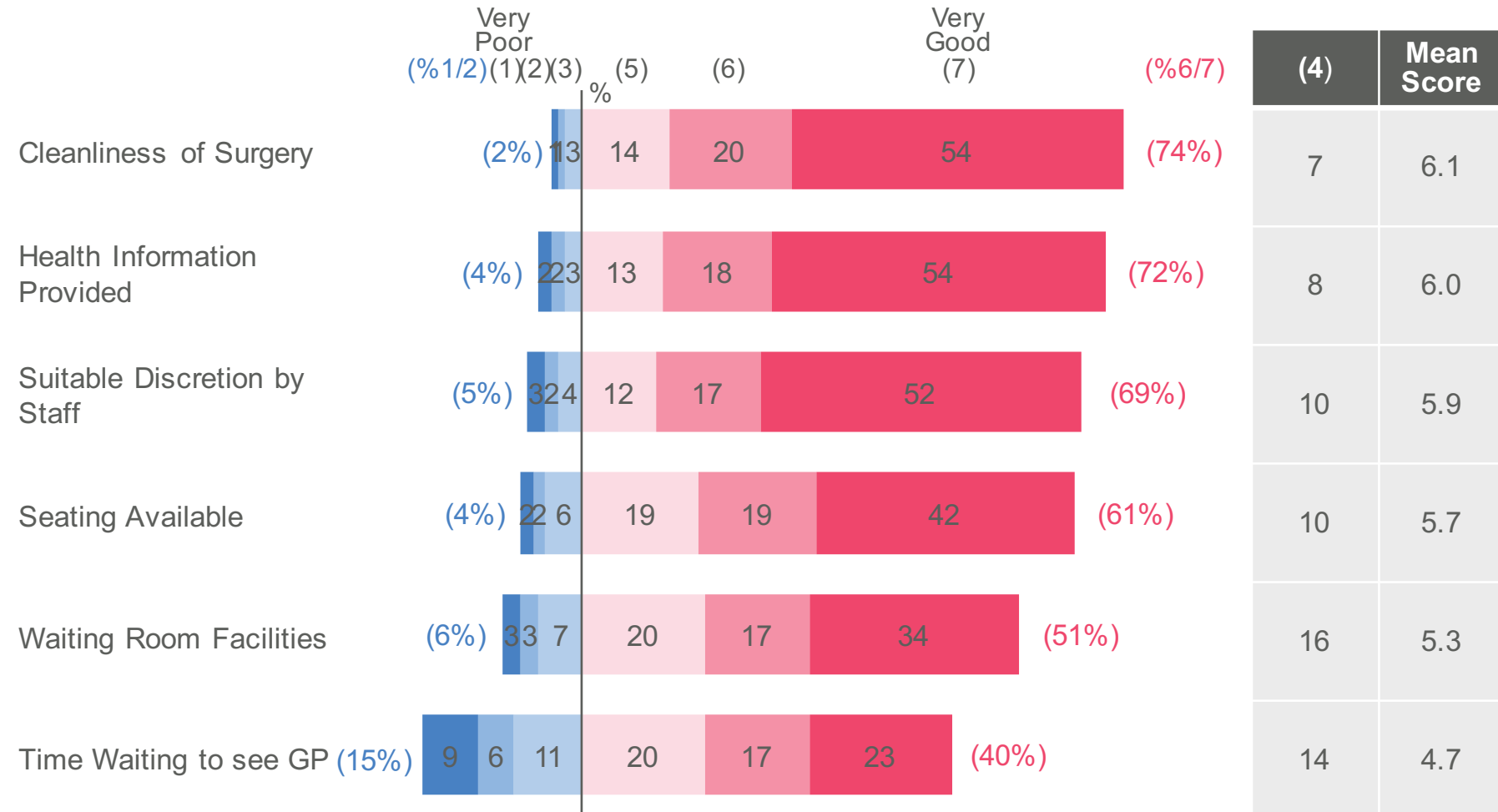
Base: All visited GP in last 12 months - 529 Nat Rep



Overall, very positive rating of facilities during most recent visit, especially in terms of cleanliness and discretion of staff. However, circa 1 in 10 were unfavourable towards the amount the time waiting to see a GP.

## Rating of Experience – Facilities (Public)

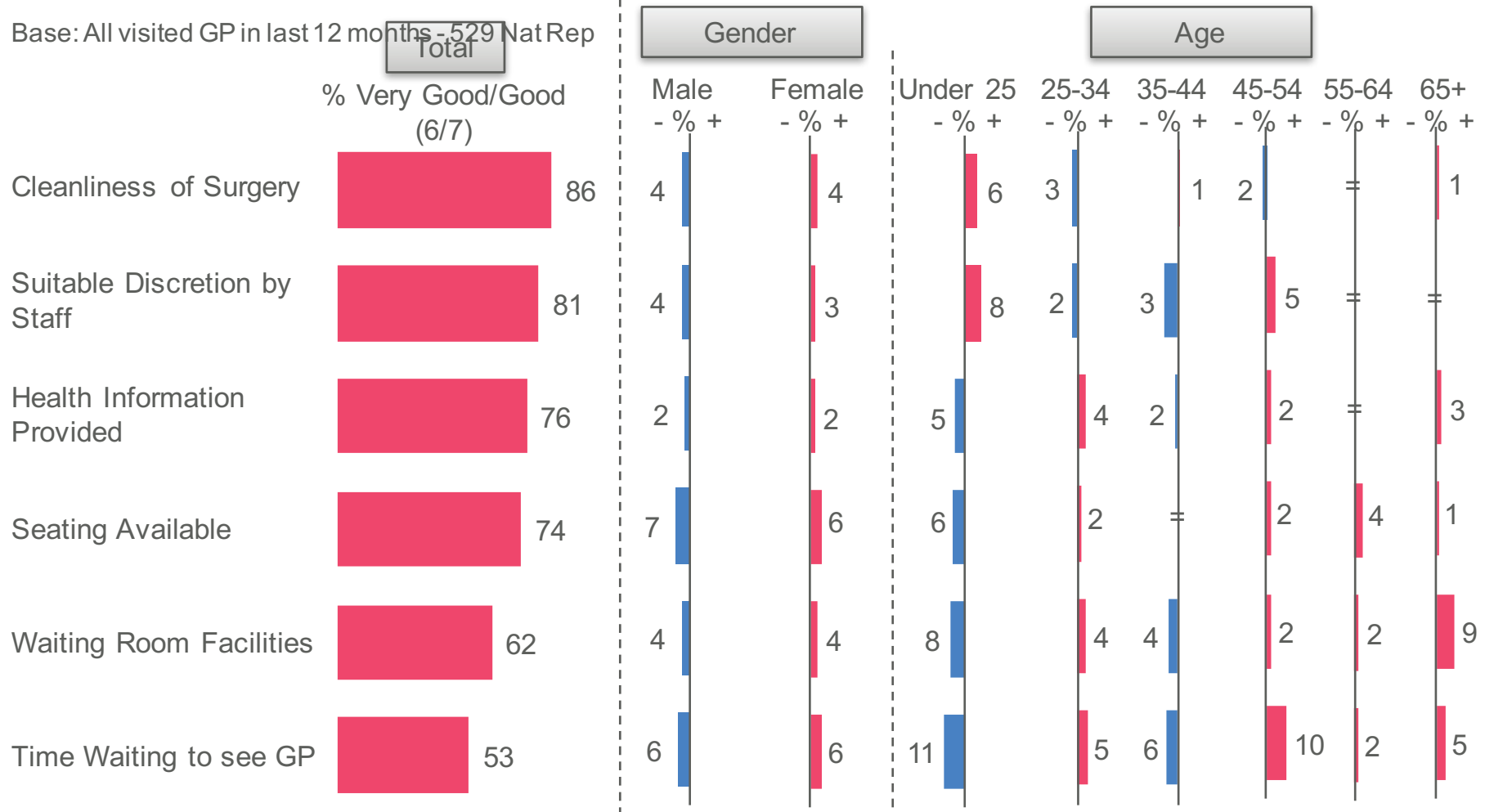
Base: All visited GP in last 12 months – 3,842 Public



Satisfaction levels lower amongst the public survey population, however, overall positive ratings with waiting room facilities and again time waiting to see the GP driving lowest satisfaction, with only 2 in 5 very/quite satisfied.

# Rating of Facilities x Demographics (Nat Rep)

Base: All visited GP in last 12 months - 529 Nat Rep

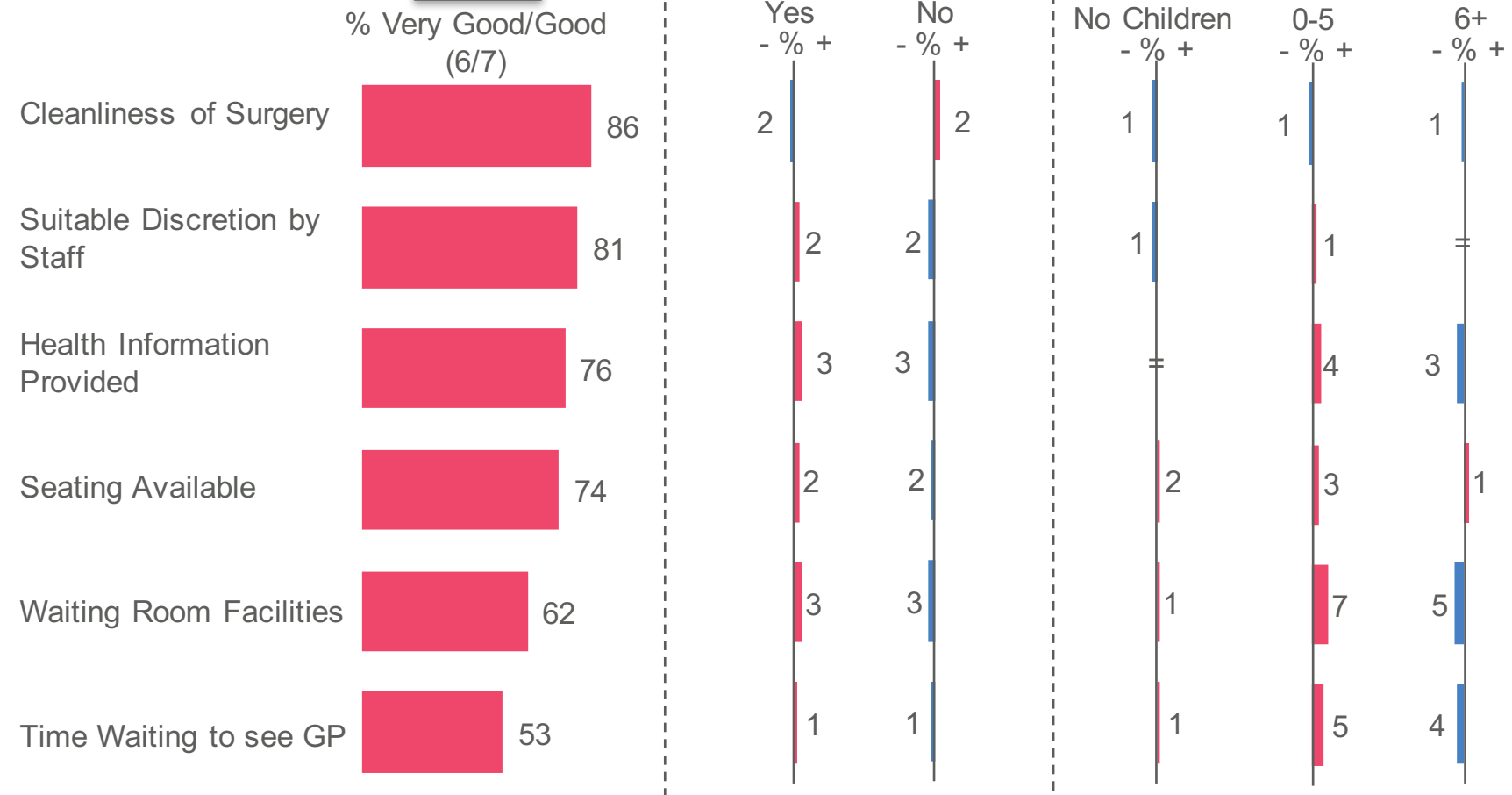


Overall males are notably more dissatisfied with facilities. Those under 25 are notably more likely to be dissatisfied with waiting times.



## Rating of Facilities x Demographics

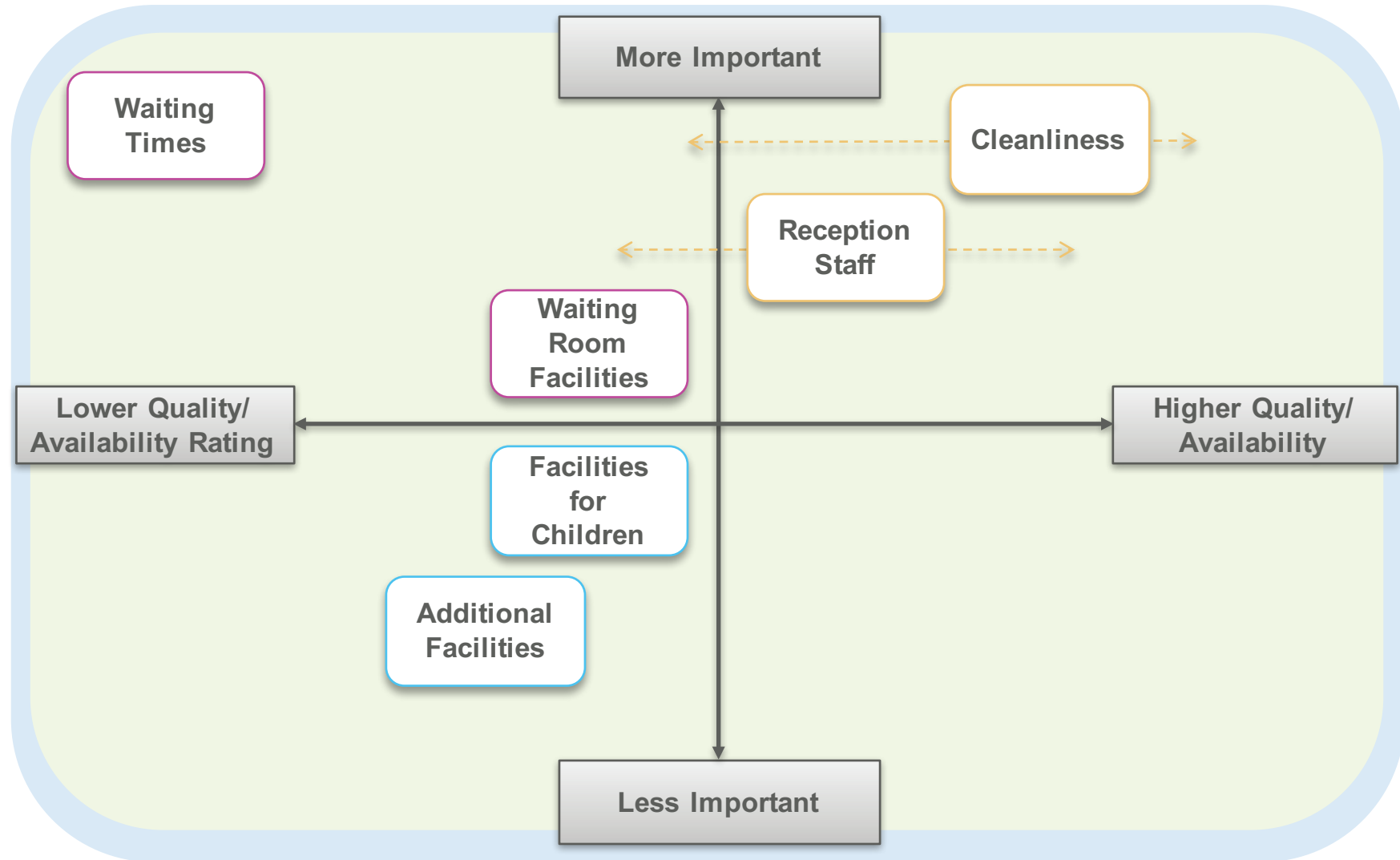
Base: All visited GP in last 12 months - 529 Nat Rep



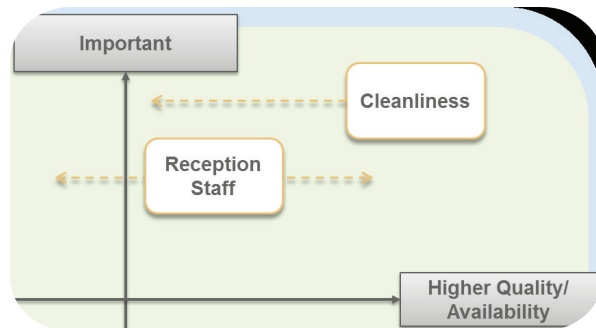
Parents with children between the ages of 0-5 are most content with waiting room facilities (69%) and time spent waiting to see the GP (58%).



# Overview of Rating of GP Facilities (Qualitative)



# Rating of GP Facilities – I



*"Mine is in an old house, it has a 12 inch telly up in the corner, loads of kids running around. It is out of date, it is just a horrible place to be" Young Singles*

## Reception Staff

- As the 'face of the surgery', reception staff are considered key to the initial impressions and experiences of patients.
- Positive experience more evident amongst those who have an established relationship with their GP and therefore often the receptionist too.
  - Important for them to have some knowledge/awareness of patient requirements to ensure they can handle requests appropriately.
- Again, niche cohort had bad experiences with reception staff. Driven by:
  - Lack of empathy/understanding
  - Impoliteness
  - Impatience.

## Cleanliness

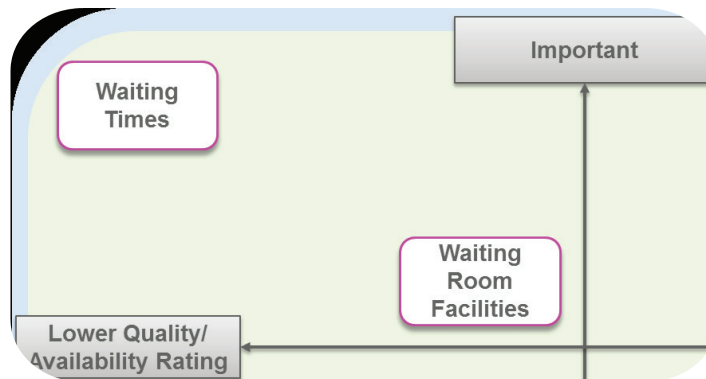
*"It is clean enough". Young Singles*

- All would expect a basic level of cleanliness and hygiene within a GP surgery.
- Cleanliness varied by location and practice size.
  - Overall positive ratings of cleanliness within practices which would be considered a basic requirement for any GP surgery.
  - Smaller practices more likely to be in older buildings/houses with less modern decoration and therefore feel less clean or fresh.
    - Niche minority had negative experiences in previous practices where lack of cleanliness/hygiene drove them to leave the practice.

*"Receptionists are the face of the practice, if she has a bad attitude, it puts you off." Middle Aged Men*

# Rating of GP Facilities – II

## Waiting Times



*"I just don't understand the waiting. You're first in and you're still waiting there an hour later"* Mums of Under 6s

*"I was in and out in half an hour because there was so many doctors".* Retirees

- Universal agreement that waiting times can be too long and unpredictable.

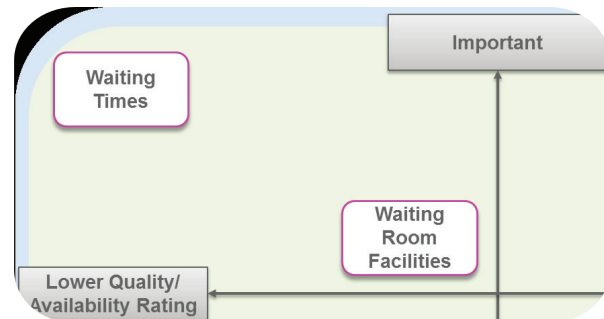
- Majority are understanding of the situation, however, would prefer this to be managed by GP Surgeries
  - e.g. update on current wait time, widespread praise for practices that pre-warn patients if delays are circa 30 minutes or more.
- Higher dissatisfaction with wait times evident amongst younger age cohort, who are more likely to be paying to see the GP.

*"My doctor is very expensive, she is €65, and if you want more than 15 minutes you have to make two appointments, that is €130 and they don't check you out properly; you are only in there for two minutes.* Young Singles

*"A few years ago my Dad got a phone call to say they were running behind so that was great!"* Young Singles

# Rating of GP Facilities – III

*"Our walk in place has no baby change area. That's just a very basic requirement" Mums of Under 6s*



*"There's water fountains and it's nice and warm too." Mums of Under 6s*

## Waiting Room Facilities

*"There is not enough seating in my one, if somebody older comes in or somebody is taking up a few seats because they have kids or whatever." Young Singles*

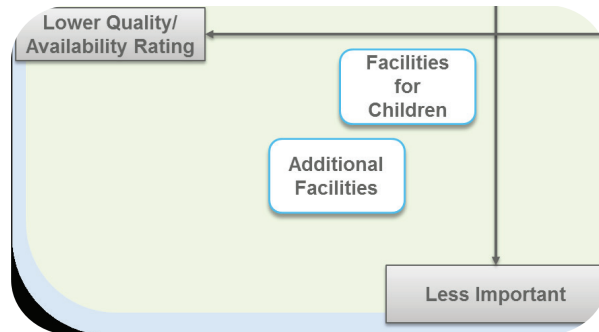
- Existing waiting room facilities vary greatly by individual practice.

- Service users key priorities are:

1. Adequate seating – enable all patients to sit down. Majority were unsatisfied with the current offering. Niche minority (mainly in older buildings) felt offering was lacking.
2. W/C and baby changing facilities – considered essential, especially with ill patients.
  - Mums referred to lack of changing facilities as being a key driver of dissatisfaction.
3. Suitable space/privacy – in an environment where patients are ill and sharing personal information, adequate space is required.
  - Again, those in older buildings are more likely to encounter problems e.g. being able to hear patient in with the GP.
4. Information leaflets/health information – all referenced availability of health information in the waiting rooms. Considered part of the offering of a GP as a healthcare provider.
  - However quality and volume varies from poster to multiple leaflets that can be taken away and up to date information on screen.
5. Water – not expected but does improve patient experience.
  - Again fee payers are more expectant regarding facilities.
6. Other entertainment – majority happy with current entertainment offering, ranging from magazines to Sky TV!

*"Sky news is always on in my practice." Middle Aged Men*

# Rating of GP Facilities – IV



*"There needs to be facilities for children. They should change it up."* Mums of Under 6s

## Facilities for Children

Again evident variation by practice.

- From no facilities or entertainment to a specific area with colouring charts and toys for children.
- Understandably parents place a higher importance on this, however, those without children also want children to be quiet/entertained.
- Majority of patients reference often taking their own entertainment, so expectations of provision are relatively low.
- In addition toys in GP surgery's are often negatively associated with transmitting germs.

*"It's nice to have good facilities for children."*  
Young Singles

## Additional Facilities

- Low experience of, and expectations of, any additional facilities being available in GP surgeries such as blood pressure checkers.
- Service users did not have any other requirements – priority would be access and clinical expertise.

*"There's no blood checker in my practice".*  
Retirees

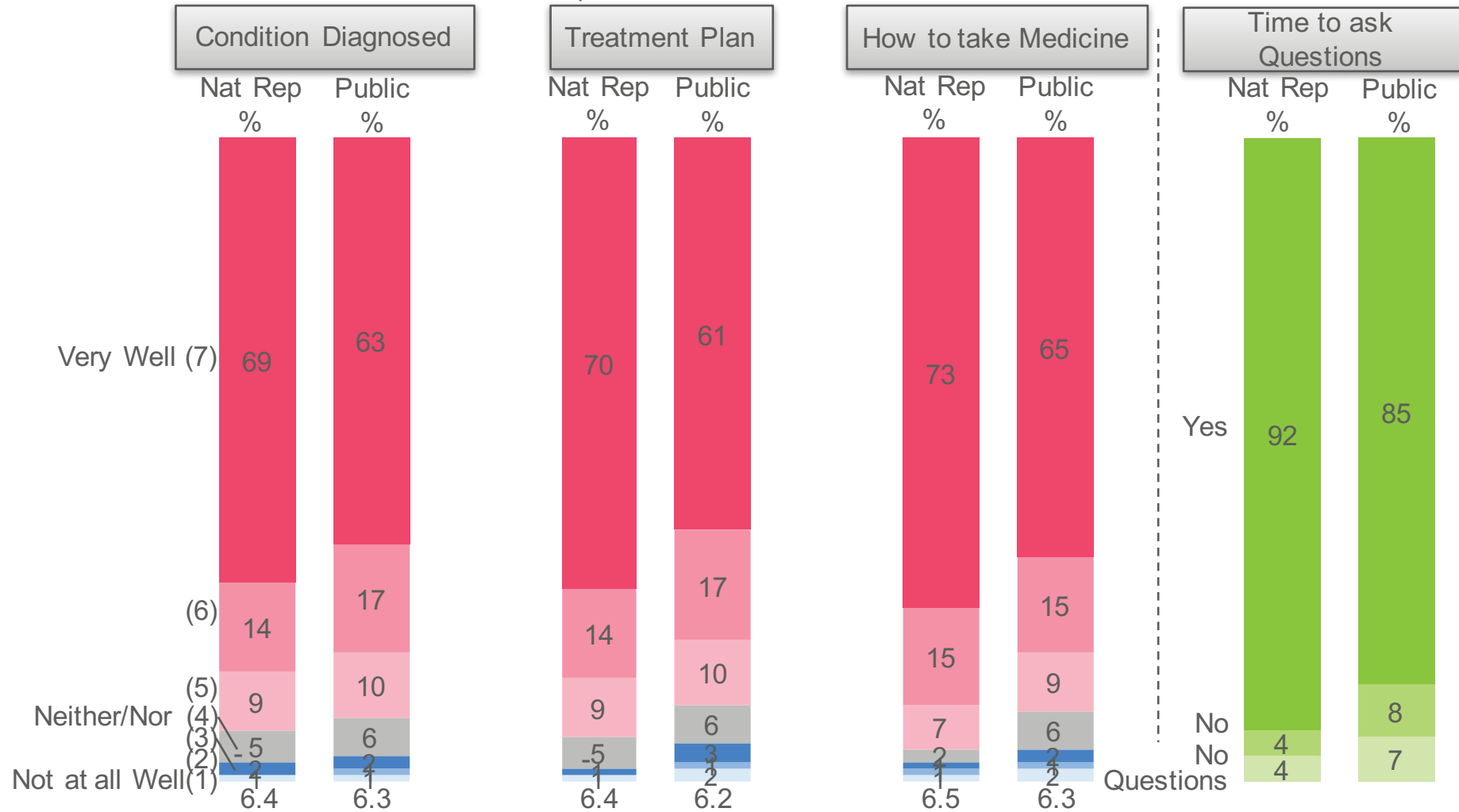


## 1.5 Appointment Experience

# Understanding Following Appointment

Base: All visited GP in last 12 months - 534 NatRep/3,877 Public

\*Based on all question was applicable to

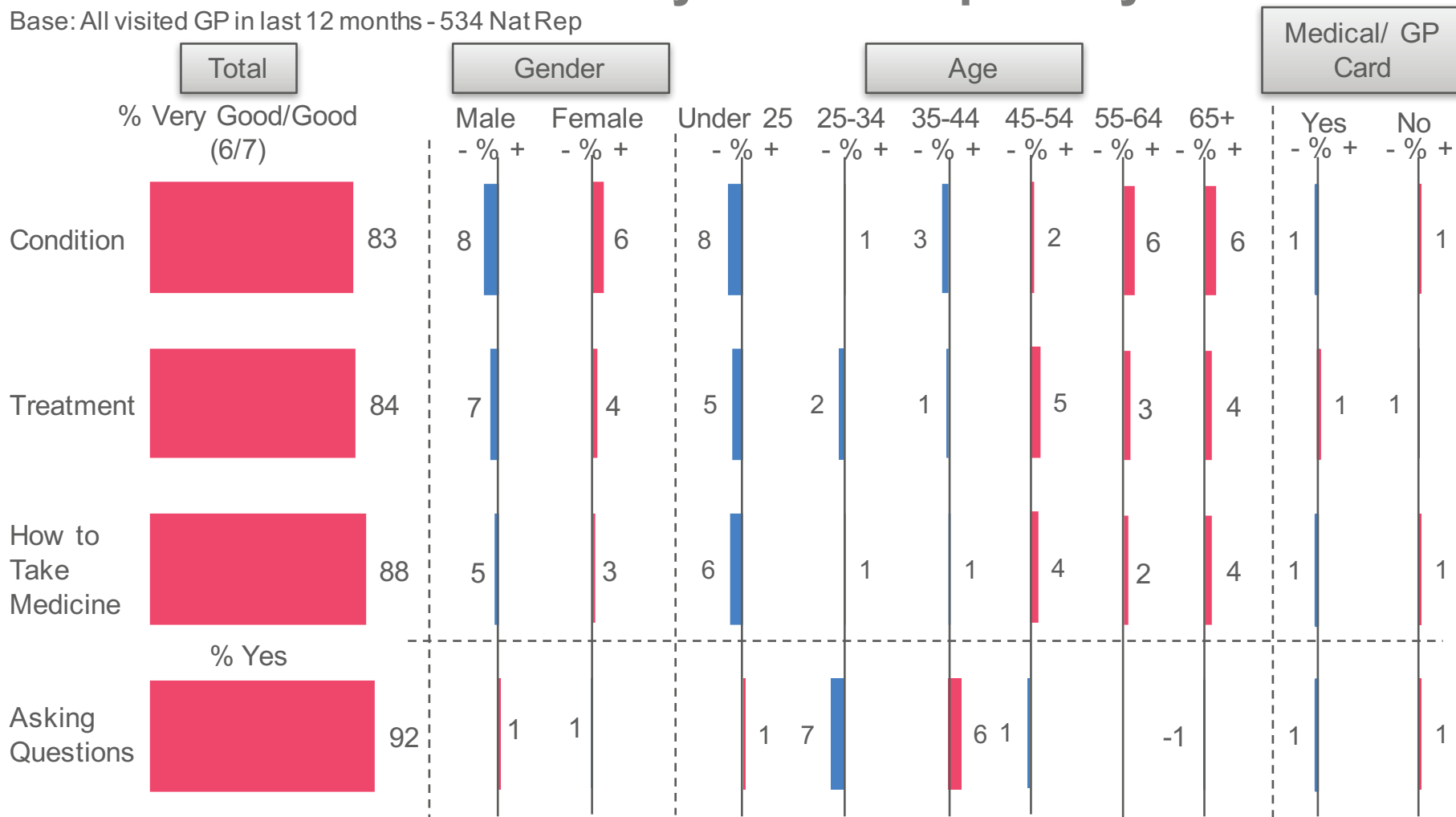


Overall, quality of communication from GPs is high with over 4 in 5 understanding diagnosis, treatment plan and medication instructions.



# Understanding Following Appointment By Sub Group Analysis

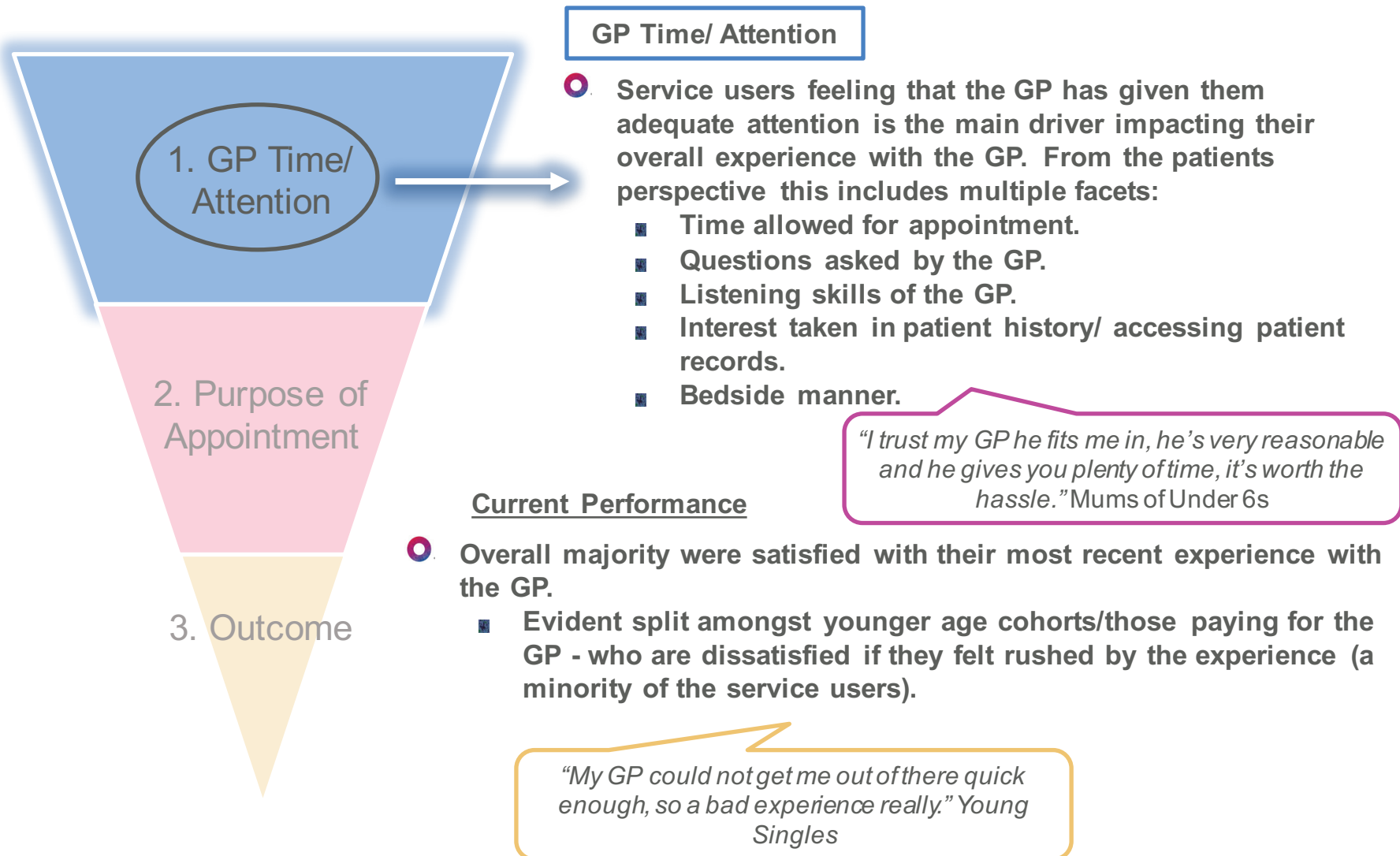
Base: All visited GP in last 12 months - 534 NatRep



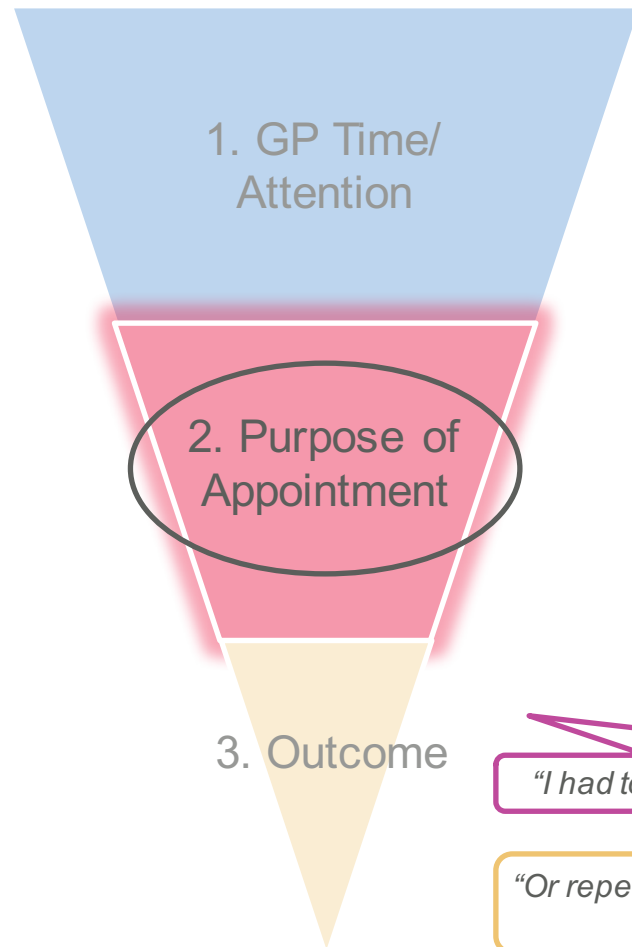
Younger age cohorts and those without a medical or GP card are more likely to be dissatisfied with appointment experience, particularly understanding of how to take medicine.



# Factors Impacting on Appointment Experience – I (Qualitative)



# Factors Impacting an Appointment Experience – II (Qualitative)



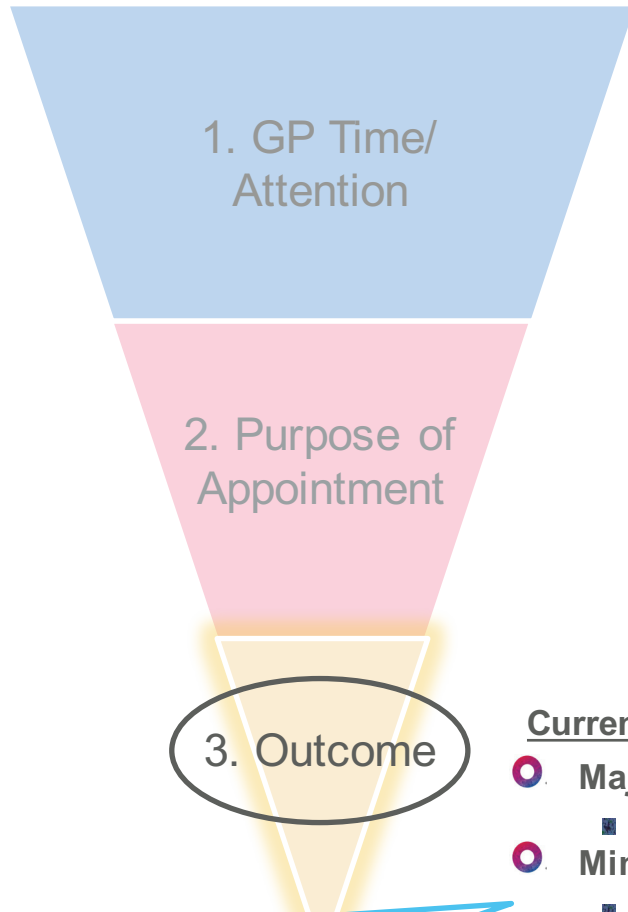
## Purpose of Appointment

- Patients visiting the GP for a repeat prescription versus those visiting for a complex illness have different levels of expectation and requirements.
  - However, majority feel like all patients are treated the same.
    - Some suggested a form of triage service to identify patients that could be dealt with outside of a GP appointment e.g. by a nurse or just requiring a signature.
  - In addition those paying would prefer to pay for what they receive i.e. appointments for repeat prescriptions that last 5 minutes should cost less than an appointment requiring a detailed assessment, lasting 15-20 minutes or more.

*"I had to pay €10 to ring in a prescription." Mums of Under 6s*

*"Or repeat prescriptions, maybe it should be €10 to collect at the desk, something like that." Young Singles*

# Factors Impacting on Appointment Experience – III (Qualitative)



*"He always makes sure to tell me why he's prescribed the medicine to the kids."*  
Middle Aged Men

## Outcome

*"When you are paying €50 you are entitled to ask questions." Young Singles*

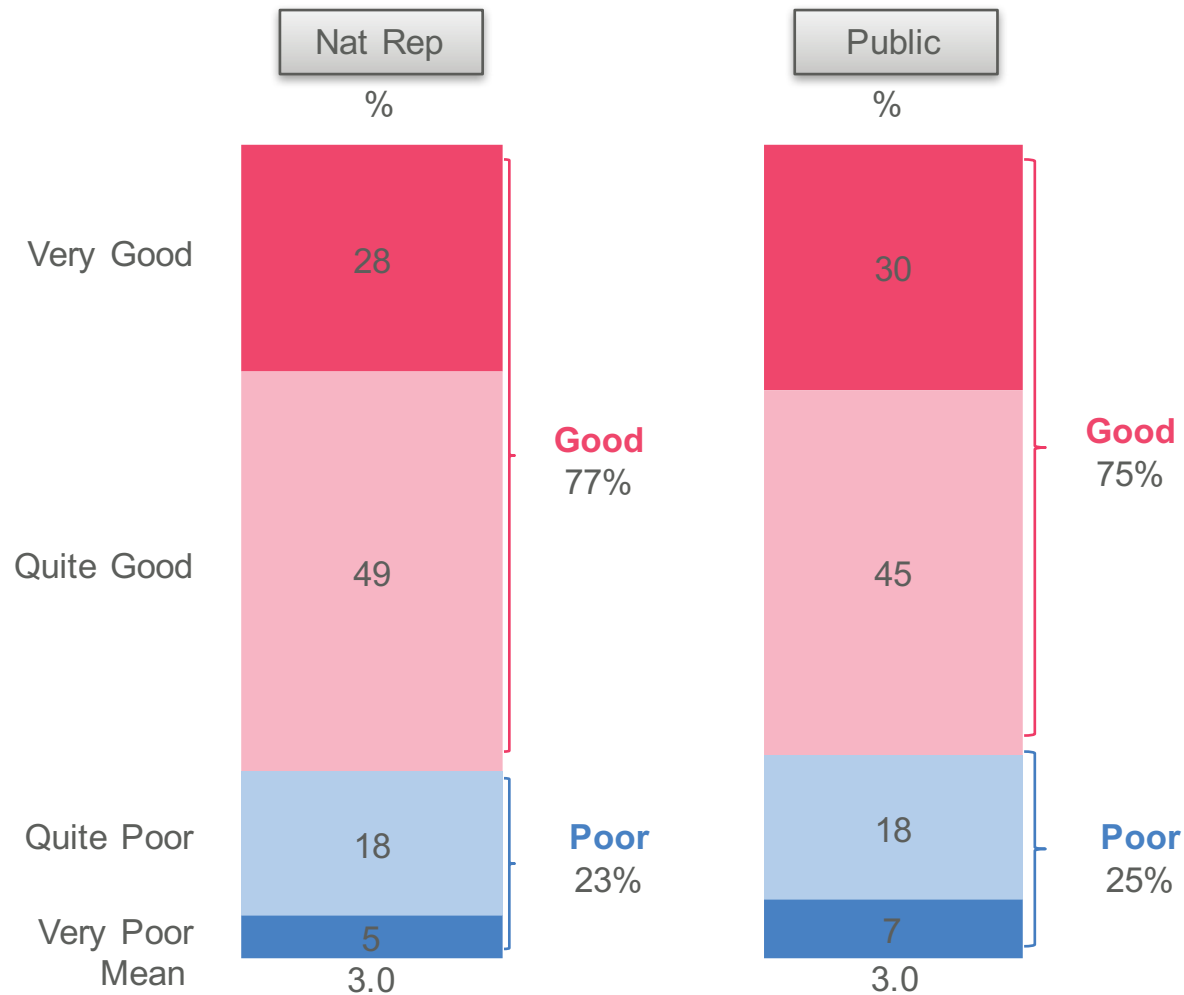
- The outcome of the appointment will also impact on overall experience and satisfaction.
- Service users are more positive if they feel a solution has been offered e.g. prescription given, diagnosis made.
  - This was particularly evident amongst those who had paid a fee – they wanted something to show for it. Viewing it as a more transactional relationship despite it being about their health.
- GP's communication of their diagnosis, explanation of action to take etc. is key to driving satisfaction with 'outcome'.
  - In addition those paying for the GP service are more likely to be dissatisfied if they have to pay for bloods or other additional services.

## Current Performance

- Majority were happy with the outcome.
  - Felt they understood what GP had done and why.
- Minority were dissatisfied.
  - Either given antibiotics and didn't understand why or not given antibiotics and didn't understand why not
  - Dissatisfaction driven by lack of clarity in GP communication.

# Value for Money of Recent Visit to GP (Amongst Those Paying)

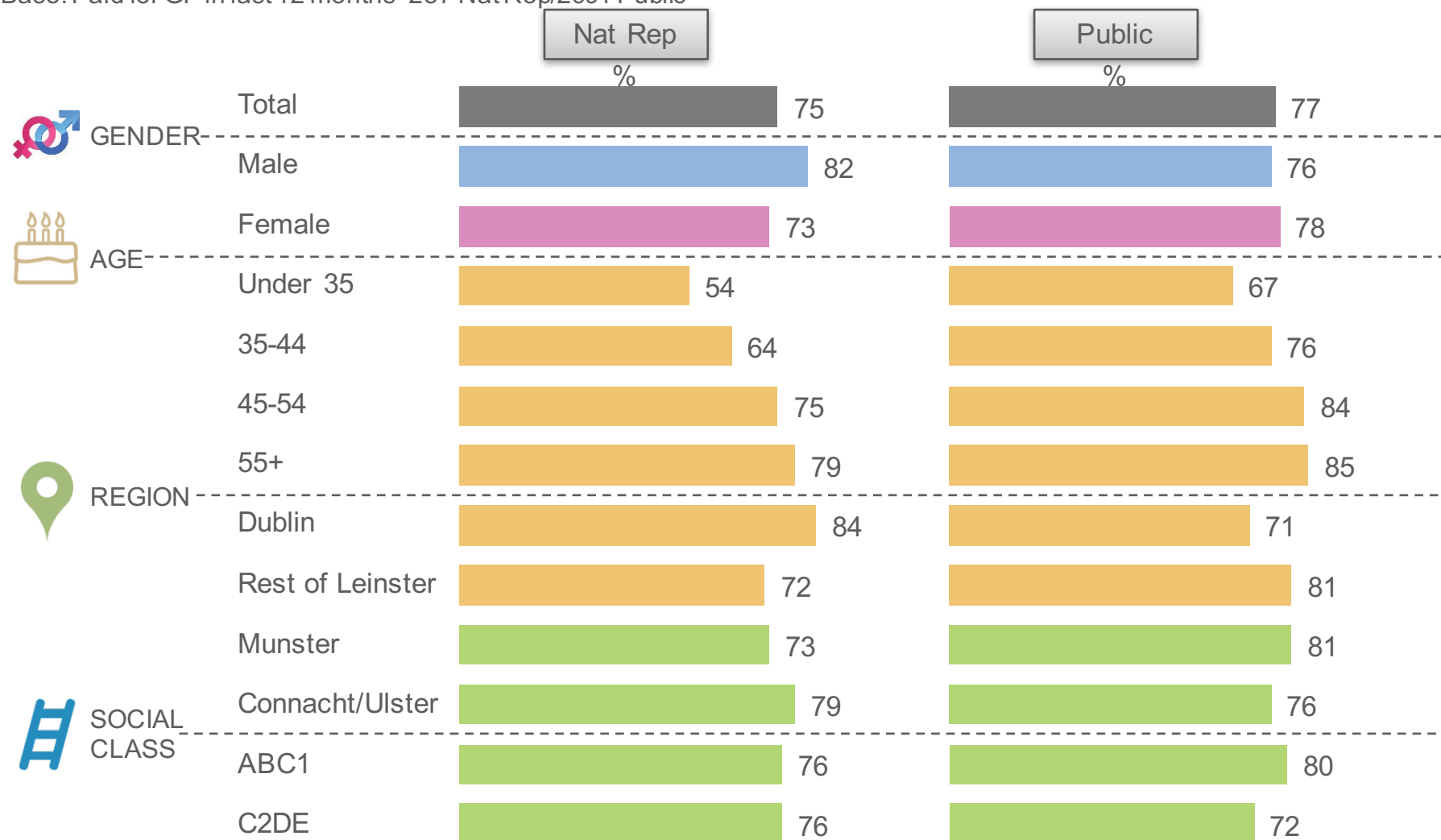
Base: Paid for GP in last 12 months- 287 Nat Rep/2991 Public \*Based on all question was applicable to



Majority of both samples claim to be satisfied with the value for money provided by the GPs, however, circa 1 in 4 claim there is room for improvement.

# Value for Money x Subgroup

Base: Paid for GP in last 12 months- 287 Nat Rep/2991 Public



Q.16

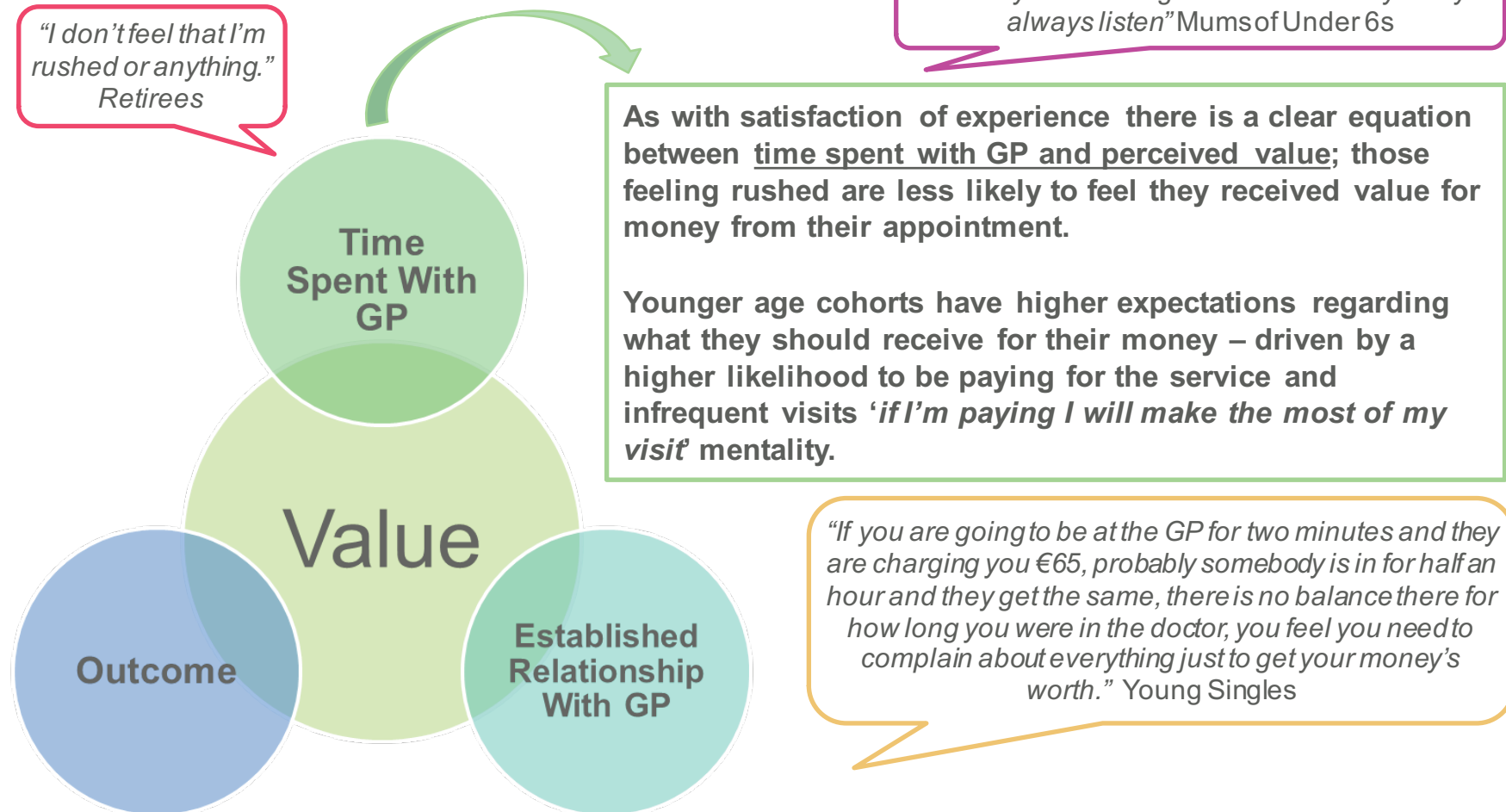
Older age cohorts notably more satisfied with value for money. Variation by region evident – with Dublin highest in the total population but low amongst the public sample.

# Perceptions of Value – I (Qualitative)

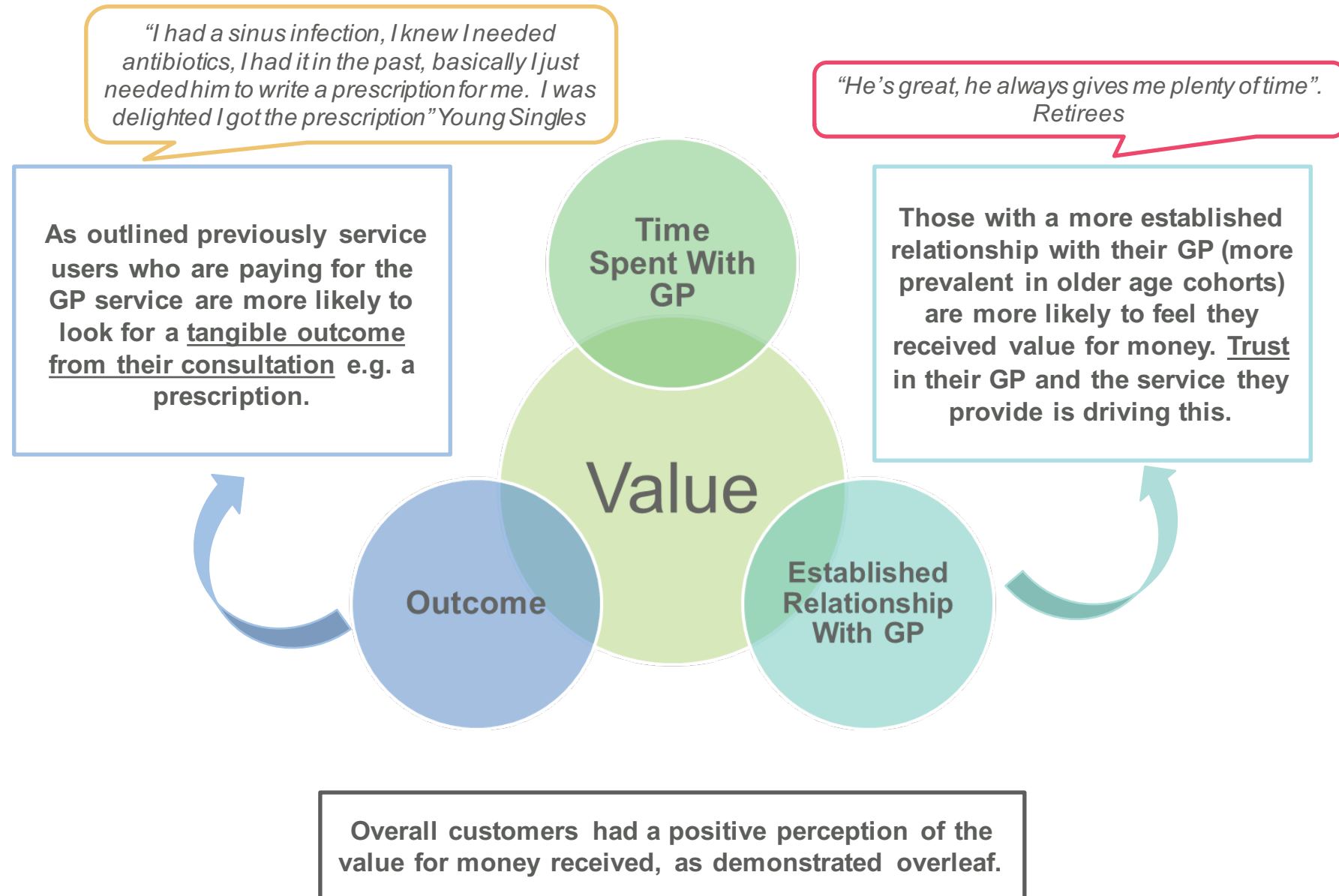
- Linked to their satisfaction with their experience with the GP, perceptions of value are impacted by several interlinking factors.

*"I don't feel that I'm rushed or anything."  
Retirees*

*"I always feel that I get value for money. They always listen" Mums of Under 6s*



# Perceptions of Value – II (Qualitative)



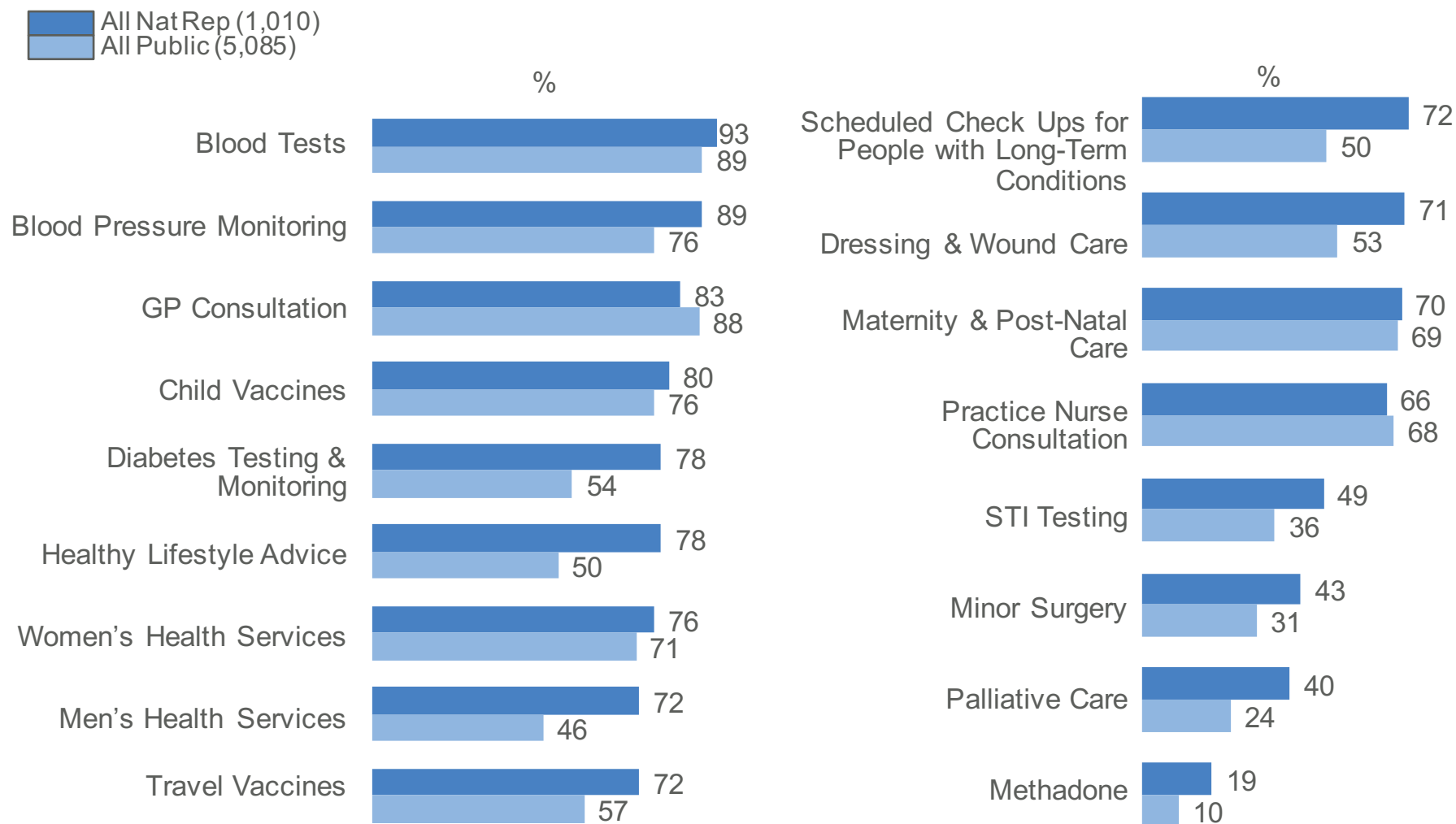




## 1.6 GP Service Range

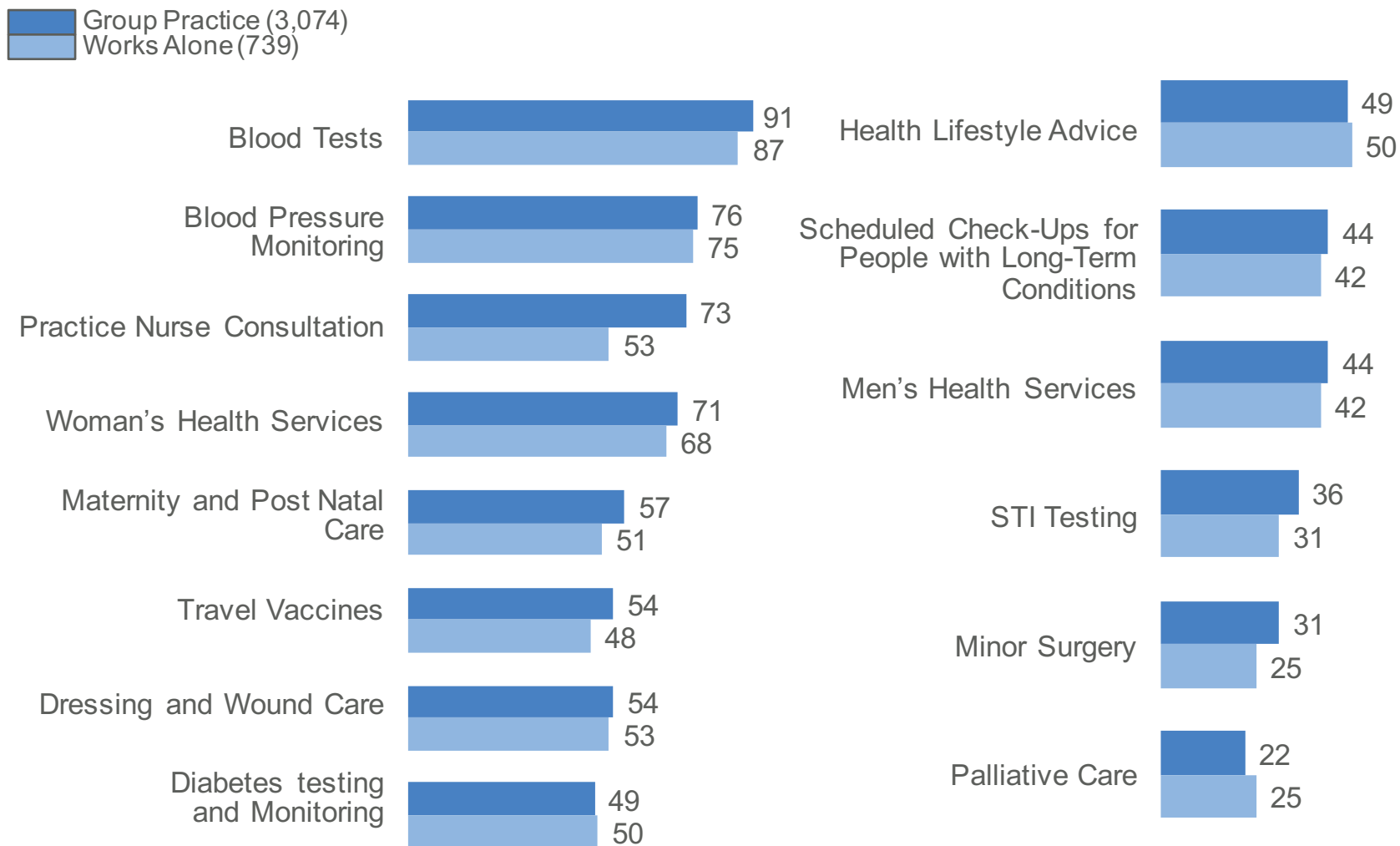


# Awareness of GP Services Available



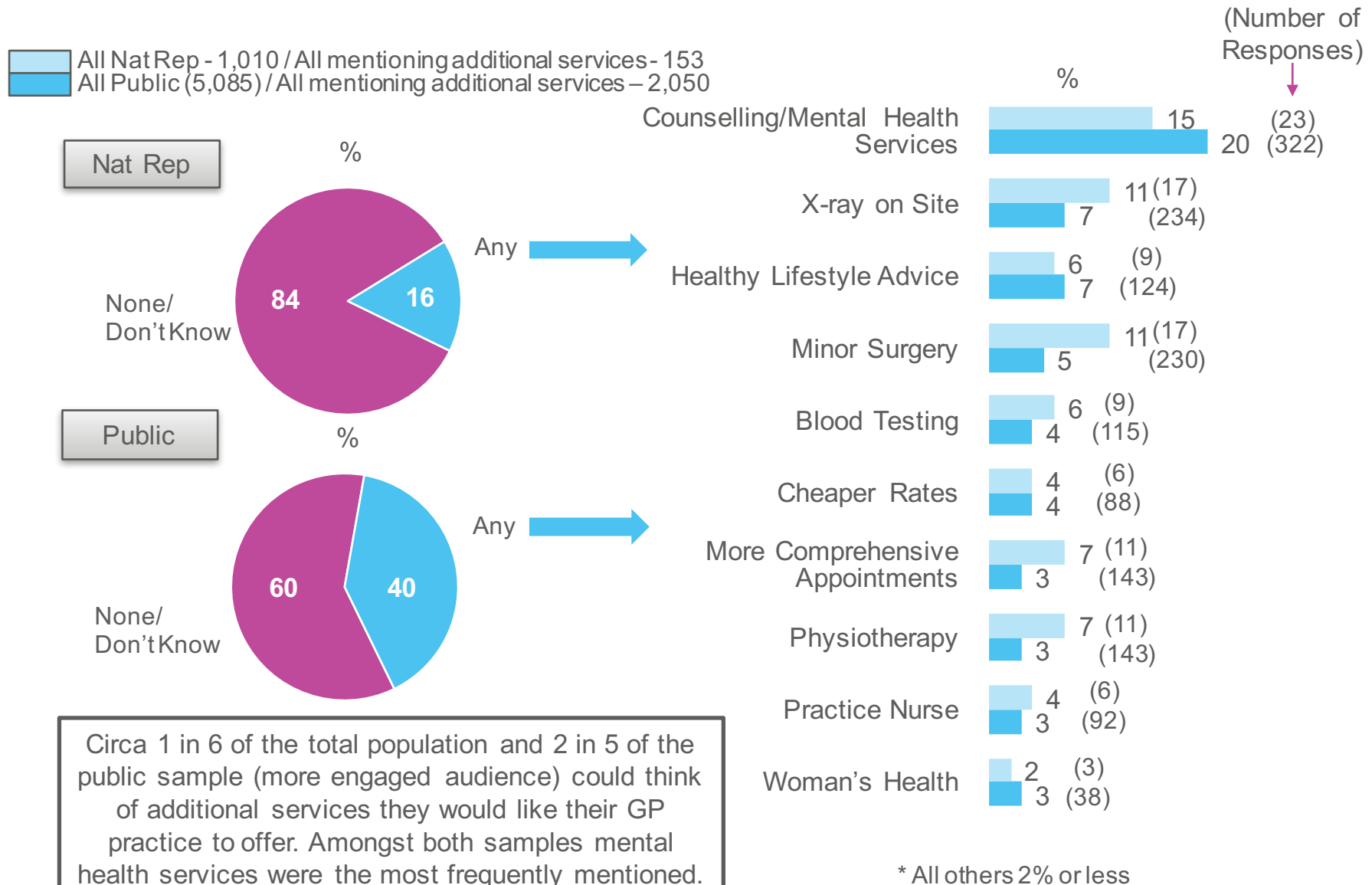
Overall awareness of service availability at own GP high amongst the total population with at least 2 in 3 aware of the majority of services being available.

# GP Size By Services Offered

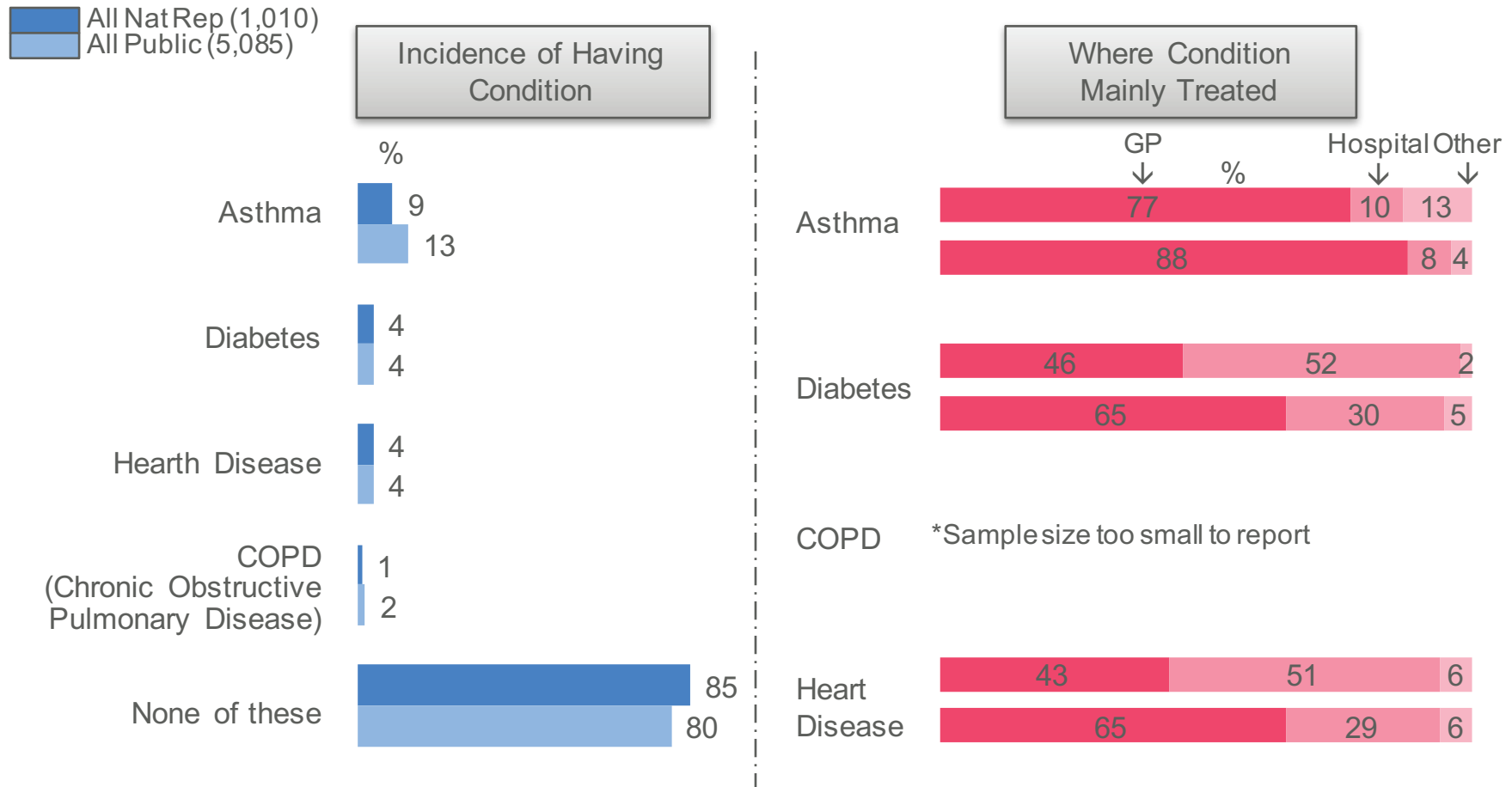


The biggest differences between services offered in group practices and single practices are with practice nurse consultations and maternity and post natal care.

# Additional GP Services Interested In (Open Ended Question)

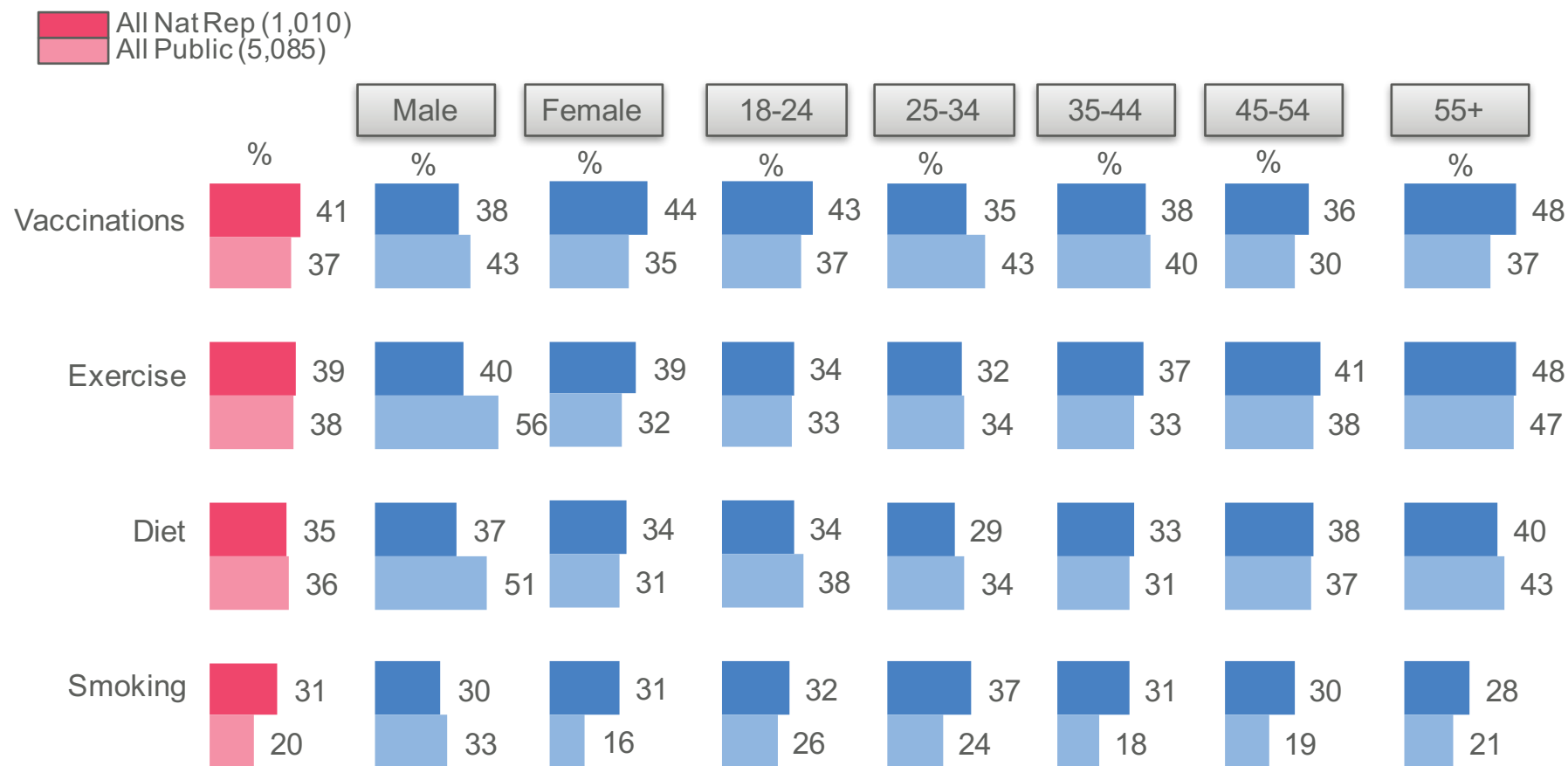


# Condition Management



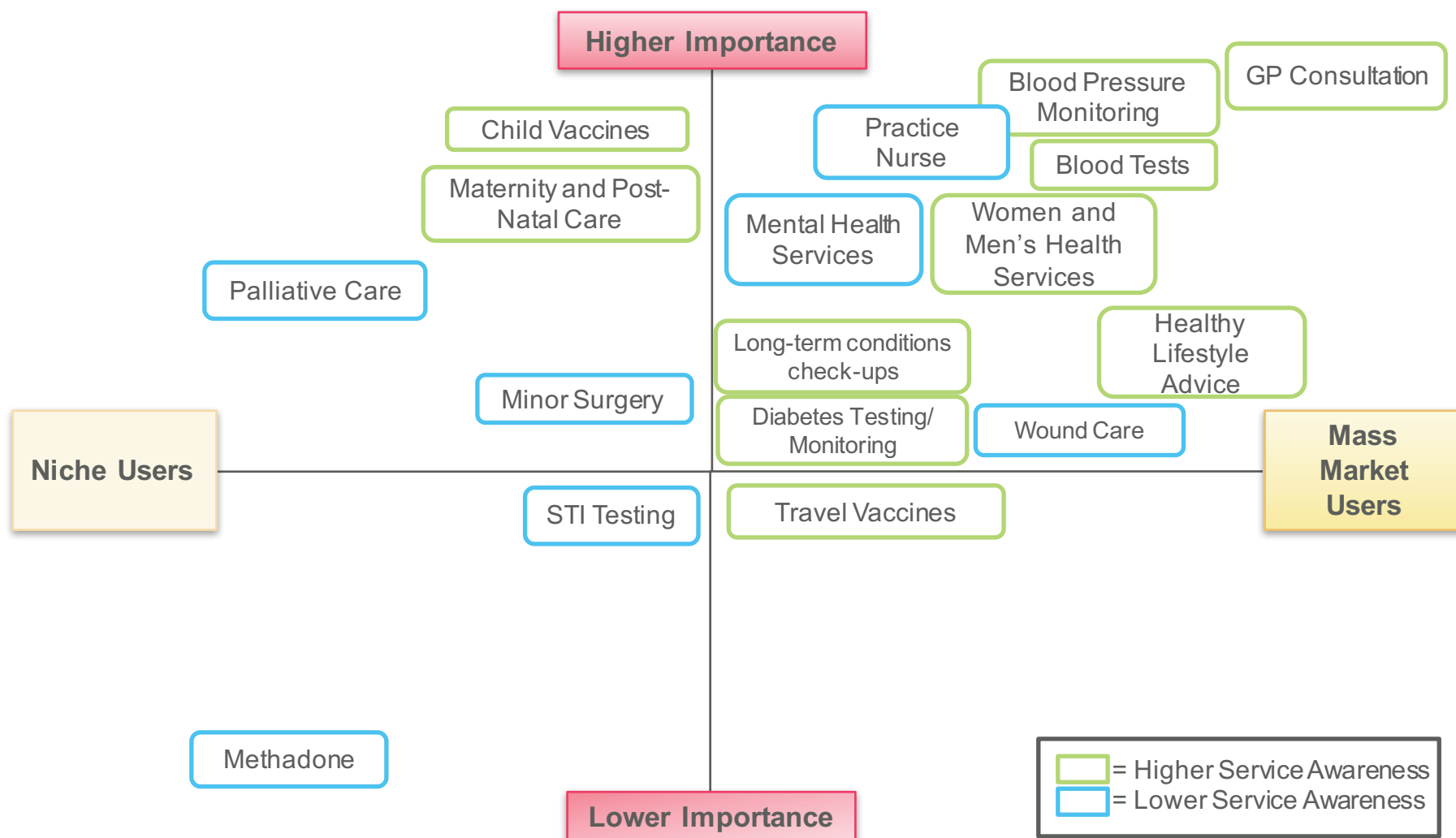
Asthma is the most prevalent condition, with circa 3 in 4 sufferers managing this via their GP surgery, whilst circa 2 in 5 of those suffering from Diabetes or Heart Disease manage this at the GP surgery.

# Life Style Changes GP Talked About



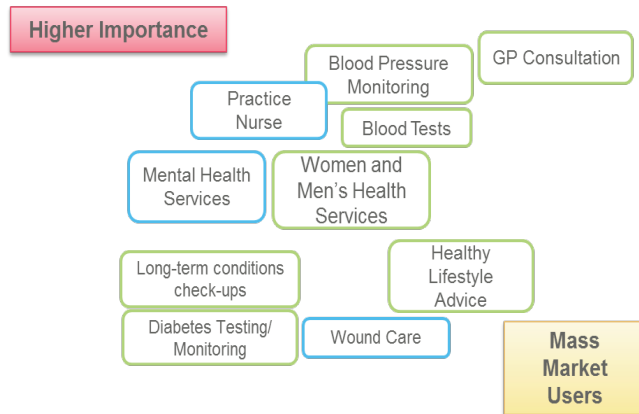
Older patients are notably more likely to have been talked to about lifestyle changes, as are men.

# GP Service Overview (Qualitative)



Overall service users are keen for the majority of care to be conducted at the GP Practice. High level of trust felt for GP and patients value consistency of care, in addition all acknowledge the importance of avoiding visiting hospitals if feasible.

# GP Service Provision – I (Qualitative)



## GP Consultation

- Core offering of the GP essential for all users.
- All utilised this service.



## Healthy Lifestyle Advice

- Often considered part of the standard consultation and/or interlinked with other treatment plans.
- All would expect this to fall into the GPs remit.



## Blood Pressure

- Again considered to be part of a standard GP consultation as part of the diagnostic process, and necessary for all patients.
- All aware that this would be done by their GP.



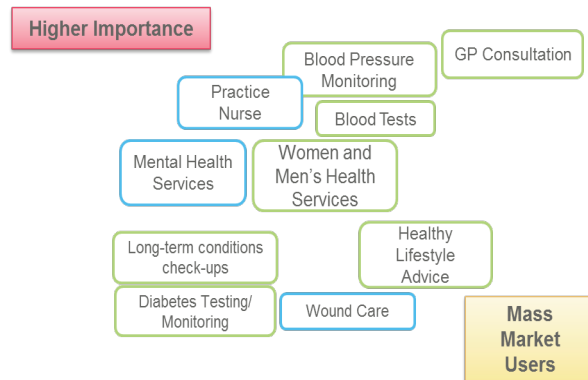
*"Anytime you go to the doctor he does that." Retirees*

## Blood Tests

- Older cohorts had more experience of this, with majority going for regular check-ups. All would expect that a GP practice would offer this either via the GP or the practice nurse.
- Considered essential that a GP practice can conduct blood tests and deliver results to patients.

*"I'd get my bloods done once a year." Retirees*

# GP Service Provision – II (Qualitative)



## Practice Nurse

- Availability of practice nurse differs, with those visiting the larger practices more likely to have this service.
- However, all felt service could be beneficial and would improve chances of preventing unnecessary visits to hospitals for patients.
- Those accessing practice nurse services at a GP practice were universally positive about their experiences: avoids appointment with GP or hospital. Considered to be efficient use of time and services.

*"It's a great service [practice nurse]. You're not paying as much for going in to do something simple. It takes pressure off the doctor too."*  
Mums of Under 6s

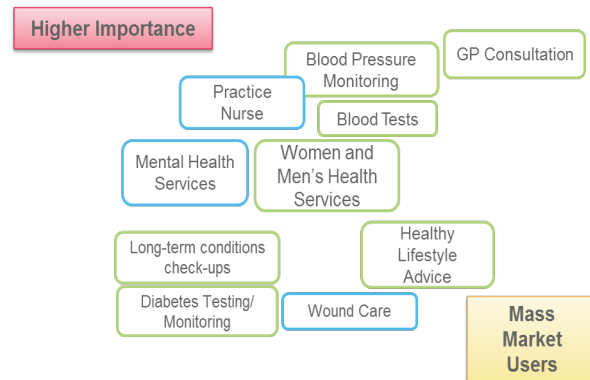
## Women's/Men's Health

- Again considered a standard part of the GP offering for more basic women's and men's health services and check-ups e.g. Smear Test.
- Those from smaller practices cited a lack of a female resident as a barrier to utilising these services at times.

*"My wife would want to go and speak to a female doctor, so she feels comfortable."* Middle Aged Men



# GP Service Provision – III (Qualitative)



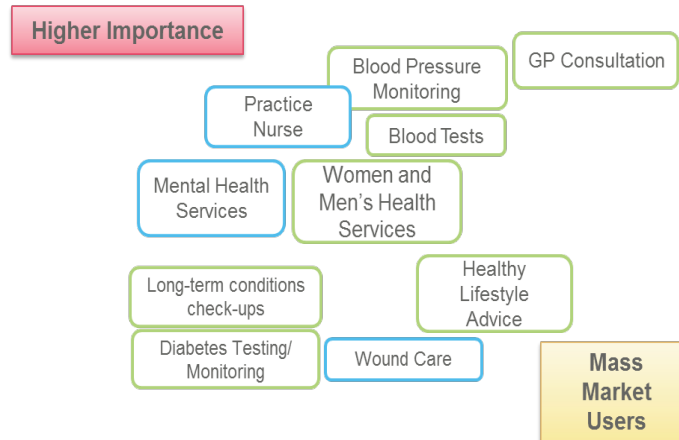
*"I'd say that's part of the GP consultation in general."* Mums of Under 6s

*"If you are going to a GP about mental health, in my experience of going to the GP I am always rushed, it is not something that you want rushed, if you want it sorted out it is not the place you go"*  
Young Singles

## Mental Health Services

- Low awareness of mental health service offerings in existing practices – some thought this would be offered as part of a standard consultation whereas others felt it was too specialist.
- Widespread agreement that this is an important service to be offered at a local level, and that at the moment, huge variation exists regarding availability and quality of the service.
- Felt that GPs should be cognisant of this as part of all check-ups – trying to understand if there are underlying issues affecting patients.
- However, universal agreement that this would not be feasible in current appointment allocation.

# Service Provision – IV (Qualitative)



## Wound Care



- Limited experience of this service. However, expectation that a practice nurse would be able to provide this service.
- Again considered important by all to avoid patients having to go into hospitals where possible.

*"The nurse does wound care as well."* Young Singles

*"I presume the nurse does that."* Mums of Under 6s

## Check-Ups on Long Term Conditions

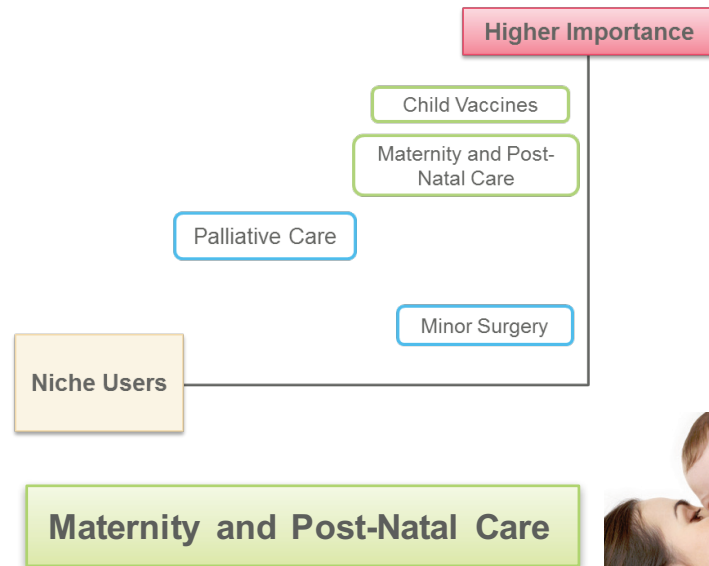
and

## Diabetes Test and Monitoring



- Considered to be condition dependent.
- Widespread awareness that diabetes can be tested, treated and monitored via the GP.
- Those in larger practices have higher awareness and expectation of these services being offered.

# Service Provision – V (Qualitative)



## Child Vaccines



- All would expect this service to be offered.
- Essential for parents to be able to visit GP for routine healthcare services for children

*"I just presume they all do them."*  
Mums of Under 6s

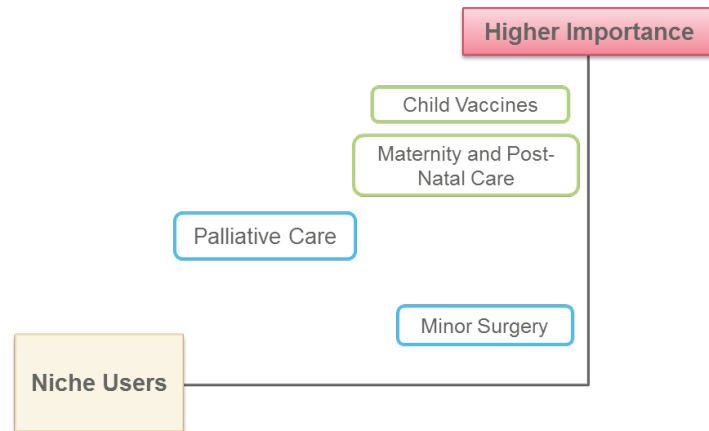


- Level of service provision within this area varied by practice. All would expect basic provision, whilst scans or more complex procedures and checks were only available within a minority of practices.
- Availability of local service offering for maternity and post-natal care considered important amongst those with children.

*"That would be very important for women."*  
Middle Aged Men

*"My GP doesn't do scans."*  
Mums of Under 6s

# Service Provision – VI (Qualitative)



## Minor Surgery



- Evident difference by practice size, with only those attending larger practices aware of minor surgery services being offered.
- All felt this was a positive development, again to reduce hospital visits where possible.
- However, widespread acknowledgement that small practices lacked resources and facilities to offer this service.

## Palliative Care

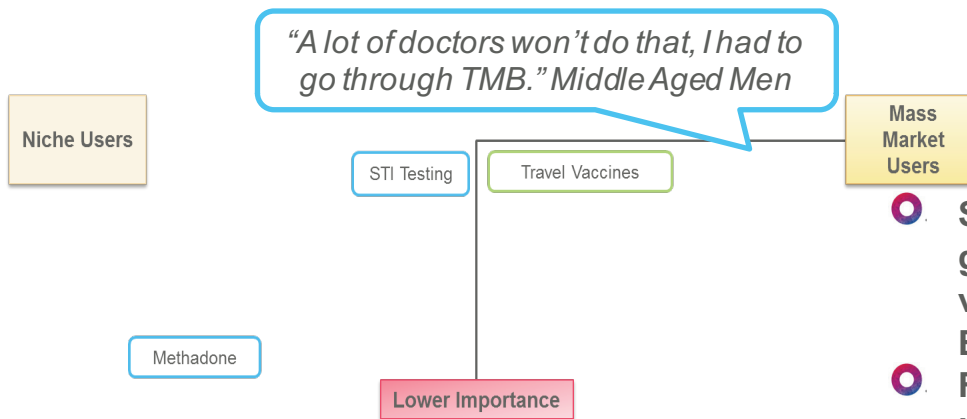


- Understanding of current service provision varied, with some feeling this was part of a GPs standard care offering, whilst others thought this was the role of hospices or other primary institutions.
- Lack of exposure to the service drives lack of clarity in this area.

*"No, it is more the hospitals do that, I have never heard of a GP being involved in that process."*  
Young Singles

*I don't know if they do palliative care? I don't think they do?".* Middle Aged Men

# Service Provision – VII (Qualitative)



## Travel Vaccines

- Service provision varied with some able to get this from the GP, whilst others had to visit a specialist clinic (e.g. Tropical Medical Bureau).
- Felt to be 'a nice to have' for GPs, but given infrequent requirement per patient, it would not be a priority service.

## STI Testing

- Awareness of specialist clinics either in GP surgeries or at hospitals for STI testing.
- All felt current service offering was appropriate.

"There's a separate clinic in town."  
Mums of Under 6s

"My GP set up a methadone clinic. You'd go in and there would be a junkie out of his head. It's not something you want to see". Middle Aged Men

## Methadone

- Niche minority had exposure to a methadone clinic being available at their surgery.
  - It was considered to negatively impact on the experiences of other patients.
- Vast majority felt this service offering was important but more appropriate to be run by a specialist service provider instead of general practitioner.

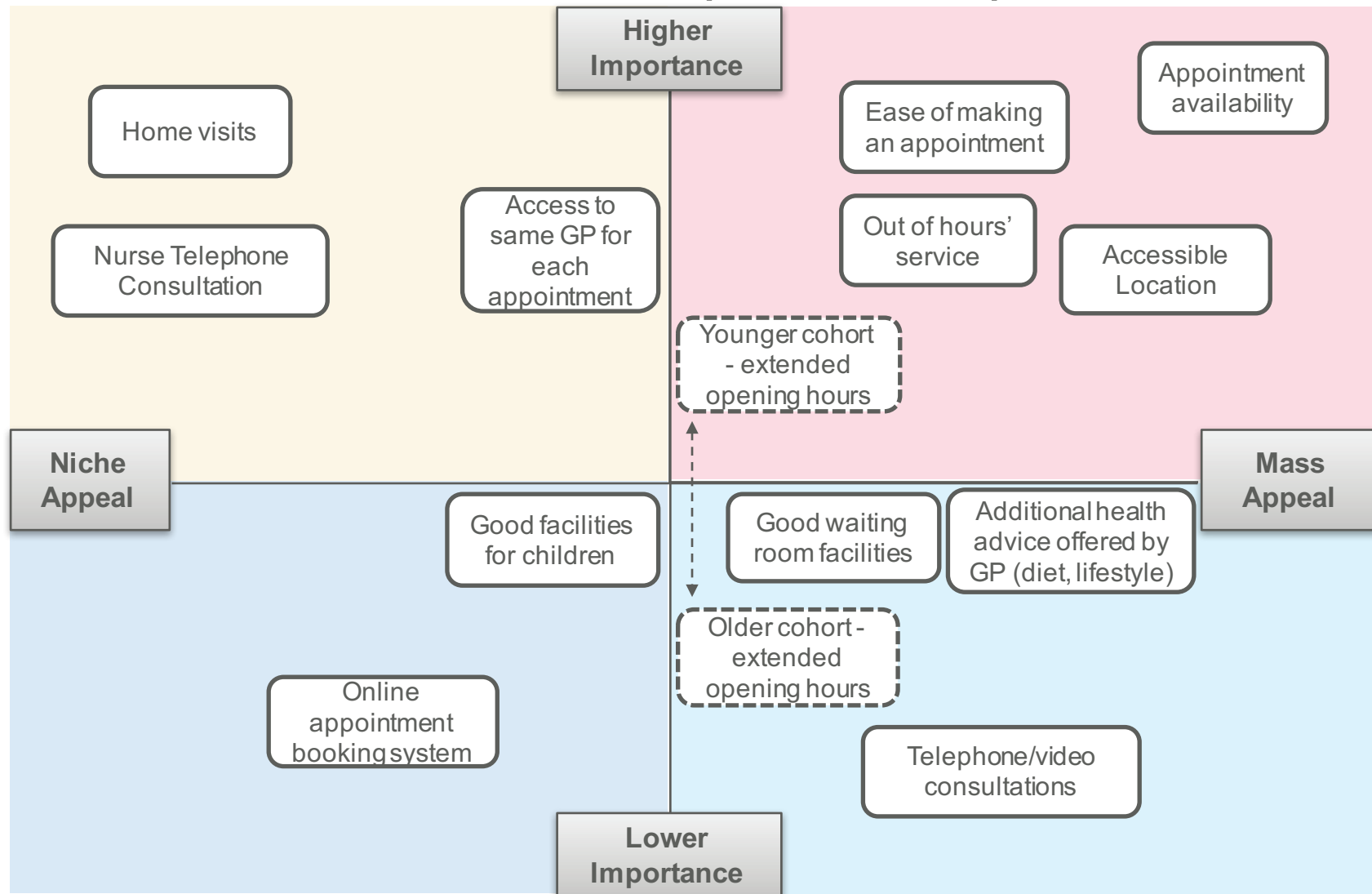
"You can get it in the Blackrock Clinic. They don't dispense it, they just prescribe it." Young Singles





## 1.7 GP Offering Priorities

# GP Offering Priorities Overview (Qualitative)

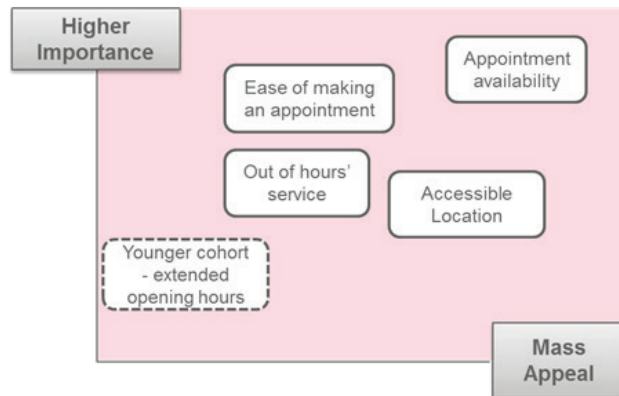




# GP Offering Priorities – I (Qualitative)



*You just ring and you have an appointment.” Retirees*



*“I make an appointment by phone. It’s very easy” Mums of Under 6s*

*“Great, 5 minutes walk.” Middle Aged Men*

- Access factors are all considered more important for the majority of the population.
- Appointment availability: Overall high awareness that the ability to get an appointment for the same day or next day is a good service. Essential that this continues/is available for all service users.
- Ease of making an appointment: Majority happy with current process of booking an appointment, with the vast majority doing this via phone. Speed and efficiency of the process is also considered important – particularly amongst time poor cohorts – working parents, young professionals.

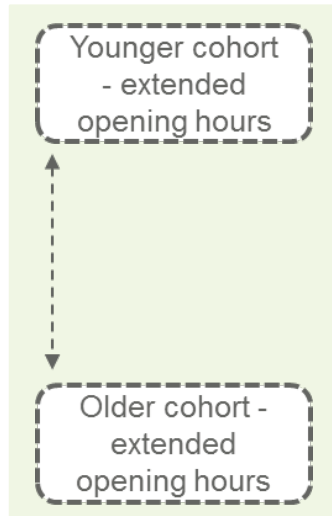
- Accessible location: Location near home and/or work important for all. Vast majority happy with current GP location and journey to this; varying from circa 5-20 minutes travel.
- Out of hours service: Provision of some form of out of hours service considered essential. All would prefer to visit their own GP where feasible but preference for D-Doc or South-Doc over A&E evident amongst all.

*You’re better to go to southdoc. You’d be waiting hours in A&E.” Retirees*

- Some form of assurance of consistency of quality of care within out of hours service considered appealing. e.g. access to patient files for locums/doctors from other medical centres.



# GP Offering Priorities – II (Qualitative)



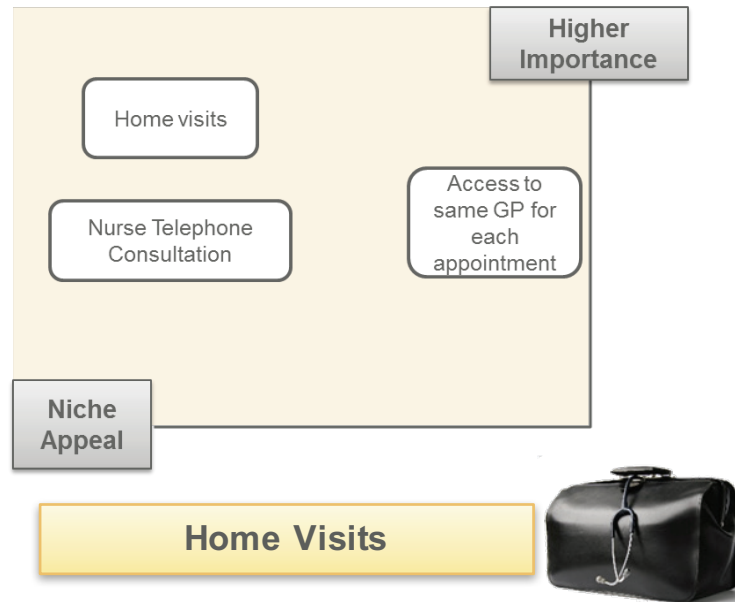
## Extended Opening Hours

- Younger age cohorts unanimously agreed that extended opening hours would be beneficial. e.g. 2 evenings a week until 7pm, Saturday AM.
  - Hard to fit in within the working week without taking time off – not finishing work until after 6pm.
- However, older age cohorts feel current opening hours are suitable for their needs.

*"It is not great, she works mostly half days and it is quite hard to get an appointment with her. Thursday she works till about 7, and the rest of the time it is 2 to 6 and even to get there for 7 I would be rushing." Young Singles*

*I wouldn't have an issue with opening hours". Retirees*

# GP Offering Priorities – III (Qualitative)



- Considered essential for a niche audience.
- Majority of younger audience had no experience of the service.
  - Those with children more likely to go to GP or use out of hours service.
- Perception that this was a service that had reduced in availability overtime due to resource pressures, but all felt it was important for a more vulnerable cohort.

## Access to Same GP

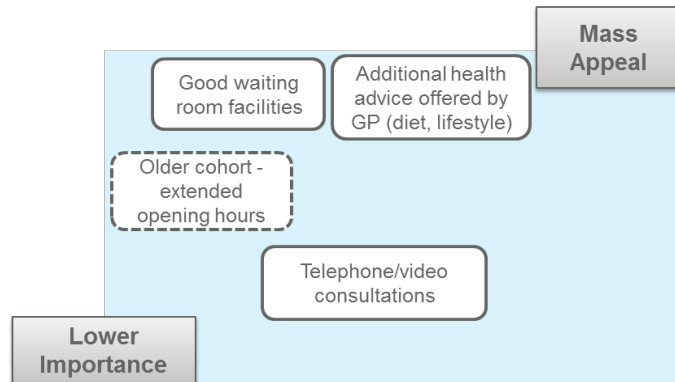


- All would prefer to see the same GP for each appointment but this was not considered a necessity.
- Considered more important for older patients and/or those with more complex illnesses, where continuity of care is important for treatment.
- In addition, older patients who are more likely to have a more established relationship with the GP felt this was more important.
- If multiple doctors are seen, patients feel detailed patient record/note sharing are essential to build the trust with the GP.

*"They're Important, that's what the local doctor should be doing, that's what the family doctor is all about." Middle Aged Men*

*"I wouldn't expect that as a service." Mums of Under 6s*

# GP Offering Priorities – IV (Qualitative)



## Good Waiting Room Facilities



- As identified earlier, current provision of waiting room facilities varies.
- A pleasant and suitable waiting environment was considered a 'nice to have' by all versus access and clinical quality which are of utmost importance.
  - Those paying for the service more likely to feel that facilities are important.

## Additional Health Advice

*"Nice to have, they'll tell you in any case."  
Retirees*

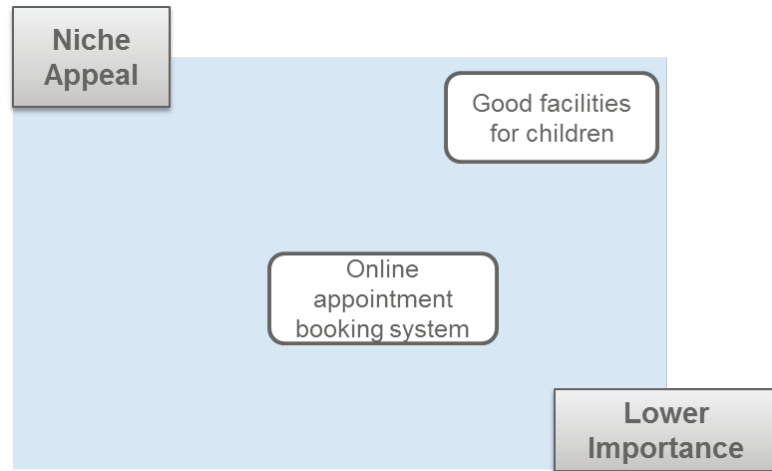
- Considered relevant to all, and increasingly salient in public discourse to prevent illness rather than treat it.
- However, again, versus access to the GP this would be considered a lower priority.

## Telephone/Video Consultation

*"Telephone is nice to have." Retirees*

- Little experience of this service.
  - Minority had spoken to the doctor on the phone, when deciding whether they should come for an appointment.
- All felt this service would be useful, (not essential) for some cases, but would not want this to prevent face to face consultations.
  - Those paying would expect lower charge and would find this appealing to basic queries that they do not want to pay €50- €60 for.

# GP Offering Priorities – V (Qualitative)



## Good Facilities for Children



- Facilities for children not considered a driver of GP choice or overall satisfaction.
- However some form of entertainment for children seen as a relatively cheap service that can bereft parents and those in the waiting room.
  - Important to consider toys/entertainment that are hygienic and quiet!

## Online Appointment Booking System

- Niche experience of the system.
- Majority prefer booking via the phone, or for routine appointments sometimes face-to-face.
  - Driven by reassurance offered by human contact.
- Would appeal to the time poor cohorts who have limited time to call during the day.
  - Also appealing to those who currently find it hard to contact/get through to the surgery on the phone.



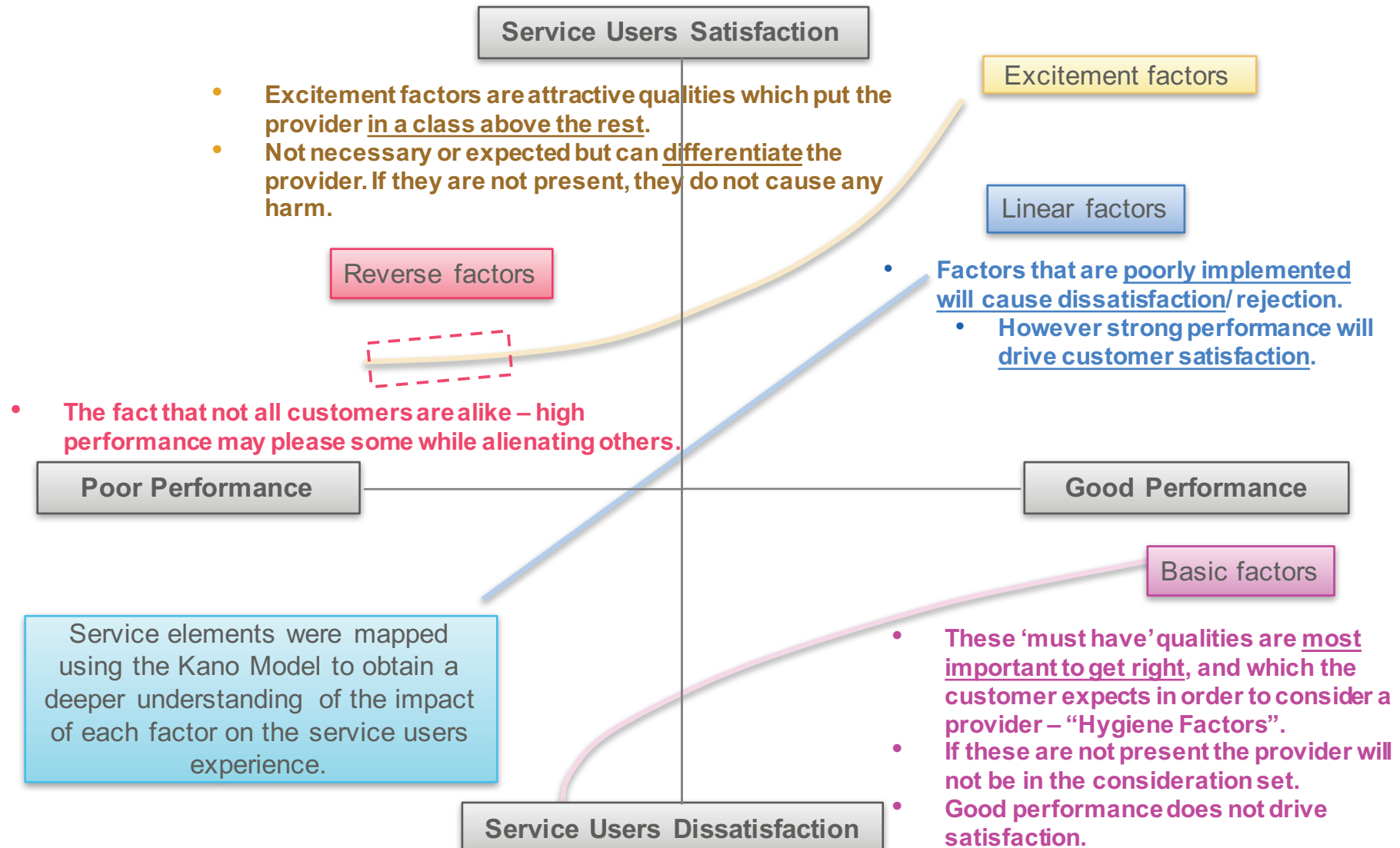
Schedule an appointment online.

*"Keep the kids occupied for everyone's benefit." Middle Aged Men*



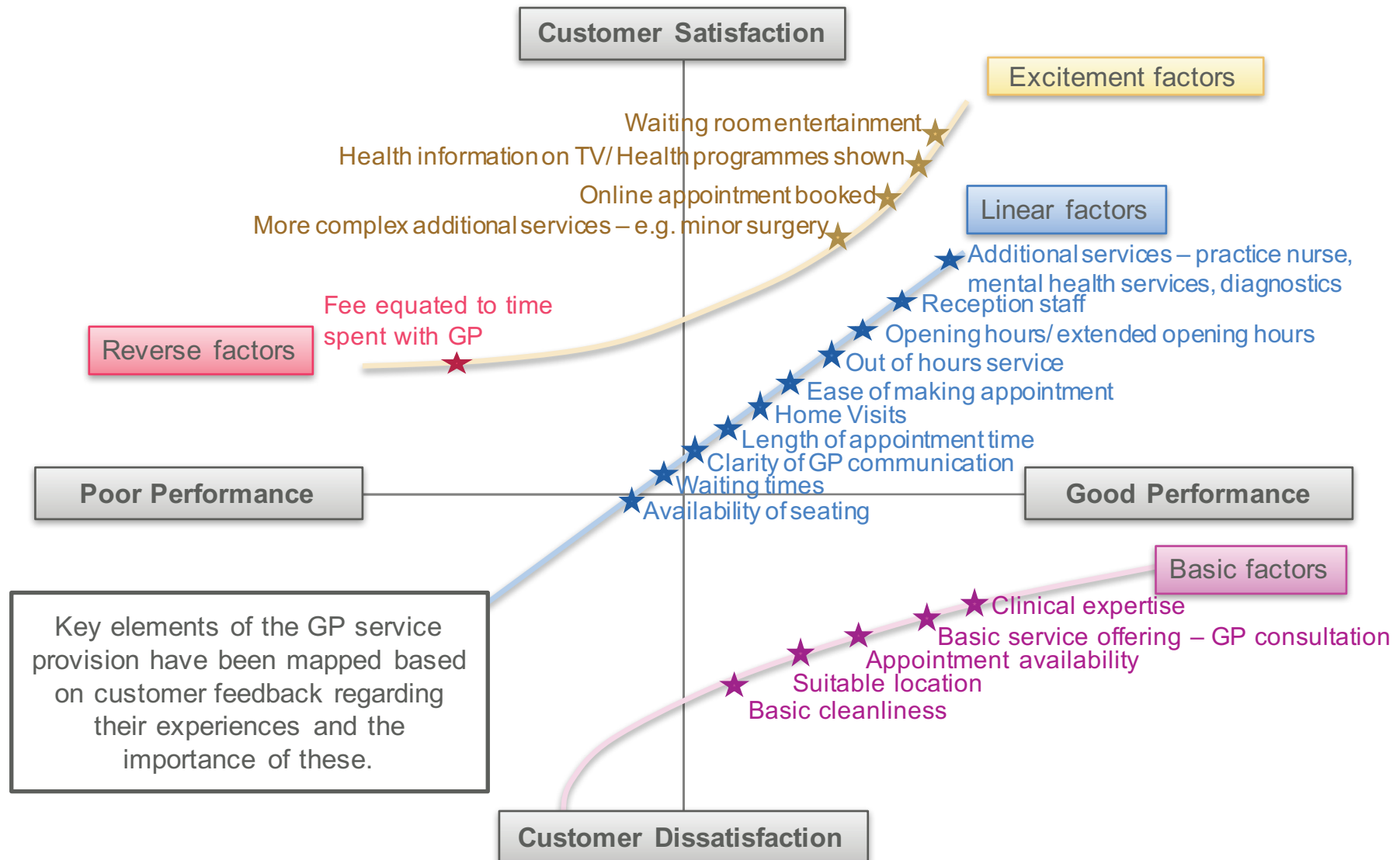
## 1.8 Service Users Summary

# Service Elements: Kano Model\*



\*Source: wikipedia.org

# Service Elements: Kano Model\* - GP Service Users



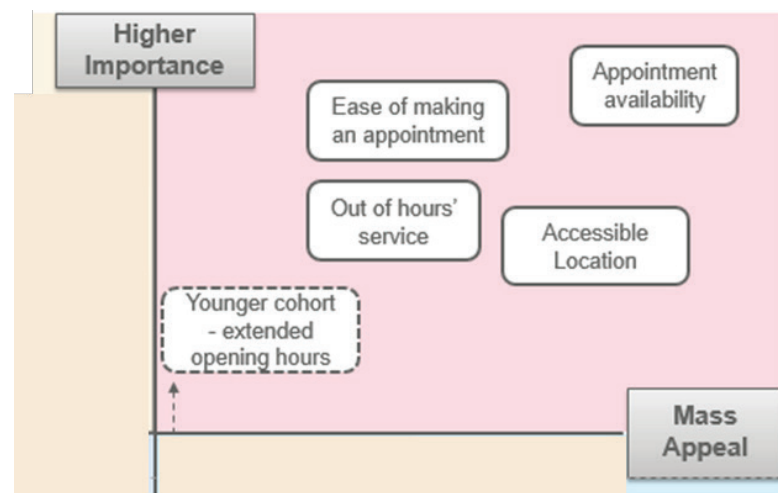
\*Source: wikipedia.org



# Key Take Outs - I

## Access

1. Access factors are all considered essential for to a good GP service provision. Therefore any changes to or reduction in the current offering will negatively impact on service users experience and satisfaction.
2. Current levels of satisfaction with access (appointments and location) are high.
  - However, there is evidence of inconsistencies by practice.
3. Current provision of extended opening hours varies and is important for younger age cohorts – with a preference for later evening or a weekend day amongst this cohort.







## Key Take Outs - II

### Facilities

1. Overall GP facilities of lower importance than access and quality of appointment (mainly time spent with GP).
2. Current facility ratings high overall, however, huge variation evident across practices.
3. Waiting times drive the highest level of dissatisfaction.
  - Service users keen to be kept up to date with current wait times and warned where possible.
  - Suggestions for coding of patients where possible to plan for different consultancy lengths, similar to a triage service either on the phone or at the surgery e.g. check up with elderly patient will take longer than repeat prescription for the contraceptive pill.

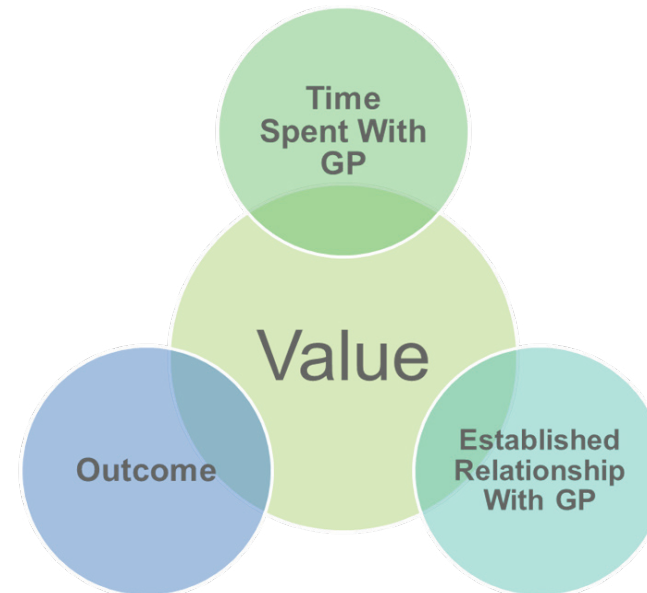
### Service Provision

1. Overall majority of service users aware of main service offerings, however, notable differences by practice evident again.
2. The main services not currently as widely received which service users feel are of importance are:
  1. Mental health services
  2. Practice nurses
  3. On site diagnostics e.g. x-rays
3. Consumers keen for more communication around service availability and what users should/ could go to GP for.

## Key Take Outs - III

### Cost/ Value

- Value mainly equated with time and quality of time spent with GP.
  - Notable variation in experience driven by relationships with GP and outcome.
- Majority of service users felt they received good value from the GP service.
  - However, Young Singles who are fee paying service users would prefer to pay for the time spent with the GP rather than a set fee per appointment.
  - In addition majority would like to have access to other services for a lower fee e.g. nurse appointment, repeat prescription service.





## SECTION 2: Service Providers

# Profile of GPs - I

- A range of GPs were consulted as part of the research. They were segmented on the following key criteria:



## Location

- ✓ Urban and Rural
- ✓ Dublin and Outside Dublin

## Practice Size



- ✓ Solo GPs and Group Practices.

- The experiences, opinions and priorities of GPs were impacted by the above criteria on some topics and this has been highlighted where relevant within the report.

In addition to the above we also achieved a spread of gender and age within the final sample interviewed

## Profile of GPs - II

- Day to day routines predominantly similar.
  - Starting 8:30 – 9am, finishing anywhere between 5:30 – 8pm, with evening surgeries 1 – 2 nights per week.
  - Phone calls with patients and consultants often made/ taken during lunchtime or after hours.
  - Paperwork and referrals fitted around appointments and often conducted after hours.
- Some GPs working across more than one surgery or spending time out of the surgery at nursing homes or home visits.
- Volume of administration and paperwork dependent on practice size and support staff in place (i.e. receptionists, practice managers).



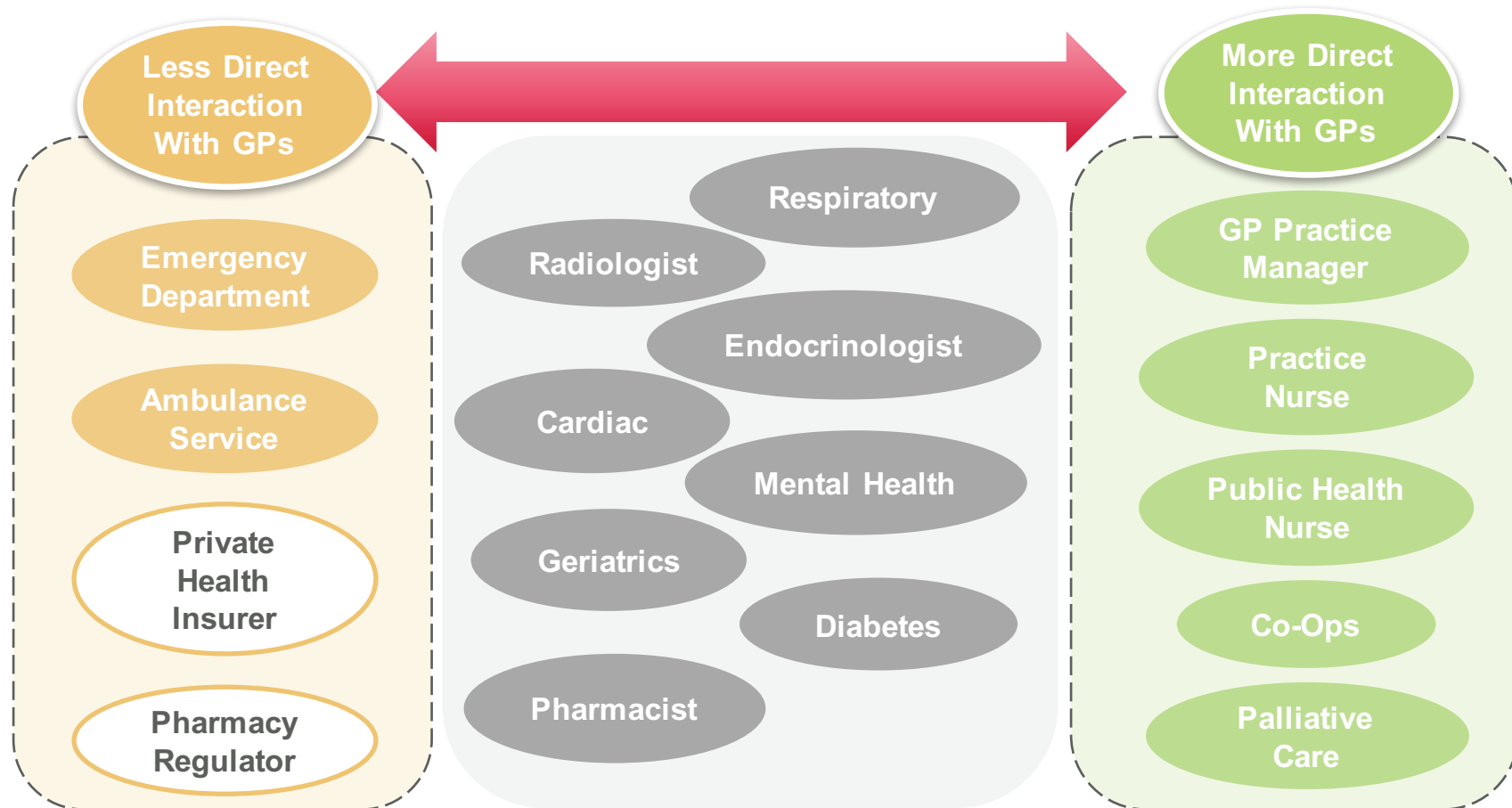
*"I'm strict in that I work through lunch and only stay here till 6 as I have two young kids." GP, Rural*

*"The nurses may phone with minor problems and say this has come in what do we do, someone may need an antibiotic or may need to go to the main land for an x-ray." GP, Rural*

*"I'm there most evenings until 7.30, 4 times a week, and I take a half day on Wednesdays." GP, Urban*

*"We run over time as well. It's fairly busy with referrals and paperwork after hours too." GP, Urban*

# Profile of HealthCare Stakeholders



*N.B Quotes from the above cohorts are tagged as 'Healthcare Stakeholders' throughout the report*

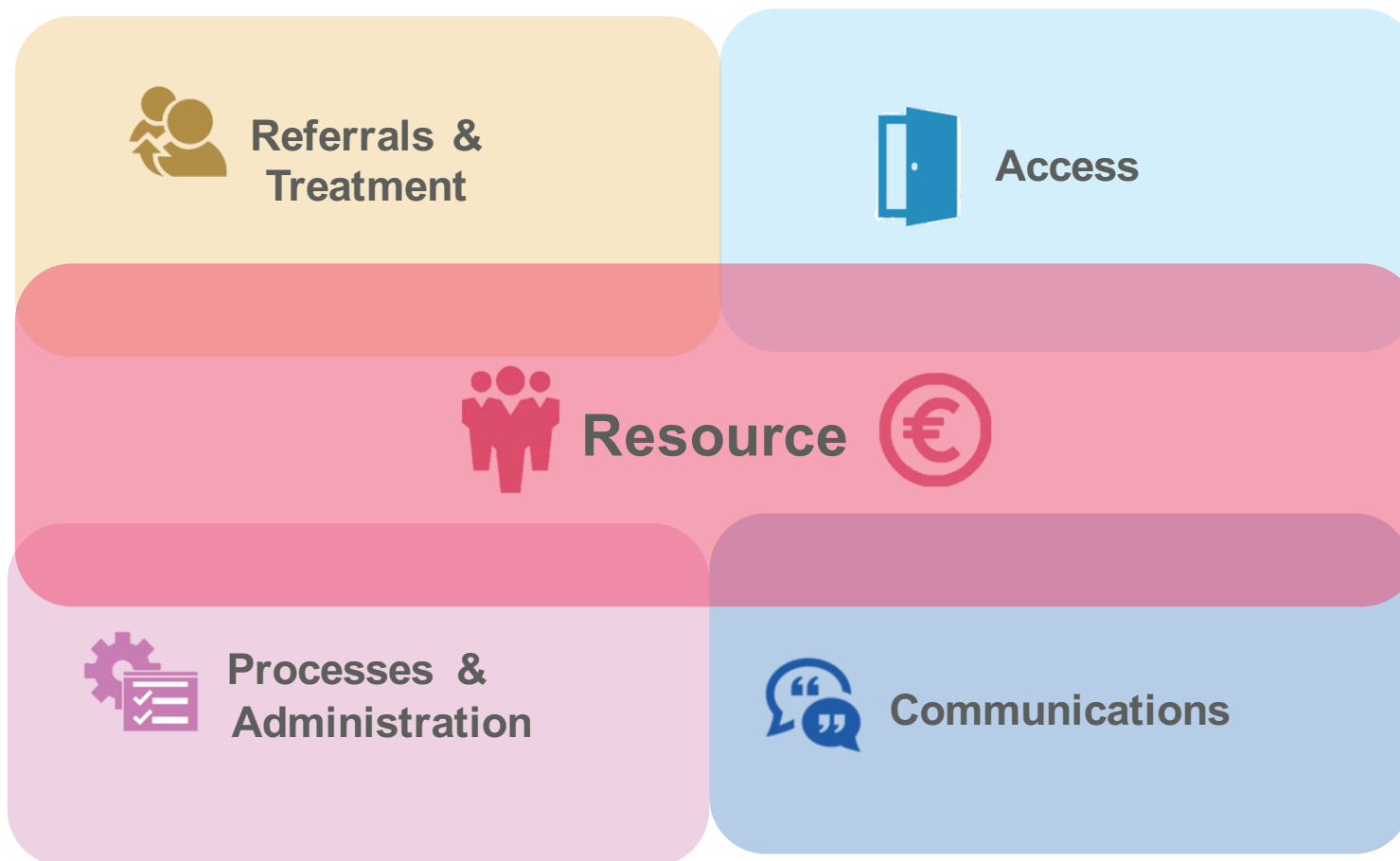
Healthcare stakeholders were interviewed across a wide range of disciplines in order to examine the general relationship, communication and access needs between consultancy and primary care, and also identify any specific department needs for the GP contract where evident.



## 2.1 Current Landscape



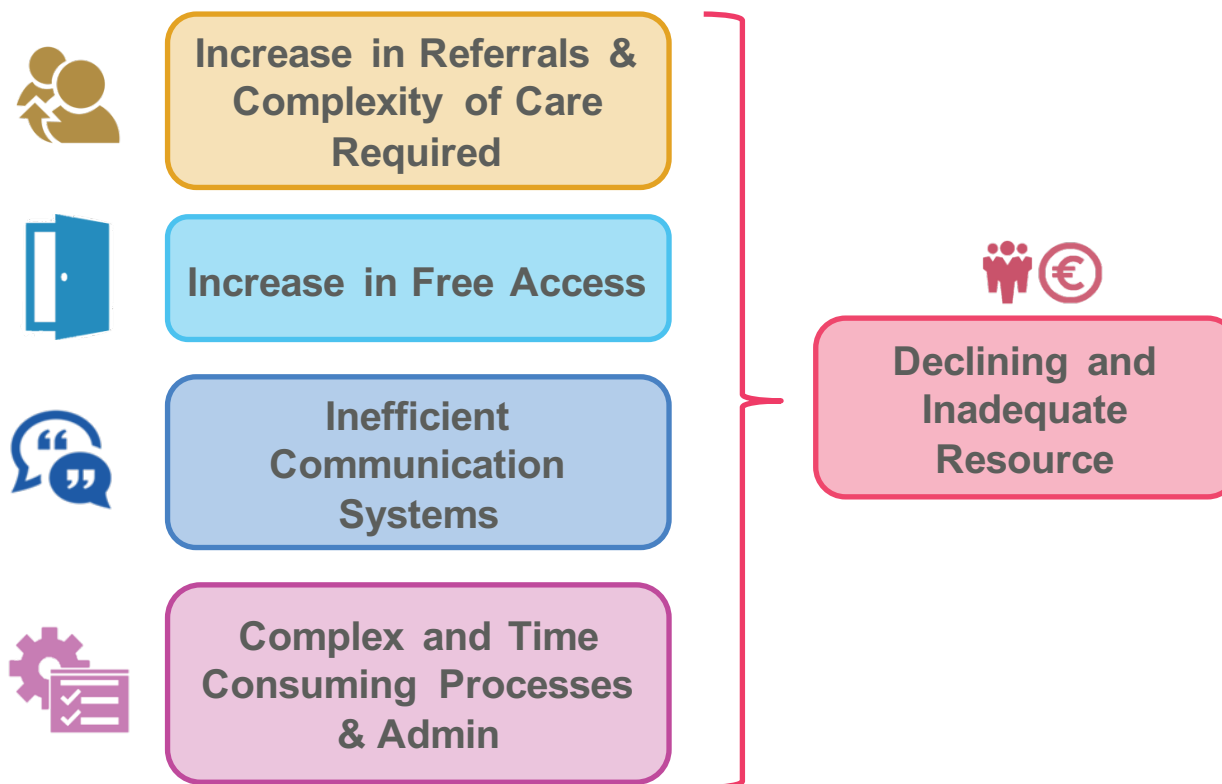
## Key Themes



The above key themes will be addressed throughout this report, from the GP and healthcare stakeholders perspective.



# Key Changes Impacting GPs – Overview



The key changes GP and healthcare stakeholders felt had and were impacting the profession are summarised on the following pages.

# Key Changes Impacting on GPs - I



## Declining and Inadequate Resource

- All GPs referenced the FEMPI cuts, from 2009, 2010 and 2013, as a key change impacting negatively on the current status of their profession.
  - Overall GPs referenced a “40%” cut in funding. Resulting in wage cuts and loss of staff.
- Key cuts referenced were:
  - Removal of distance coding.
    - Negatively impacting rural GPs. Putting them at a disadvantage and reducing appeal of rural GP positions.
  - Removal of living out allowance for NCHDs’.
    - Reducing attraction of profession for newly qualified doctors.
  - Reduction of nursing home patient capitation fee.
    - Reduction of funding whilst service requirements increase due to the ageing population and national drive for maintaining continuity of care at a primary level.

*“There has to be an acceptance that there is a different level of demand on the system to say 30 – 40 years ago.” Private Health Insurer*

*“GPs turnover was cut just under 40%, that brought problems such as less staff, fragmentation of care and less trust with the HSE.” Practice Manager*

*“It hit the rural areas very hard and that makes no one want to come out and work here.” GP, Rural*

Issues of resource are linked to all other key changes that GPs and Healthcare Stakeholders highlighted over the past 5 – 10 years.

## Key Changes Impacting on GPs - II



### Increase in Referrals & Complexity of Care Required

- All GPs, Pharmacists and Nurses felt that their remit had and was continuing to widen in terms of care provision.
  - Recent health policies and initiatives focus on continuity of care and focusing care at a local level where possible.
  - As part of the above GPs involvement in chronic disease management has also increased.
- Some GPs specifically referenced getting more complex referrals back from consultants requiring the GPs to repeat investigations and/or manage patients health on an on going basis.
  - All GPs felt this should be part of their role if adequately resourced.
- Mental health issues were specifically called out by some GPs and Nurses as something that they were dealing with more.
  - Required specialist training to handle effectively and time, both of which are limited (as outlined on the previous page).

*"Patients are coming from hospital with instructions for the GP to follow up on investigations or repeat investigations or do ongoing management in ways that I don't think they were 10 years ago. It's the expectation and the complexity." GP, Urban*

*"I've noticed a huge epidemic of mental health issues, especially in young people. Complex, modern Ireland has created a lot of problems. There are no resources in dealing with it apart from sending them to a psychiatric unit. We're landed with a huge amount of stuff that we don't have the resources to deal with." GP, Urban*

**Overall GPs felt they required more training, more staff and more funding in order to deal with the increase in complex cases being dealt with at a primary care level.**

# Key Changes Impacting on GPs - III



## Increase in Free Access

- Overall all GPs felt that those accessing the GP for free had increased over time.
- Free access for under 6's was referenced by the vast majority of GPs as a key recent change.
  - Evidence of an increase in patient visits.
  - There was also anecdotal evidence that free under 6 access had particularly impacted on out of hours demand.
  - In addition GPs felt that parents were making appointments for unnecessary reasons, e.g. a papercut, because it was now free.
- The ageing population was also felt to impact on GPs workload with increased volumes of patients and increased complexity of issues.

*"Our patients are getting older, they've all got a lot more wrong with them." GP, Urban*

*"The under 6's was an absolute disaster, it was a bad contract but we are seeing more under 6's coming in. They're coming in for silly things, it makes very little financial difference to us. A new contract is needed basically." GP, Rural*

*"The under 6 card has changed everything. Attendance of under 6's is up 40% in this practice. I have some kids that have been seen up to 40 times a year and we get paid 100 euro for that. They are completely normal, healthy children." GP, Rural*

*"There is a demographic tidal wave and we simply have to invest to deal with it"*  
Private Health Insurer

**Again this was linked back to a resource issue as demand increases whilst available resources decrease.**

# Key Changes Impacting on GPs - IV



## Inefficient Communication Systems

- Poor technology infrastructure, particularly within hospitals, seen to cause inefficiencies with;
  - Communications between GPs, Nurses and consultants.
  - Referrals processes.
  - Maintenance of patient records.
- Over time the gap between the systems that the GPs have invested in, versus those within hospitals, are considered to have notably increased.
- Communication between the HSE and GPs also seen to have deteriorated over the past 5 – 10 years.
  - Trust with the HSE evidently broken down due to the handling of the under 6's changes and the lack of reinstatement of FEMPI cuts.



## Complex and Time Consuming Processes & Admin

- The majority of GPs referenced an increase in administrative requirements linked to the GMS contract over the past 5 – 10 years.
  - All had seen an increase in workload for their practices, with a lot of this attributed to Primary Care Reimbursement Service (PCRS) requirements.
- In addition GPs had noticed an increase in patients or organisations (e.g. Tusla) requiring forms to be signed by a GP.

*"It's very frustrating with the PCRS." GP, Rural*

*"The amount of extra administration has gone through the roof, people bringing all sorts of different letters with them." GP, Urban*

*"The amount of paperwork the practice nurse does is frightening." GP, Rural*



## 2.2 Resources

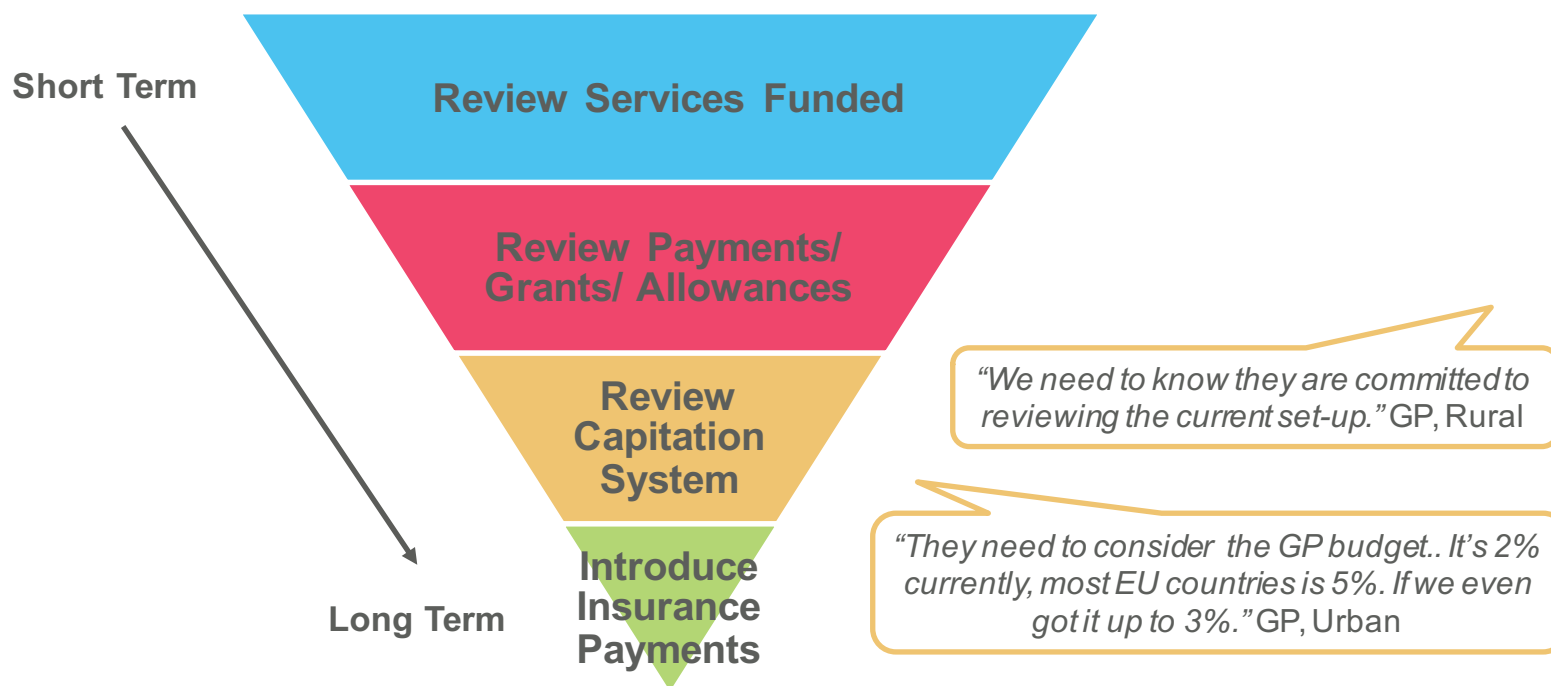
# Resourcing – Overview of Key Issues





# Financing Structures – Key Issues

- Current levels of funding are not considered sustainable for the increasing demand placed on GPs and their practices.
  - These funding issues were raised by both GPs and healthcare stakeholders.
- The key areas that are considered important to address are outlined below.

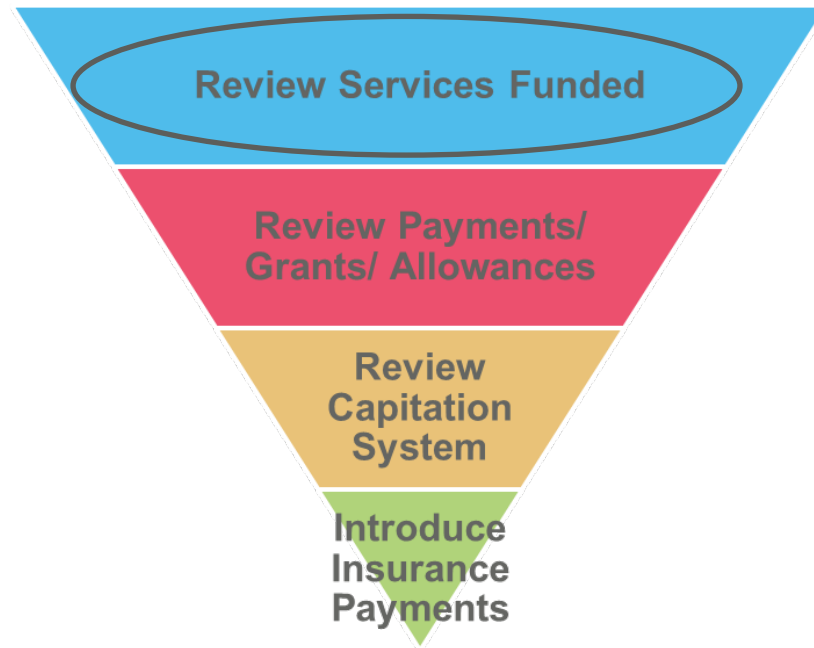


Both GPs and other healthcare stakeholders perceived the current financing structure for GPs to be a key area for addressing as part of the HSE consultation and GMS contract review.





# Financing Structures – Service Funding- I



- Widespread agreement, amongst both GPs and consultants about the importance of reviewing and widening payments that GPs currently receive for Special Type Consultations (STC's) or other treatments outside of the standard consultation.

- All GPs and practice nurses claimed to advocate GP practices taking on more complex care if they are properly equipped to do so i.e.
  - Available time
  - Equipment
  - Appropriate staff/ training.

All of which require funding/ an appropriate incentive to encourage GPs to undertake them.

- In addition the current contract requires modernisation as provision is included for services no longer performed e.g. instruction of fitting a diaphragm.

*"There is willingness to do more at a primary care level but there is a dearth of resources."*  
Private Health Insurer

*"You need to incentivise more complex care."* Healthcare Stakeholder

*"There needs to be more resources provided to GPs. Procedures such as a phlebotomy which could be easily done in practice for patients that have too much iron in their blood should be funded."* GP, Rural



# Financing Structures – Service Funding- II

## Chronic Disease Management – I

### GPs

- All GPs and healthcare stakeholders referenced the increasing importance of chronic disease management at a primary care level.
- However, funding and appropriate resource allocation for this is required.
- In addition patients without a medical card have to pay for appointments or procedures at a GP practice and are therefore more likely to go to the hospital for their procedures.
- Key priority areas that GPs and healthcare stakeholders referenced managing at a primary care level, if appropriately funded were:
  - Haemochromatosis – e.g. GPs/ trained nurses can conduct the therapeutic phlebotomy to treat this.
  - COPD and asthma - monitoring disease and patients lifestyle.
  - Diabetes – develop and roll out cycle of care.
  - Heart Failure - managing and monitoring patients with existing heart conditions.
    - Roll out of ARCH – flexible interaction between GPs and consultant.

*“A lot of patients could be treated at home [for COPD] if GPs were facilitated and equipped to.” Healthcare Stakeholder*

*“There is no integrated care with GPs and I think a lot of GPs just tend to send COPD’s into hospitals and not have a long term interest in looking after it.” Healthcare Stakeholder*

*“We can advise GPs from afar without patients having to travel or visit a consultant [about ARCH].” Healthcare Stakeholder*

*“The HSE does not see what it is costing them in the hospital and if we got that across to them it might change.” Practice Manager*



# Financing Structures – Service Funding- II

## Chronic Disease Management – II

### Pharmacists

- Pharmacists were also aware and concerned with the increased pressures being placed on GPs surgeries due to the re-focus of chronic disease management into primary care.
- Some pharmacies already offer testing and monitoring services such as Warfarin, blood pressure and cholesterol testing.
  - However, this is currently being conducted on an ad-hoc basis.
- Both pharmacy representatives indicated a strong interest in expanding and formalising the provision of these services, with appropriate funding.
  - This presents an alternative opportunity for sharing of responsibilities in primary care.
- The ideal process is that more simplistic testing and monitoring is conducted in the pharmacy, with pharmacists able to further refer back to the GP more complex cases or patients who require further testing.
- The perceived patient benefits include;
  - More on-going monitoring of patients through the pharmacists.
  - Greater access for patients to regular testing, without having to book an appointment at a GP surgery.
  - The pharmacy location may also be more convenient for patients.

*"There is capacity there for the less complex patients to have their monitoring done in a pharmacy. Some do I&R testing, blood pressure or cholesterol checking. It requires development and formalisation." Pharmacist*

*"We know doctors are swamped, they have to take on a lot of management of chronic disease management because the system can't afford to keep treating people in hospitals for conditions that should be managed in the community." Pharmacist*

# Financing Structures – Service Funding- III

- The majority of GPs and healthcare stakeholders had examples of programmes or initiatives where they felt that structured care programmes were currently working well, or could work well over time.

## Case Study: Diabetes Cycle of Care

- ✓ Type II diabetes patients with a medical or GP card have been given access to a free review with GPs twice a year.
- ✓ GPs are paid a set rate for these appointments.

### Positives:

- Proactive management of chronic diseases in the community.
- Reduce risk of condition worsening/ related illnesses developing.
- GPs financially supported for provision of service.
- GPs and nurses in some areas have access to additional support from specialist diabetes nurses – running clinics, training, advice on patients.

- Patient self management education sessions offered as part of it – encouraging patients to take responsibility for their own health and understand impact of lifestyle choice.
  - Lessons can be learnt from this approach for other health management education schemes

### Challenges:

- Variation by area in terms of patients wanting to access the service and resources provided.
- Considered to be '*the tip of the iceberg*' in terms of chronic disease management.

*"€100 capitation fee received for the management of Type 2 Diabetes does not cover the cost of man hours required to complete the 2 annual visits per year."* GP Urban

*"It is working well in some places but there is too much variety across the country."* Healthcare Stakeholder

*"The diabetes nurse clinic has been really successful."* GP Urban



# Financing Structures – Service Funding- IV

## Case Study: Heartwatch Monitoring Programme

- ✓ Monitoring of patients who have had an MI, coronary bypass (CABG) or coronary angioplasty (PTCA).
- ✓ Involves continuation of care from GP after these procedures.

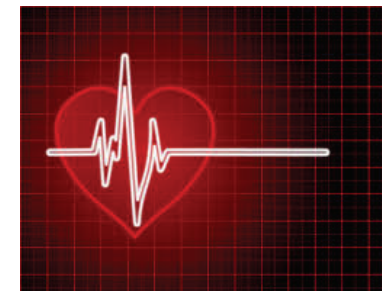
### Positives:

- Perception that it was successful – reduced mortality.
- Encourages patients to review risk factors and current lifestyle choice with GP to manage condition and prevent deterioration.
- Ensures at risk patients are monitored and avoids unnecessary visits to secondary care.

### Challenges:

- Not rolled out nationally.
- Lack of access to 24 hour heart monitors.

*“We still have the heart watch programme here, it was intended to be rolled out nationally but I think it was because of resources. It keeps people out of hospitals and it saves lives.” Practice Manager*



# Financing Structures – Service Funding - V Patient Check-Ups

- In addition to chronic disease management consultants referenced the importance of GPs taking a proactive approach to patient care, thus avoiding the development of serious illnesses and the need for acute care.
  - Current perception is that this approach varies by practice dependant on GP resources and relationships with both consultants and patients.
- For example:
  - Mental health patients are much more likely to be prone to make poor lifestyle choices and therefore be at risk of contracting physical health problems linked to obesity, smoking etc.
  - Regular patient monitoring at a primary care level, instigated by the GP or by the Pharmacist can avoid a multitude of more complex physical medical conditions for patients.
- Again it was acknowledged that GPs would need to be adequately resourced in order to be able to have the time to take this more proactive approach. Alternatively, Pharmacies represent an opportunity for simple health screening to be conducted in primary care, with direct referral to GPs when needed.

*"There needs to be a system in place to recall those with particular mental health issues to ensure they have a check-up."* Healthcare Stakeholder

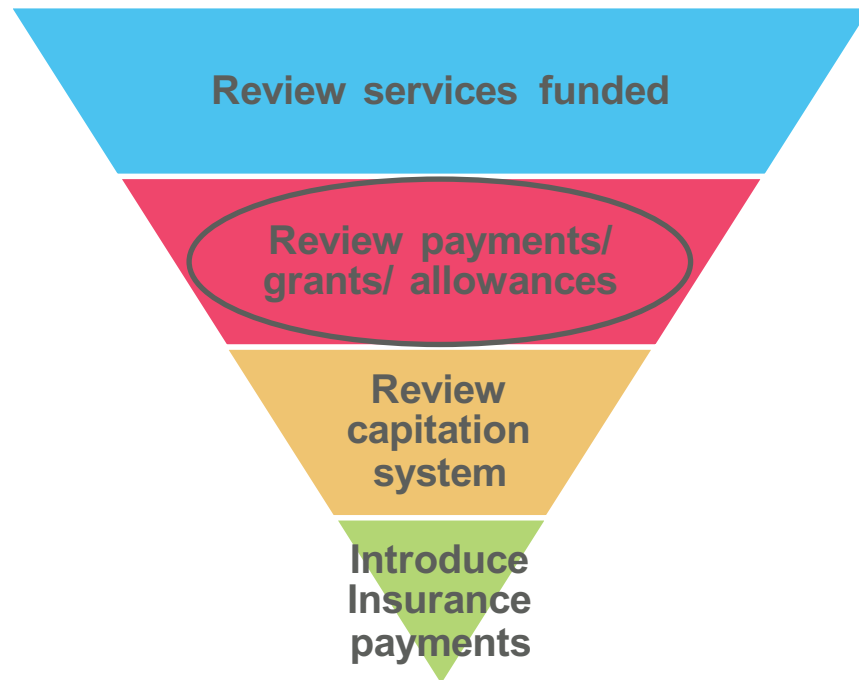
*"[In mental health] there is a real need for GPs to be monitoring patients physical health and being very proactive in this regard."* Healthcare Stakeholder

*"The big strategy that we would want to see is people getting out of hospitals and back to GPs as people are now getting cured of cancer, that is were the contract is very efficient now."* Healthcare Stakeholder





# Financing Structures – Allowances/ Grants



*"The distance coding needs to be brought back because rural practitioners need to be acknowledged because of the distances they travel." GP, Rural*

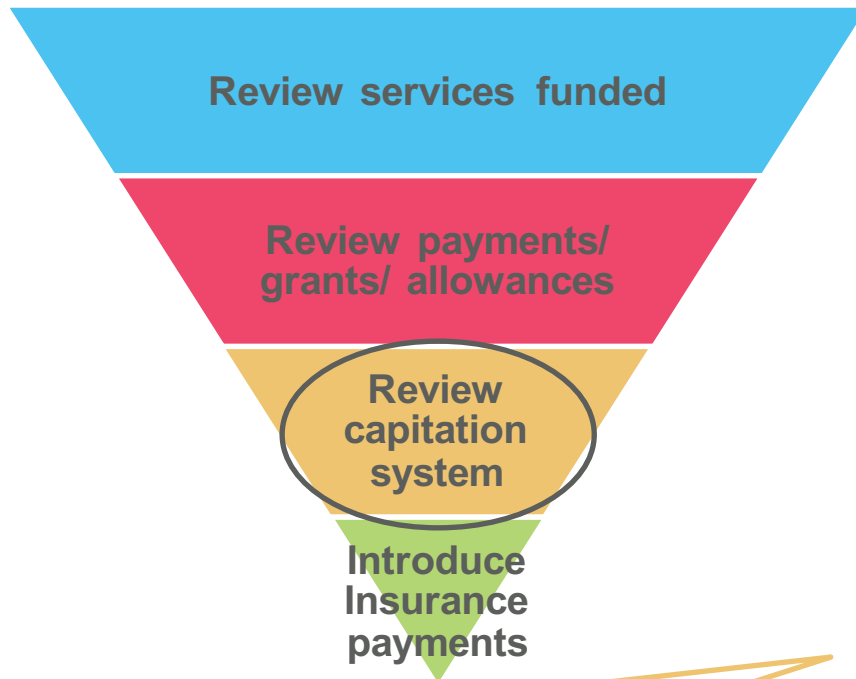
*"Every GP should be entitled to a subsidy for a practice manager." GP, Rural*



- All GPs referenced the requirement for certain grants/ allowances from the HSE in order for them to meet the current demand with quality patient care provision.
- These include:
  - Reinstating the rural allowance / distance coding and introducing a social deprivation grant to encourage GPs to more rural and deprived areas.
  - Reinstating higher nursing home patient capitation payments.
  - Reviewing out of hours funding/ support particularly for rural GPs.
  - Widening / increasing grants for funding of both practice nurses and practice managers to support GPs and ensure their is time spent most effectively.
  - Locum payments which are reflective of what actually has to be paid to a locum.
  - Funding for equipment to enable more complex care provision at a primary level.



# Financing Structures – Capitation Payments



*"There's a problem with the flat rate because if you have an elderly patient and they're in very often, taking up a lot of time, you don't get paid for it. There should be extra payment accordingly." GP, Urban*

*"The overall capitation needs to be increased." GP, Rural*

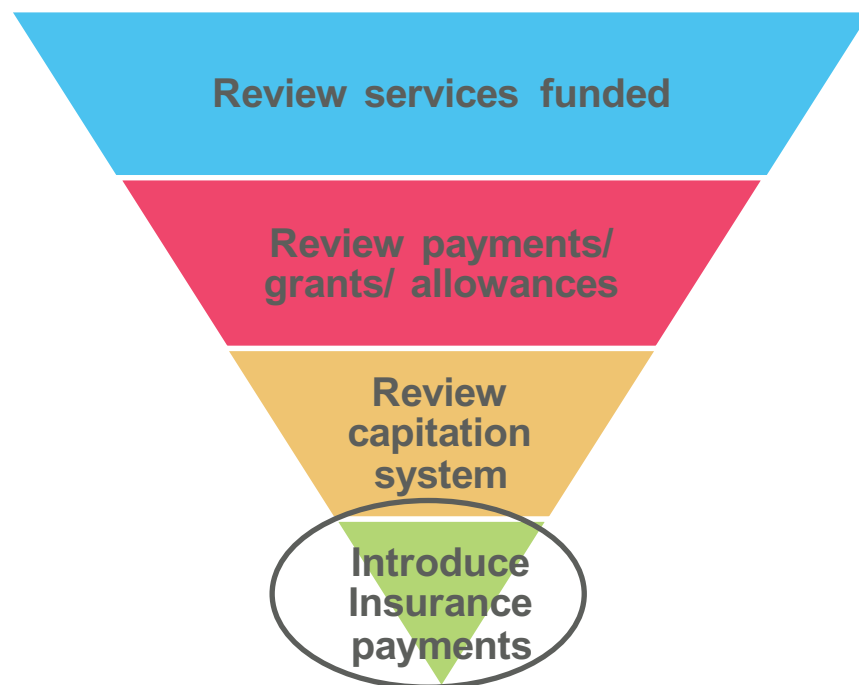
*"We had someone come up to the practice looking for an antibiotic for her dog!! Because she would have to pay the vet if she went there .... That's the wasteful resources GPs are dealing with everyday." Practice Manager*

- The majority of GPs were in favour of a co-payment system being considered.
  - Asking medical and GP card patients to pay a small fee for each visit, in order to deter unnecessary visits – likened to the prescription charge or the plastic bag levy.
- In addition a review of the current capitation amount and structure were also considered important.
  - Incentivise quality care by reflecting time spent with patients, particularly for more complex cases which cannot feasibly be addressed within the 10-12 minute time slot e.g. mental health issues.

*"I think there should be a co payment for medical card holders. So for anyone that gets free GP visits, even if it is 2 euro a visit, it might stop people coming all the time." GP, Rural*



# Financing Structures – Insurance Payments - I



- A niche minority of GPs referenced the option of private health insurance payments as an additional source of funding for GP practices.

- Reference to systems in other countries such as Australia and Canada that allow for, and support this approach.

- Private health insurance payments would help fund chronic disease management services.

- Particularly for non GMS patients who would go to secondary care institutions to avoid payment at the GP.

- GPs felt that private health insurance providers would need to drive this change in consultation with the HSE.

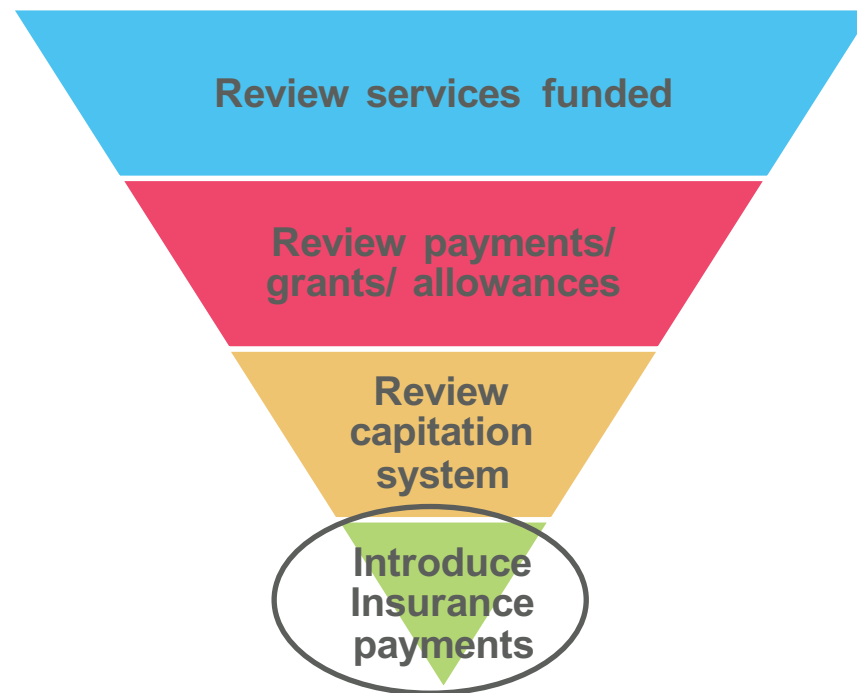
*"We need to change how we charge people. The only way we can do that is if the insurance companies cover general practice in a meaningful way." GP, Urban*

*"One thing I would like is insurance based payments for GPs. They do it in Australia. It changes the whole mind-set. You're paid for what you do. It would bring a lot of changes. We don't have the opportunity to generate income here." GP, Urban*

*"If it was made economically advantageous for insurers to get involved then they could start looking at patient management, the delivery of services, efficiencies of patient care, as is done in Germany" Private Health Insurer*



# Financing Structures – Insurance Payments - II



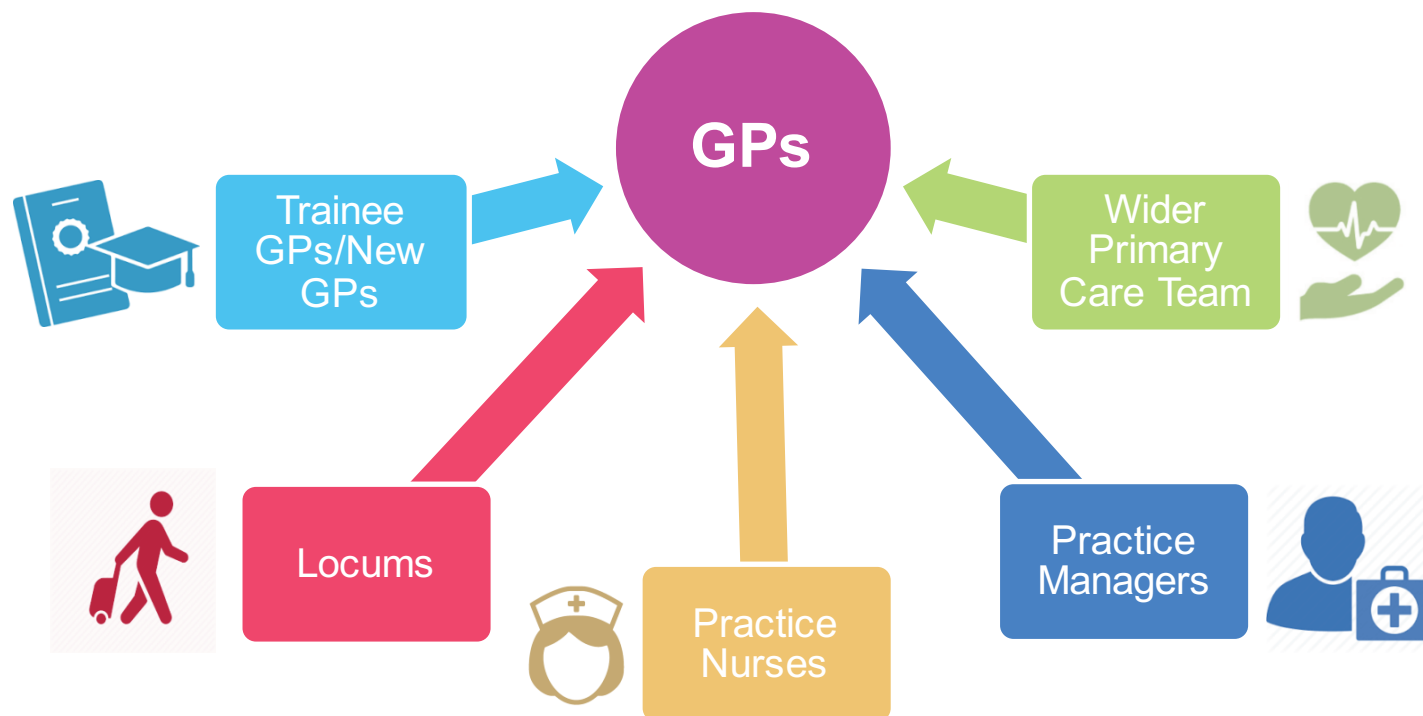
*"The regulation of the market makes it very difficult for insurers to actually enter significantly into the funding of chronic disease management in primary care." Private Health Insurer*

- However, the private health insurance sector reference the current regulatory system as a barrier to their involvement in primary care funding.
  - There is an inadequate risk equalisation system, meaning the current rating system encourages insurers to have young, healthy customers versus looking after the health of older or sicker people.
- Germany is seen as an example of a country where the regulatory market encourages insurers to fund chronic disease management at a primary level.

*"It needs to accelerate [change of current regulatory market]...our population is getting older and primary care has to be a much larger part of looking after those patients." Private Health Insurer*

# Staffing

- Both GPs and consultants referenced the importance of adequately trained staff in order to deliver a quality service and to meet the increasing demands on their time.
- Staffing includes GPs, support staff and the wider Primary Health Care teams, as outlined below.



The current situation and suggested improvements from those consulted are outlined on the following slides.



# Staff – Trainees and New GPs (I)



- All GPs referenced an evident lack of newly qualified GPs staying in Ireland for their career.
  - Considered particularly challenging for rural practices, who struggle to attract new staff members.
- Many attribute the current situation to the existing terms and conditions which are not considered attractive.
  - Requirement to be 'available 24/7, 365 days a year'.
  - Lower pay and longer hours than other countries.
  - Large debt from training/ education.
  - Pressure of self employment from those wanting to be partners.
  - Increased cost of medical indemnity insurance.
- Also current perception that the GMS contract is inflexible and excludes qualified doctors who would otherwise be interested in a GMS contract.
  - e.g.
    - 40 hour week minimum requirements excludes working parents who are looking for part time, flexible opportunities.
    - No job share or contract sharing provision in place.

*"The current model isolates many female doctors who work part-time but would like a GMS contract." GP, Rural*

*"All the young GPs are gone, emigrating. Young doctors don't see a future for themselves in this system, especially when there's no GP contract." GP, Urban*



## Staff – Trainees and New GPs (II)



- ✓ **Funding and communications should focus on encouraging GP trainees/ newly qualified GPs to stay in the country.**  
e.g. offer debt reduction, tax breaks, rural or social deprivation allowances.
- ✓ **Otherwise, wide agreement that any funding currently spent on education and training is partly wasted on those who take knowledge and expertise abroad.**
- ✓ **In addition a more modern and flexible approach should be taken when considering the GMS contract terms and conditions to ensure it is accessible for all GPs.**

*"Graduates that are coming out don't want to work in GP, Rural areas. They want to in the city, work 9-5 and not have to do out of hours. They don't want a premises and staff to be responsible for, they want a salary." GP, Rural*

*"They are facing a real recruitment challenge."*  
Private Health Insurer



*"It's purely terms and conditions. Nobody will take a job when the bottom line on the contract states that they reserve the right to reduce the salary at any time they want." GP, Urban*





## Staff – Locums



- Locums also considered hard to access, particularly in rural areas where they would seek higher payment to encourage them to make the journey.
- In addition, as previously referenced, allowances for locums from the HSE are much lower than those actually paid resulting in a loss for most GPs when paying for a locum.
- Due to limited access and limited funding rural GPs claim to avoid using locums where possible.
  - Negatively impacting on both their work/life balance and work outside the practice i.e. CPD time, attendance of PCT meetings, attendance of hospitals forums.

*"With the GMS they allow a certain amount if you're sick or going on holidays towards a locum. That amount doesn't even cover a half day." GP, Rural*

*"We've got to be able to retain doctors in the country." Private Health Insurer*





# Staff – Practice Nurses



- Practice Nurses are considered pivotal to GPs ability to deliver quality care and ensure continuity of care, in a primary care setting.
  - Ensure GP time spent efficiently.
  - Avoid unnecessary referrals and visits to hospitals.
  - Enable continuity of care for patients.
  - Can deliver a wide spectrum of services which can be under utilised if funding isn't available.
- Larger practices with more than one Practice Nurse highlighted benefits to patients in terms of service provision.
  - Double appointments available for more complex procedures such as phlebotomy.
- Majority of practices have practice nurses either full time or part time.
  - Nurses remit varies depending on training.
- However, all raised the following issues:
  - Lack of funding for practice nurse wages.
  - Lack of available funding and time to up skill/ train practice nurses.
  - Competition with HSE as an employer.

*"We have a specialised nurse but the nurse that specialises in diabetes hasn't been trained to do bloods."* Practice Manager

*"We get a nurses grant and secretary grant but we are in competition with the HSE and the HSE is far more attractive than a practice."* Practice Manager

*"Some producers are time consuming and smaller practices just aren't able to offer them."* Healthcare Stakeholder



# Staff – Practice Managers



- Increase in administrative requirements referenced by all GPs.
  - Particularly due to Primary Care Reimbursement Service (PCRS) processes and GMS prescription transcribing (outlined in more detail in 2.6).
- All GPs value the role of the practice managers within a practice.
  - However, employment of practice manager varies by practice size.
  - Lack of funding available for solo practices to employ practice managers drives dissatisfaction.
- Use of qualified GPs for administrative tasks not an efficient use of resource.

*“If I was a practice manager, I would not be able to cope with the paper work. It’s the GMS contract, so much paper and claims for everything.” GP, Rural*

*“GPs have to do a number of CPD hours a year, so why do you have to go do the PCRS then. From an admin point of view that takes up a huge amount of time.” Practice Manager*

**Broad consensus that HSE funding should help to incentivise GP practices to use resources appropriately ensuring practice nurses and managers are available to enable GPs to focus on consultations and additional services such as chronic disease management and minor surgery.**



# Staff – Wider Primary Care Team (PCT)



- Experiences of working with wider PCT's varied greatly by area.
- Both GPs and healthcare stakeholders spontaneously referenced the benefits of working closely with, and being supported by a network of primary care workers in their area.
  - Higher chance of quality care and continuity of care for patients.
  - Reduce need to refer into secondary care.
  - Access to expert knowledge and advice e.g. talk to a psychologist about a potential mental health case.
- Effective implementation of PCT's considered to be down to
  - Resource,
  - Individual relationships building these teams and networks
  - Location of teams
    - i.e. those in purpose built practices sharing space with HSE team members are able to easily engage with them.
- Interaction evident not just between GPs but also Practice Nurse and Practice Managers.
  - Attending meetings.
  - Sharing learnings and best practice.
  - Discussing complex cases.
  - Ensuring continuity of care.

*"I work in a primary care team, which works extremely well...we were a pilot scheme and were very committed to it so that's what made it work."* GP, Urban

*"Every area is different. 20 years ago we were meeting once a week all the nurses, pharmacist, physio etc. All of those people met once a week for referrals, we still do it. It's brilliant."* GP, Rural



# Staff – Wider Primary Care Team (PCT)



- Key barriers to engagement and effective working practices considered to be:
  - Deficit of wider PCT members; physiotherapists, psychologists, dietitians, occupational therapists, speech and language therapists.
    - If available they are often shared across a wide area or only available via secondary care institutions.
  - Majority not located in same building as other PCT members e.g. GP surgery separate to physiotherapist or psychologist.
  - Lack of incentive/ support for GPs to fully engage with wider PCT team.
  - Unnecessary administration and bureaucracy involved in establishing PCT's.

*"Patients need more access to Public Health Nurses, or services such as long term wound care need to be free when offered by a practice nurse"* Healthcare Stakeholder

*"Our access to primary care staff has depleted"* Healthcare Stakeholder

*"I think some primary care teams were created for the sake of it...the fact that they achieved nothing was irrelevant to the politicians,."* GP, Urban



# Training – GPs

## GPs

- Majority of GPs claimed to complete required CPD outside of working hours where possible.
- Opportunity to engage in training outside of required CPD time considered limited by the majority due to lack of time.

- ✓ Continuation of training and upskilling considered essential for the profession.
- ✓ Opportunities for training GPs in more complex care and incentivising them to do so.
  - Encourage via shadowing and training with secondary care consultants/ specialities.
- ✓ Support approach with GMS contract that recognises and supports training in a sustainable and flexible manner.

## Consultants

- Majority of consultants reference the importance of GPs Continuing Professional Development (CPD).
  - However, awareness that time is limited and this is often done outside of hours.
- Involvement of consultants in GPs CPD where possible also considered important.

*"They need to encourage practical upskilling and suitably reward this."* Healthcare Stakeholder

*"Anyone training for acute care needs to spend a lot more time in primary care and vice versa."* Healthcare Stakeholder

*"Promote integration between acute and primary care via training."* Healthcare Stakeholder



# Training – Practice Nurses - I

- There is currently no requirement for GPs to release nurses for training or to encourage their CPD.
  - Therefore, results in a varied approach across practices.
  - Where investment is made practice nurses are able to support GPs on a wider spectrum of services e.g. wound care, phlebotomy's, assistance for minor surgery.
    - Beneficial for patient experience.
    - Ensures care in the community/ at a local level where feasible.
    - Maximises use of GP time.
- GPs are restricted by a lack of funding.
  - They can't finance training and replacement staff.
  - Call for HSE to do more to support this.
- The HSE encourages a more structured training programme for public health nurses (PHNs) resulting in a divide between the practice nurse and PHN skill set.
  - Opportunity for practice nurses to attend some HSE training where roles overlap.
- Role of Irish Practice Nurses Association considered essential in supporting and representing practice nurses.
  - Potential for more collaboration with the HSE.

*"Practice nurses can attend HSE education...so the PHN and the practice nurses could share modules, for example on wound care, but practice nurses aren't released to attend. That has implications for PHNs and practice nurses working together." Private Health Nurse*



## Training – Practice Nurses - II

- Forward planning considered essential here to maximise the use of practice nurses in order to provide a better service for patients at a primary care level.
- Increase resource allocation for practice nurses – both wages and training.
- Increase types of procedures that can be carried out by practice nurses e.g. compression dressing, wound care.
  - Offers continuity of care for patients.
  - Reduces pressure, and funding demands, on hospitals and PHN's.



*"We could do the test for Hematomas here ...we could see these patients and invest in another nurse, or training, and it would free up hospitals and would be cheaper." Practice Manager*



# Medical Facilities and Equipment

- The quality of facilities and access to equipment varied greatly by practice size and practice location.
  - Smaller and more rural practices were most likely to need to refer patients to other PCT members or secondary care facilities due to a lack of suitable equipment on site.
- In addition ability to purchase equipment (replacements or new equipment) varied by practice and their financial situation.
  - However, all felt that current GMS payments did not cover any funding for medical equipment/ machinery etc.
- Practice Nurses using equipment regularly for height and weight check-ups, felt more funding should be provided for equipment maintenance and upgrading.
  - Particularly since the introduction of free access for under 6's, which has increased the usage considerably.
- A minority of GPs also referenced the current variation in services offered to GP practices versus consultants – with lower priority being given to testing blood samples from GP practices leading to samples being unusable and/ or requiring retests.
- Minority referenced current ban on inter-referrals between practices as a barrier to improving access to care for patients.
  - This inflexibility seen to drive more patients into secondary care unnecessarily.

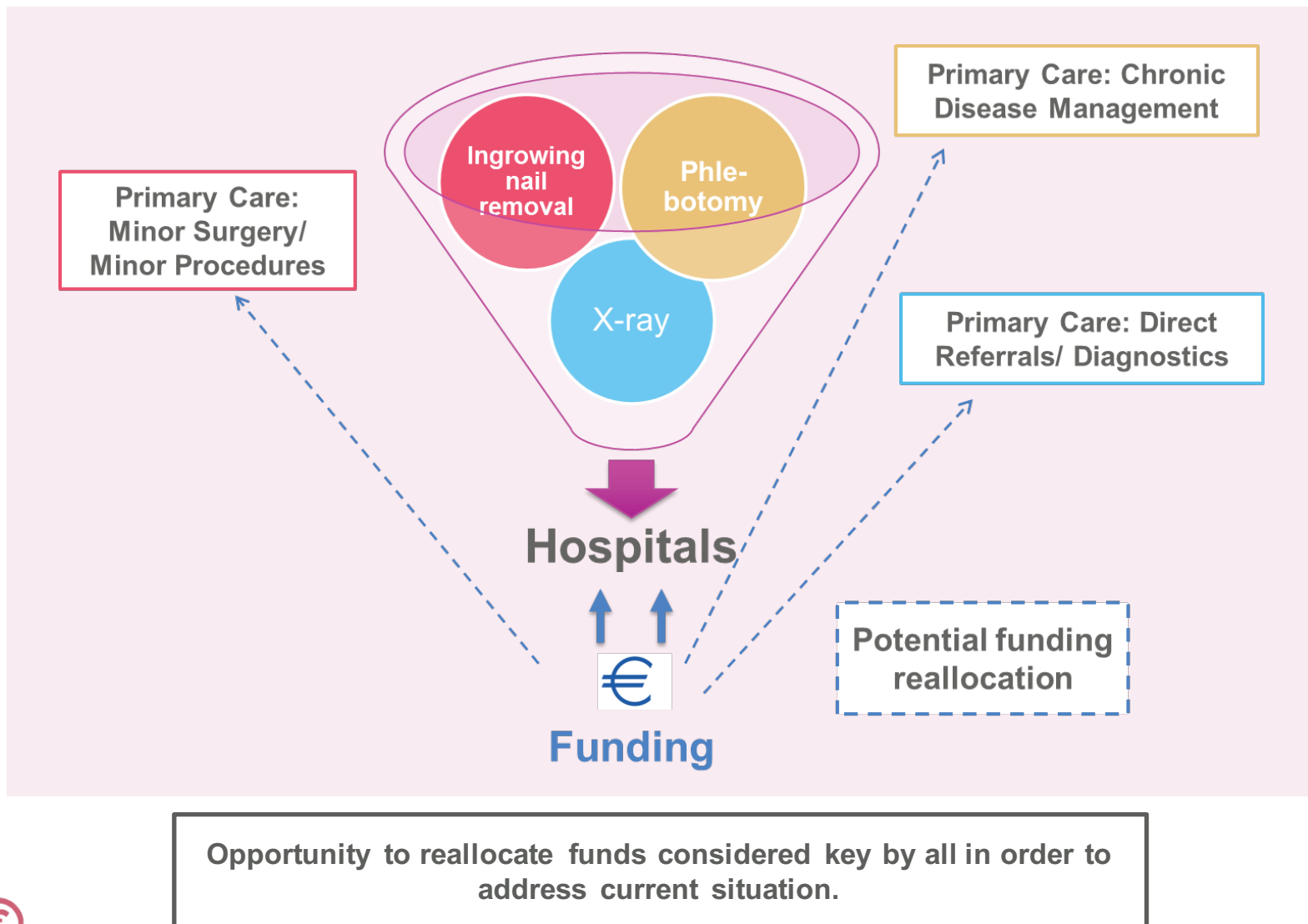
*"A kidney specialist said that the blood samples need to be checked in a certain amount of hours, they do consultants first over GPs' due to hospitals being so busy and the GP ones are left sitting on the desk and then are too old." GP, Rural*

*"Testing for blood clots, you can buy the machine but it would cost €2,000 and the test for each consumer would be about €50. If that was resourced in general practice it would save someone having to go to the hospital." Practice Manager*

*"I use my own instruments, if you use disposable ones it costs a lot more money and it's only in the past 6 months that the HSE pay but there wouldn't be any profit from it." GP, Rural*

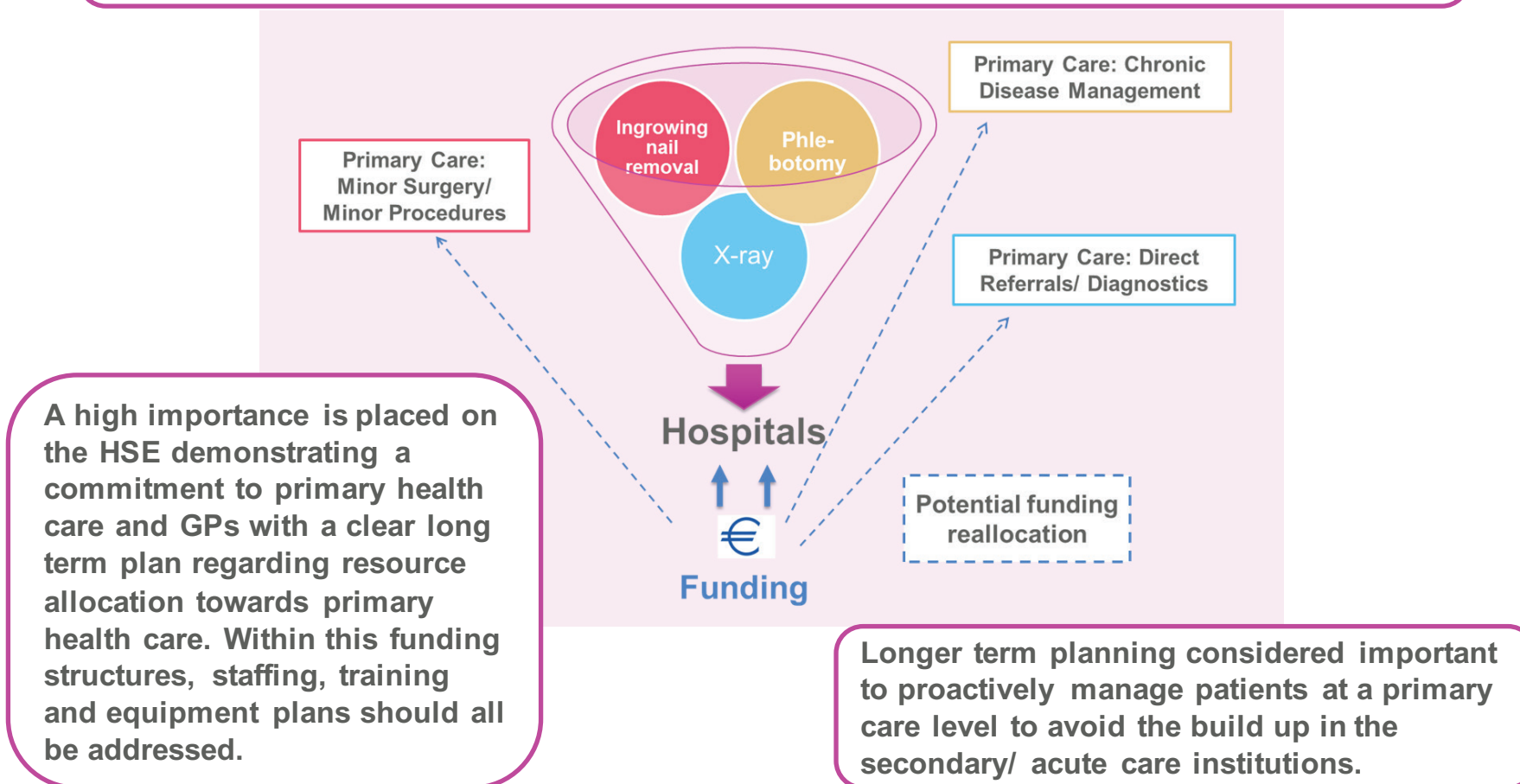


# Resources – Summary - I

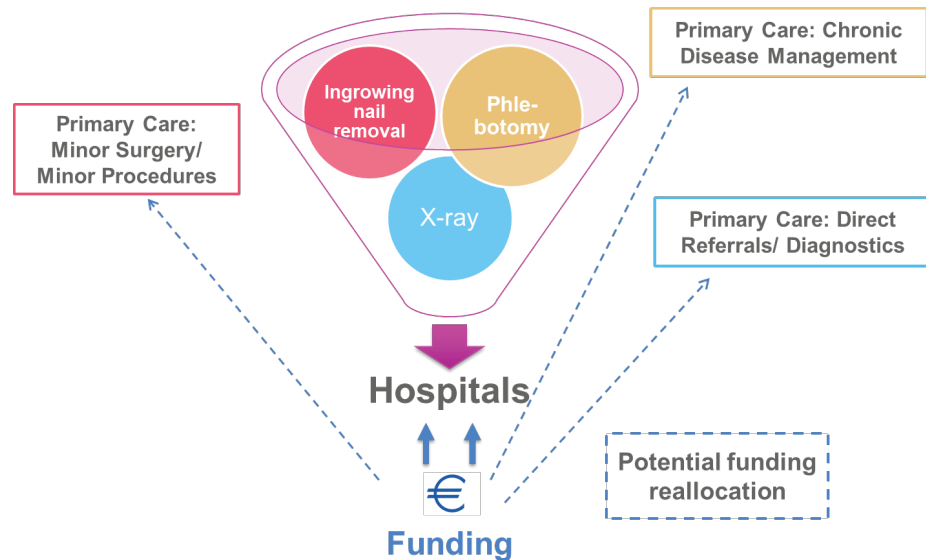


## Resources – Summary - II

Widespread agreement that the current funding allocation from the HSE to GPs needs to be reviewed. Too many patients currently being unnecessarily funnelled into secondary care. Resulting in long waiting lists and blockages at entry points – most notably A&E.



## Resource – Summary - II



- Widespread agreement that the current funding allocation from the HSE to GPs needs to be reviewed.
  - Too many patients currently being unnecessarily funnelled into secondary care. Resulting in long waiting lists and blockages at entry points – most notably A&E.
- Longer term planning considered important to proactively manage patients at a primary care level to avoid the build up in the secondary/acute care institutions.

- A high importance is placed on the HSE demonstrating a commitment to primary health care and GPs with a clear long term plan regarding resource allocation toward primary health care.
  - Within this funding structures, staffing, training and equipment plans should all be addressed.
- The formalisation of more simple chronic disease management through pharmacies should be explored, in order to potentially relieve pressure on GP. However, need to have a simple procedure for pharmacists to make further referrals back to the GP if necessary.

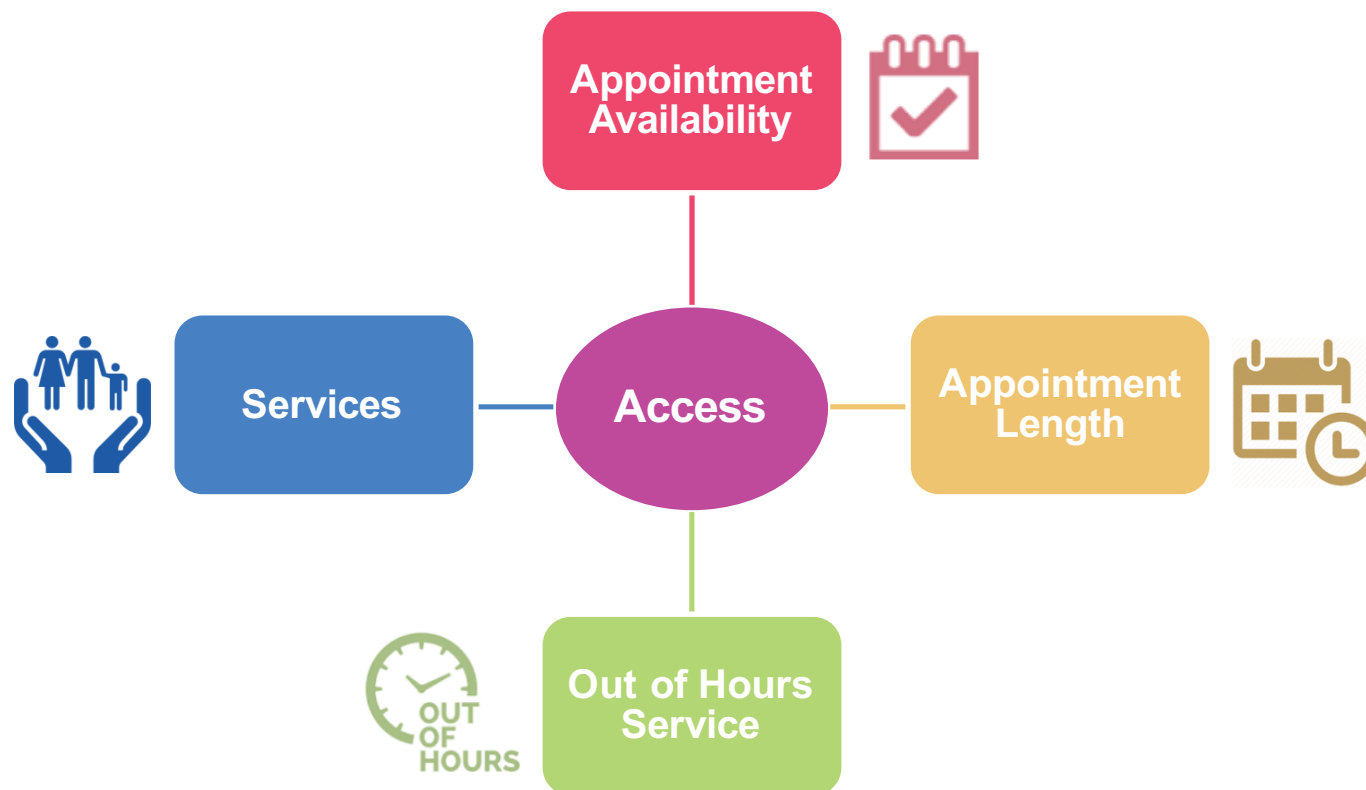




## 2.3 Patient Access

# Patient Access – Overview

Patient access to GP care has been analysed across the four key areas outlined below.



Overall perceptions of both GPs and consultants was that free access to GPs had increased overtime e.g. GP card, under 6 free access. With the decline in funding (post FEMPI cuts) and the increase in free access to GPs, the current situation is not considered to be sustainable for GPs.



# Access – Appointment Availability



- All felt access to GPs was relatively good, with most able to accommodate patients in less than 24 hours with urgent patients able to get more immediate access.
  - GPs and healthcare stakeholders referenced waiting times in the NHS being over a week on average.
- However, those in larger practices acknowledged that patients may not always get to see the GP that they wanted, something which they feel has changed and will continue to change over time as pressure increases i.e. more access, less funding.
- Prevalence of visits outside of the practice also varied.
  - All would do some home visits or visits to nursing homes.
  - All acknowledge that this is an essential part of the GP service, and again important to ensure care at a local level.
    - However, this requirement increases pressure on limited resources.
- GP interaction with nursing homes and nursing home patients considered particularly challenging.
  - Current capitation not considered sustainable and administrative process considered too cumbersome.

*"At the moment I'm getting paid 180 euros a year to see nursing home patients, and you may see them once a week, 50 weeks of the year." GP, Rural*

*"Because it is such a GP, Rural area, we do a lot of house calls, which a lot of younger GPs don't want to do. We are under the Shannon Doc for out of hours, so we do our own shifts on that." GP, Rural*





## Access – Appointment Length



- GPs and Practice Nurses stated that appointments were scheduled to last between 10 – 15 minutes.
  - Majority stated actual appointment times vary from 5 – 30 minutes.
  - In addition 1-2 urgent patients would be added on to the list.
  - Overall this results in surgery times running over.
- Key drivers for appointment length considered to be:
  - Complexity of patient condition;
    - Chronic disease patients, older patents, those suffering with mental health problems all referenced as drivers for a longer appointment length to ensure appropriate quality of care.
  - Private patients look for 'value for money'/ visiting for multiple reasons.
  - Relationship with patient i.e. some patients want to have a chat with GPs.
  - Proportion of appointments out of the surgery – home or nursing home visits.
- Majority of GPs not looking for a change to the current appointment system/ set-up.
  - However, all felt that the current GMS contract and associated funding should be more reflective of required time spent with patients in order to deliver quality care.
- In addition the role of the practice nurse also considered key to reduce burden on GPs and increase access for patients.
- Consultants working closely with GPs such as geriatricians and psychiatrists value time GPs currently spend with more complex patients.
  - Need to avoid reduction in appointment times, but ensure GP remuneration is reflective of time required for more complex cases.

*"I have 15 minute slots per patient, but on a busy day I would double book and might see up to 40 patients." GP, Rural*

*"We need to build something in that reflects more complex care needs such as a discussion around end of life care with a family." Healthcare Stakeholders*



# Access – Out of Hours Service



- All GPs provide an out of hours service, as required by their contract.
- Widespread agreement that this was an essential part of their service offering for patients.
- Out of hours agreements in place varied.
- Majority part of a regional co-operative where multiple practices pool together to offer out of hours services.
  - Frequency of being 'on duty' varied for those in a co-op from fortnightly to every few months.
- Those in more rural areas experience more challenges with the co-op:
  - Distances meant patients could be circa 1 hour away from their closest out of hours surgery. Therefore practices offer their own out of hours service.
  - Much higher demands on GP time.
    - On call 1 – 2 nights a week and every 3-4 weekends.
- Both consultants and GPs noted the importance of the out of hours service in avoiding unnecessary visits to A&E and build up of waiting lists at a secondary care level.
- GPs keen to see improvements in record keeping and sharing within the out of hours services.
  - i.e. if an out of hours doctor sees a patient, records should be kept and shared with the patients own practice (see section 2.5).

*"There are some geographic limitations, there are some very isolated areas that can't join a co-op. there are some people that are very isolated."* GP, Urban

*"It means we do 1 in 4 weekends and then we do 1 or 2 nights a week. It's very full on, most nights are reasonably quiet, but you cant relax obviously."* GP, Rural

*"Out of hours we do it ourselves.. we felt it would be inadequate for patients if a service was 30 miles away, so if there was any real emergency the patients wouldn't get a good enough service."* GP, Rural



## Access – Services



- Overall all GPs felt that patients have access to a high quality GP consultation service across the country.
- However, additional services offered by GP practices differs greatly dependant on practice size and area.
- All GPs and healthcare stakeholders acknowledged the evident variation regarding what services patients could access.
  - As previously highlighted access to a practice nurse and other primary care staff outside their practice considered important to ensure timely, quality care for patients.
- In addition access to diagnostic services at a primary care also considered important.
  - See section 2.4.

- The long term goal regarding GP services, shared by GPs and healthcare stakeholders, is the provision of quality and continuous care at a primary level for all patients where it is medically advisable.



*“GP care of older people is good...but other members of the primary care team need to be bolstered up e.g. having enough physiotherapists, psychologists etc.” Healthcare Stakeholder*

*“The service is accessible and accommodating.” GP, Urban*

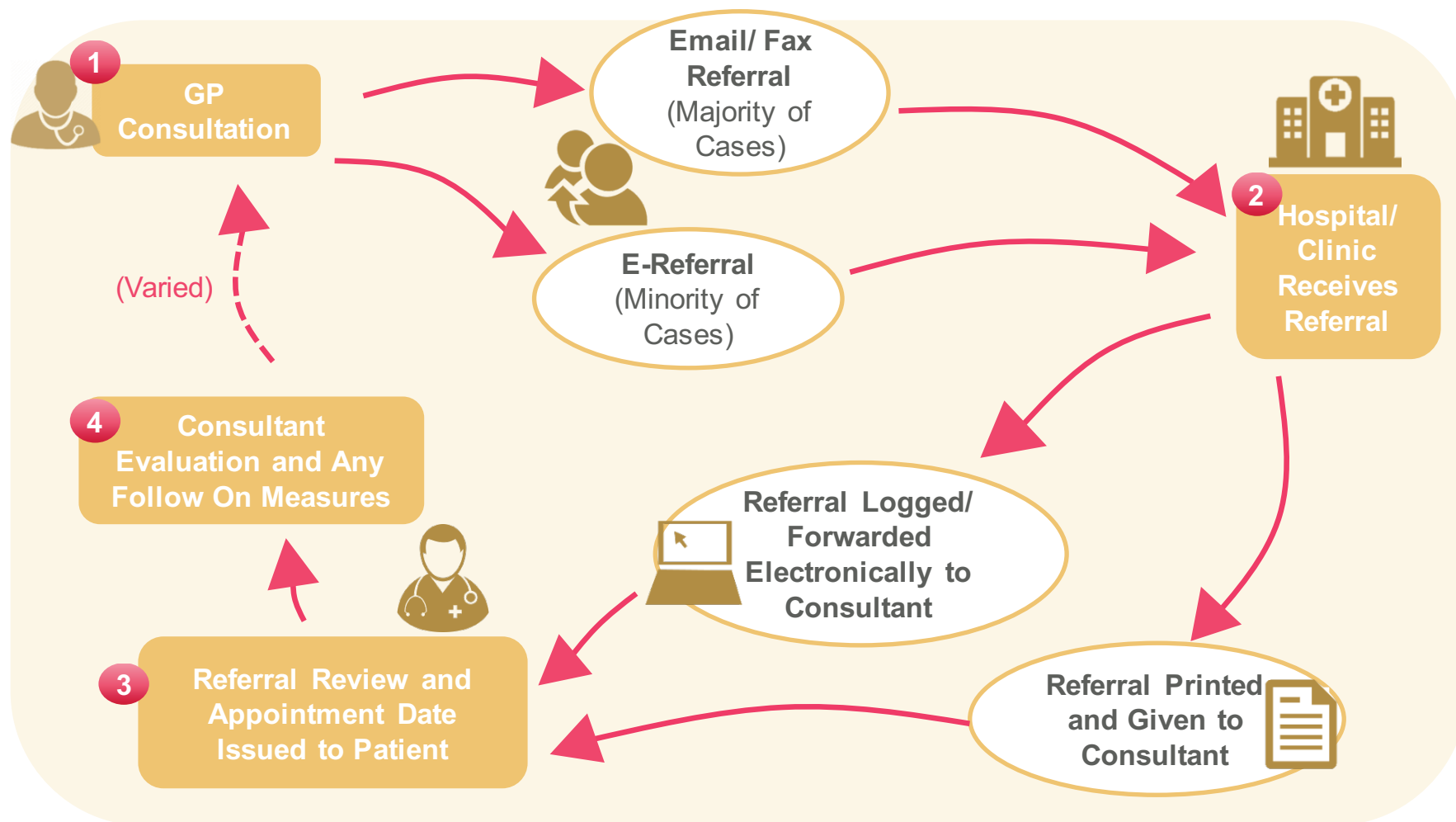
*“We need to give doctors access to diagnostics.. We have to have resources in the community so patients can actually be looked after” Private Health Insurer*





## 2.4 Referrals Process

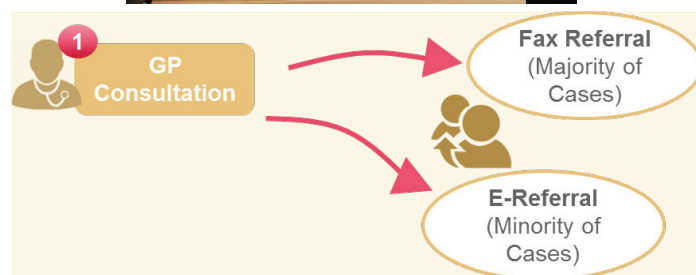
# Overview of Current Referral Pathway



The referrals process generally follows the above pathway between GPs and consultants, which will be explored in further detail on the following slides.



# Evaluation of Current Referrals Process – I (GP Referral – I)



*"There is a huge benefit of going electronic. As up to now they were faxing and they can get lost or go to the wrong place and then the patient misses out." Healthcare Stakeholder*

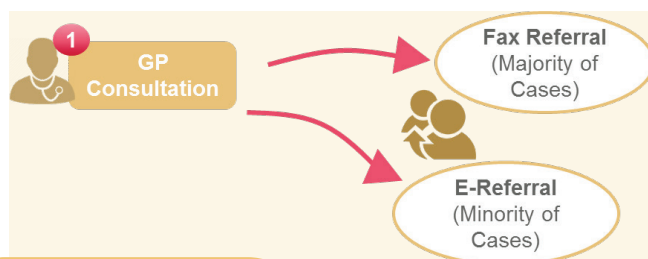
- Upon patient assessment, the GP refers the patient to the hospital/clinic via fax or electronically (where possible).
- Fax referrals considered outdated, creating extra work for hospital administrative staff, and potentially causing delays for the generation of patient appointments.
  - Consultants acknowledge the potential for faxes to get lost/not forwarded/reviewed within an appropriate space of time.
  - Mention of referrals being handwritten on occasion, causing some difficulty for consultants in deciphering illegible text.
- Where e-Referral processes are in place, e.g. some oncology areas, and easy for GPs to access, they are considered to work well and cut down on time required to administer an appointment date to patients.

Overall preference for movement towards electronic e-Referrals process, to cut down on administration time needed. However, this needs to be one centralised system to ensure efficiency and ease of use for the GPs.





# Evaluation of Current Referrals Process – II (GP Referral – II)



*"The issue GPs have is the letter referring patients urgently with suspected cancer and having access to the diagnosis test that is needed."* Healthcare Stakeholder

*"The waiting list is far too long for ultrasound and there is no access to CT or MRI. We can't refer for medical card patients. It's a resource issue, a rationing technique."* GP, Urban

*"About 40% in the emergency department would have been referred by a GP, some would be very sick while others may be needing an x-ray."* Healthcare Stakeholder



**Inability to directly refer patients for some diagnostics creates unnecessary steps and added costs for patients, GPs and hospitals.**

- GPs are unable to directly refer non emergency but still urgent patients for certain diagnostics, and instead have to refer to a consultant, which can take months for an appointment to be issued.
  - Potentially negative impact on patient healthcare.
- Alternatively, in the majority of urgent cases, the GP can be forced to refer a patient through the Emergency Department, regardless of certain patients/conditions not being advisable to visit the emergency department.
  - GPs may be aware of the exact diagnostics required, however cannot directly refer.
  - Some GPs may also be referring more serious cases they do not have time to assess to A&E.
  - Opinion of consultants and GPs that this is contributing towards hospital overcrowding.
- In certain emergency cases, a GP will have to call an ambulance, which requires that they have to follow the triage process.



# Evaluation of Current Referrals Process – III (Hospital Receipt)



Referral Logged/  
Forwarded  
Electronically to  
Consultant

Referral Printed  
and Given to  
Consultant

*"The initial way it comes in is as a letter or a fax, then is uploaded to the electronic system which is internal."* Healthcare Stakeholder

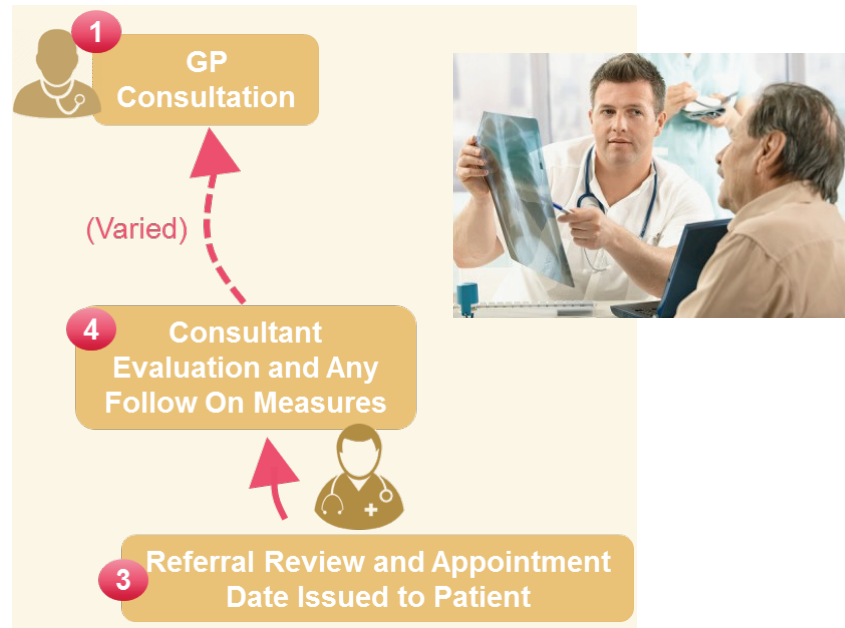
*"There are 4 sections such as inpatients, outpatients, emergency department and GPs. An administrator takes care of all 4 areas but the culture is that GP referrals lose out in overall resources. This is because if a patient is in hospital, they are considered as more urgent compared to a GP patient that is not in hospital."* Healthcare Stakeholder



- When the referral is received by the hospital there are two potential routes for forwarding to consultants;
  - Soft copy given (irrespective of whether it is received by fax or electronically).
  - Referral logged on system electronically (more time consuming if received via fax).
- Reliance on soft copy format considered cumbersome for administrative staff, negatively impacting the environment, and also potentially dangerous considering the increased risk of sensitive information being left in an easily accessible format or misplaced.
- In certain cases, administrative staff are also in charge of determining urgency of GP request – can lose out to in-patient/ emergency department cases.

*"The fact we are using a single form, we have a triage system, now that we are seeing people within certain time periods is positive. But referrals are still such a cumbersome process as it's all done over paperwork and if we could unify our access to their old results, correspondence, blood tests, make it all electronic that would make it all a lot more efficient."* Healthcare Stakeholder

# Evaluation of Current Referrals Process – IV (Consultant Review)



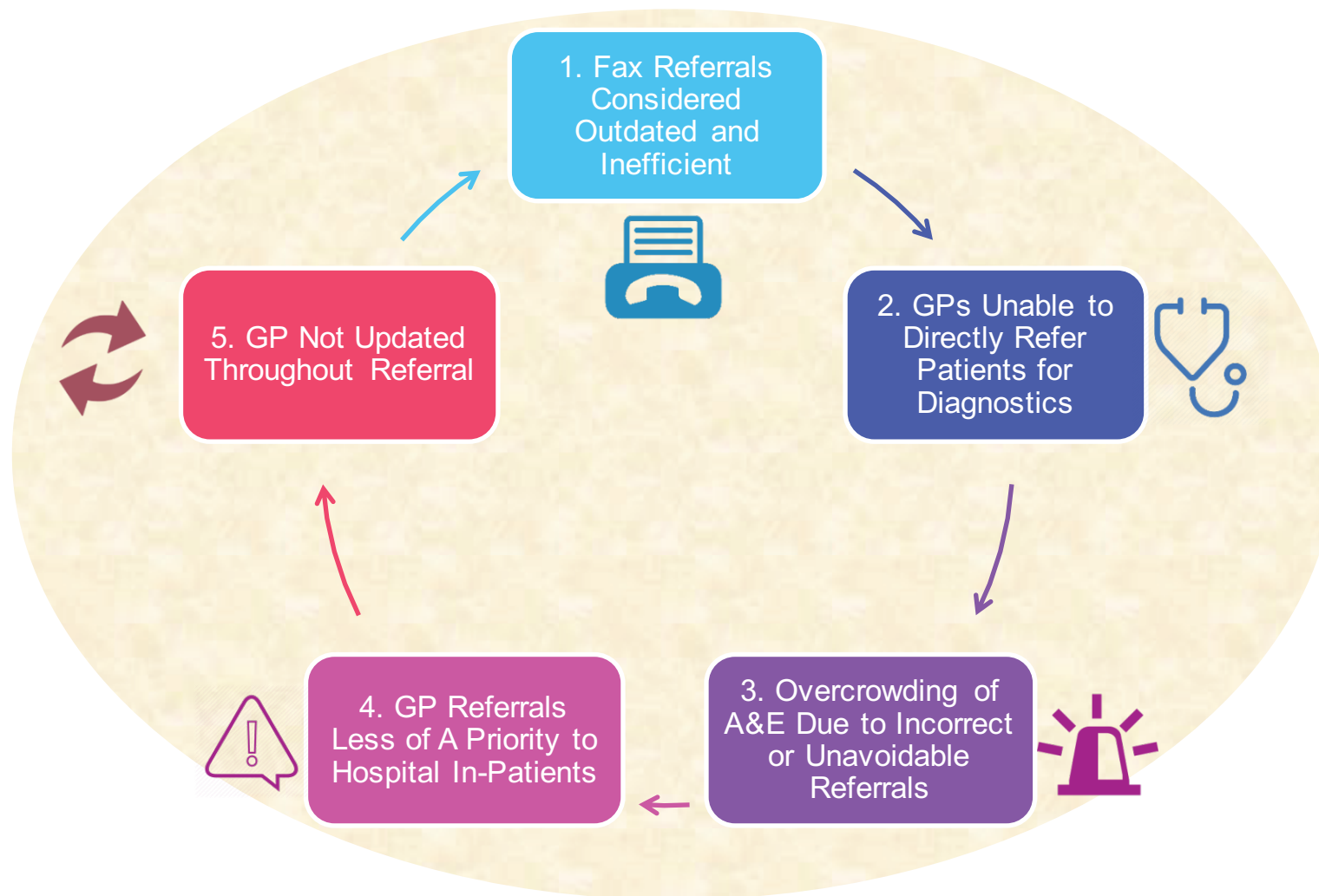
*"GPs get frustrated that they cant directly refer the patients such as acute appendicitis's, such as males if they have the symptoms they should go straight to surgery and I support them with that."*  
Healthcare Stakeholder

- Consultant required to see patients and refer for further diagnostics in some cases, even if GP is aware of the tests required.
  - This adds to pressure on waiting time for consultants.
- Some mention that GPs may also write to multiple consultants to secure an appointment date for a patient, also adding to waiting times and administrative duties within hospital/ clinic.
- Overall, whilst it was acknowledged that it was possible for GPs to contact consultants (via phone, etc.) to follow up on patient progress, a patient update was not generally sent back to the GP as standard at this stage.
  - This caused frustration amongst all practice staff (GPs, practice nurses and managers).

**Lack of formalised procedure for patient updates between GP and consultant after referral, can exclude GPs from having relevant up to date information on their patient's health and requirements.**

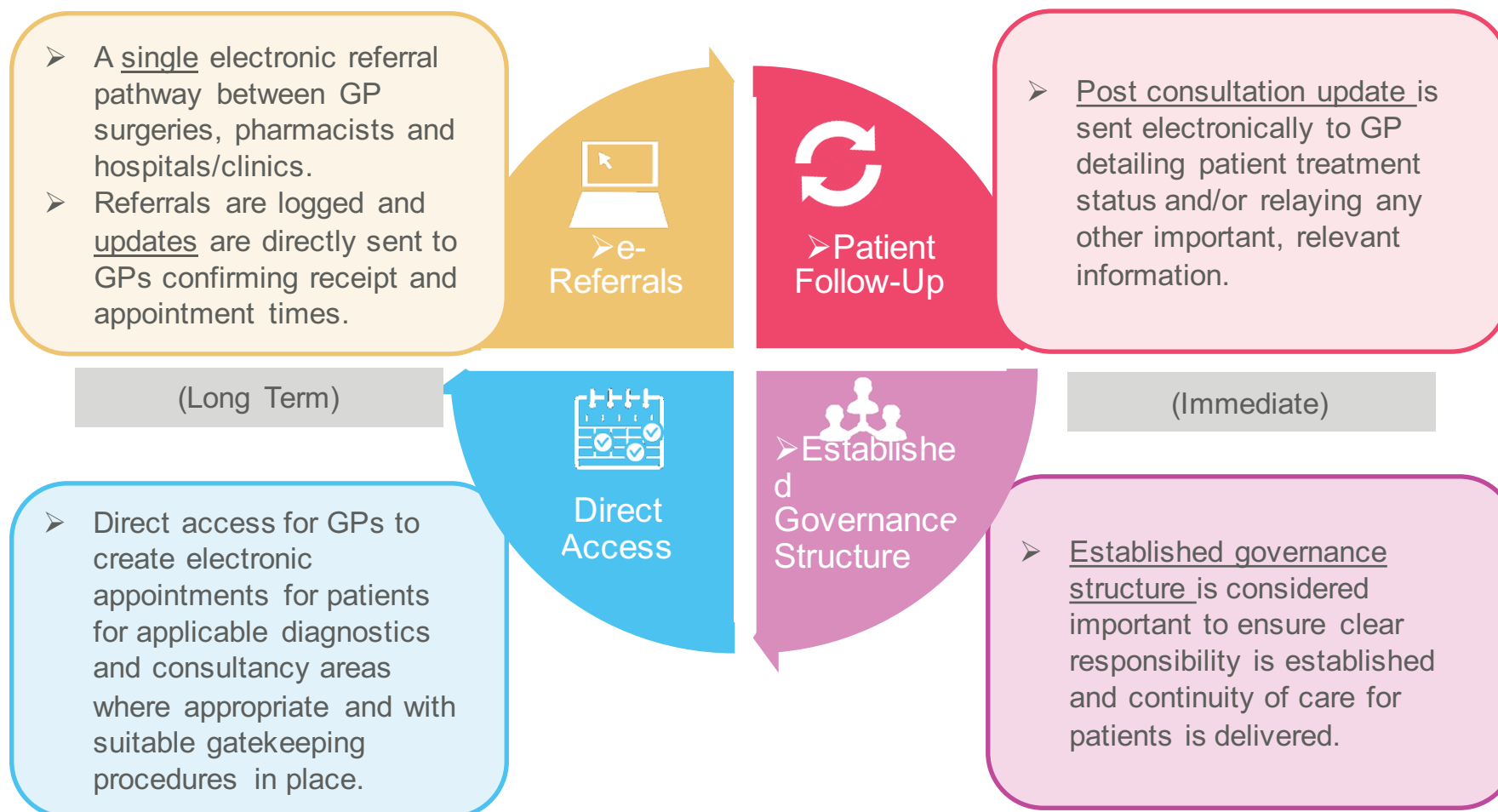


## Summary of Key Issues in Referrals Process



Recommendations to address these issues are outlined on the following slides.

# Overview of Ideal Referrals Process



The ideal referrals process would be a combination of the above processes.

# Ideal Referrals Process – Patient Follow-Up

(Immediate)

## Benefits

- ✓ Improved patient post care.
- ✓ More detailed history and record of patient needs and interactions with medications.
- ✓ GP in better position to make informed referrals in future.

## Patient Follow-Up



*“What we hope to do in the future is to email copies to GPs, so they know their patients have had an interaction with us.”* Healthcare Stakeholder

*“A huge amount of engagement with patients outside of the hospital has to happen through the GP [particularly for geriatric and mental health].”* Healthcare Stakeholder

*“GPs need to be kept in the loop around what is happening with patients as we don’t have GMS prescription rights.”* Healthcare Stakeholder

**Follow-ups by consultants could be introduced immediately as a requirement via email/electronic means, using a single standard guide. In the long term, movement towards a single, electronic patient record system would be advisable.**



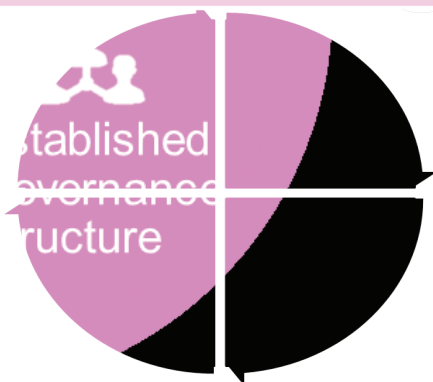
- As the primary care provider GPs should be the central source for a patient’s complete history.
  - However, patients may not be aware or remember specific medications used during a procedure, or of their previous poor responses to certain medications.
- Currently there is no standard, formalised procedure for GP updates post patient interaction with consultants or the emergency department.
  - No central record with all patient information.
- As the primary care providers, GPs are chiefly responsible for management of chronic conditions or follow-up care of patients.
  - Post care could potentially be made easier for GPs to facilitate if relevant information was made available as standard.

# Ideal Referrals Process – Governance Structure

(Immediate-Long Term)

## Benefits

- ✓ Ensure clarity for all medical professionals regarding where responsibility lies.
- ✓ Ensure continuity of care for patients where possible.



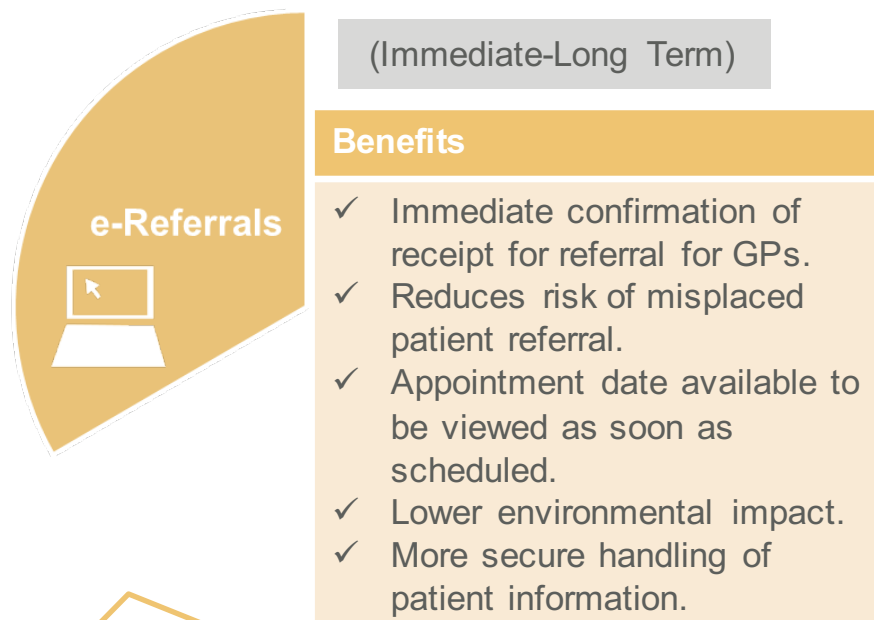
*"When we refer back to the GP there should be a clear understanding of where responsibility lies." Healthcare Stakeholder*



- An established governance structure is considered important to aid the referrals process between GPs and consultants.
  - When a patient is referred to a consultant and vice versa there should be a clear understanding of where responsibility lies for that patient.
    - This should either be with the GP or the consultant.
- The process should allow for additional PCT members or other medical professionals to be included in correspondence, but the referral communication should ensure clarity regarding who is the lead, and therefore who has responsibility for the patient.
- In tandem with the patient follow-up outlined above this should ensure:
  - Clarity for GP, consultant and patient regarding next steps in the patient pathway.



# Ideal Referrals Process – e-Referrals



*"If the e-referral was the first point in that electronic system it would be good. That is our major recommendation that everything goes electronic."* Healthcare Stakeholder

*"The referral process would be smoother if we did have a completely electronic format."* Healthcare Stakeholder

*"I think that an electronic system is far superior to a paper based system. I think e-Health should be promoted so all tests, referrals are electronic."* Healthcare Stakeholder

Overall, there was a preference amongst both consultants and GPs to move towards a single, centralised electronic system, which would allow GPs to refer electronically, receive an acknowledgement of receipt, and an update when appointment date is administered.

However, currently the burden is on GPs or on individual consultancy areas to make improvements and develop these systems, leading to very different processes being used across different areas.

■ No centralised system currently in place.

*"GPs list every consultation with patients for the past several years in a not so reader friendly way. It is then hard to pin point what the referral is for. E-referrals would be a good idea."* Healthcare Stakeholder

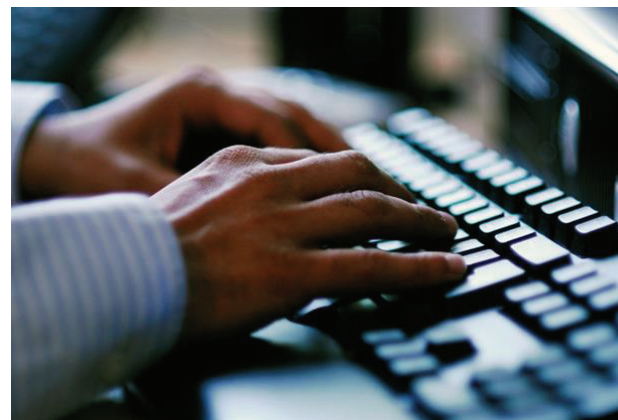
**Important that the burden is not on the GP to pay for and equip surgery with e-Referrals systems, but is provided for as part of a mandatory roll-out, or subsidised.**





# Case Study - National Electronic General GP Referral Pilot Project

- This programme was established in 2011 to deliver electronic general referral, using the HIQA/ICGP standard referral template.
- It is currently set up between GPs and Tallaght Hospital, Dublin and the 6 acute hospitals in Cork City/County and Kerry.
- This project is run in conjunction with Healthlink, the ICGP, GPIT, NCCP and the Outpatients Performance Improvement Programme.



*"It is good with common cancers where we have set up referral processes and rapid access clinics....It is linked with the ICGP and an IT group and we work hand in hand with them. GPs automatically have access to the referral template or they can go to a help link. Where we haven't done that, GPs are waiting a long time, but where we have set it up it is working fine."* Healthcare Stakeholder

*"We have e-Referral for prostate cancer. We have been using it for the past 9 months and the feedback that it is working quiet well and the services need to be extended."*  
Practice Manager

- The e-Referrals system which is current being used across a number of major cancer areas is considered a positive, timely and efficient means of getting patients assessed by a consultant.
  - Immediate acknowledgement that the referral has been received.
  - Speedy response indicating the triage category of the patient and appointment date.
- However, it is currently focused on major cancer areas, and other disciplines are not included.



**A single referrals system using the above example as a basis would be an efficient long term improvement.**

# Ideal Referrals Process – Direct Appointments

## Benefits

- ✓ GPs able to get immediate confirmation of appointment for patient, meaning they are less likely to refer to multiple consultants.

(Long Term)

Direct Access



*“Direct access meaning that they can directly refer a patient in for one of these tests as opposed to referring a patient to a hospital and then getting a request.”*  
Healthcare Stakeholder

*“It also means that GPs are aware of how long the patient may have to wait for an appointment.”*  
Healthcare Stakeholder

*“Diagnostics, in some places you can order CT scans and MRI’s but then in other places you can’t. There is stuff like that, that need to be sorted out so that GPs can order an investigation that they feel is needed really.”* GP, Rural

- GPs are unable to directly book patients in for appointments for diagnostics or for appointments with consultants.
  - Causing unnecessary pressure on waiting lists.
- GPs would preference being able to directly book patients, especially emergency cases in for diagnostics directly, without having to refer them to A&E or to a consultant.
  - However, it is understood that a gatekeeping system would be required to ensure prioritisation.
  - In addition for some diagnostics direct referral not considered appropriate due to limited resources or complexity of issues e.g. heart ultrasound.
- It would also be possible to reduce administration on hospital/clinical staff if GPs could book in appointments with consultants electronically for certain patients/conditions.
  - Strict guidelines would need to be in place to prevent any potential system abuse.

**An electronic system allowing GPs to directly book in appointments and diagnostics and view available slots would be beneficial to the patient and would reduce administrative time. However, a clear, strict procedure would need to be in place to assure responsible usage.**



# Case Study – Heart Failure Virtual Clinic

- Set-up by St Vincent's hospital to offer GPs the necessary support to aid care for heart failure patients at a primary level.
- Virtual consultations conducted between GPs and consultants via a secure online system.
- This scheme was introduced in 2015 in conjunction with ARCH.



*"This should be the gold standard moving forward." Healthcare Stakeholder*

*"Overall there has been very positive feedback so far." Healthcare Stakeholder*

- **Provision of flexible access to consultants for GPs.**
  - Remove many of the existing barriers present in the current inefficient referrals and communication processes.
- **Enables GPs to discuss specific case details and receive advice from consultants, thus reducing the need to refer patients on to secondary care.**
- **Overall the service has been well received by both consultants and GPs.**

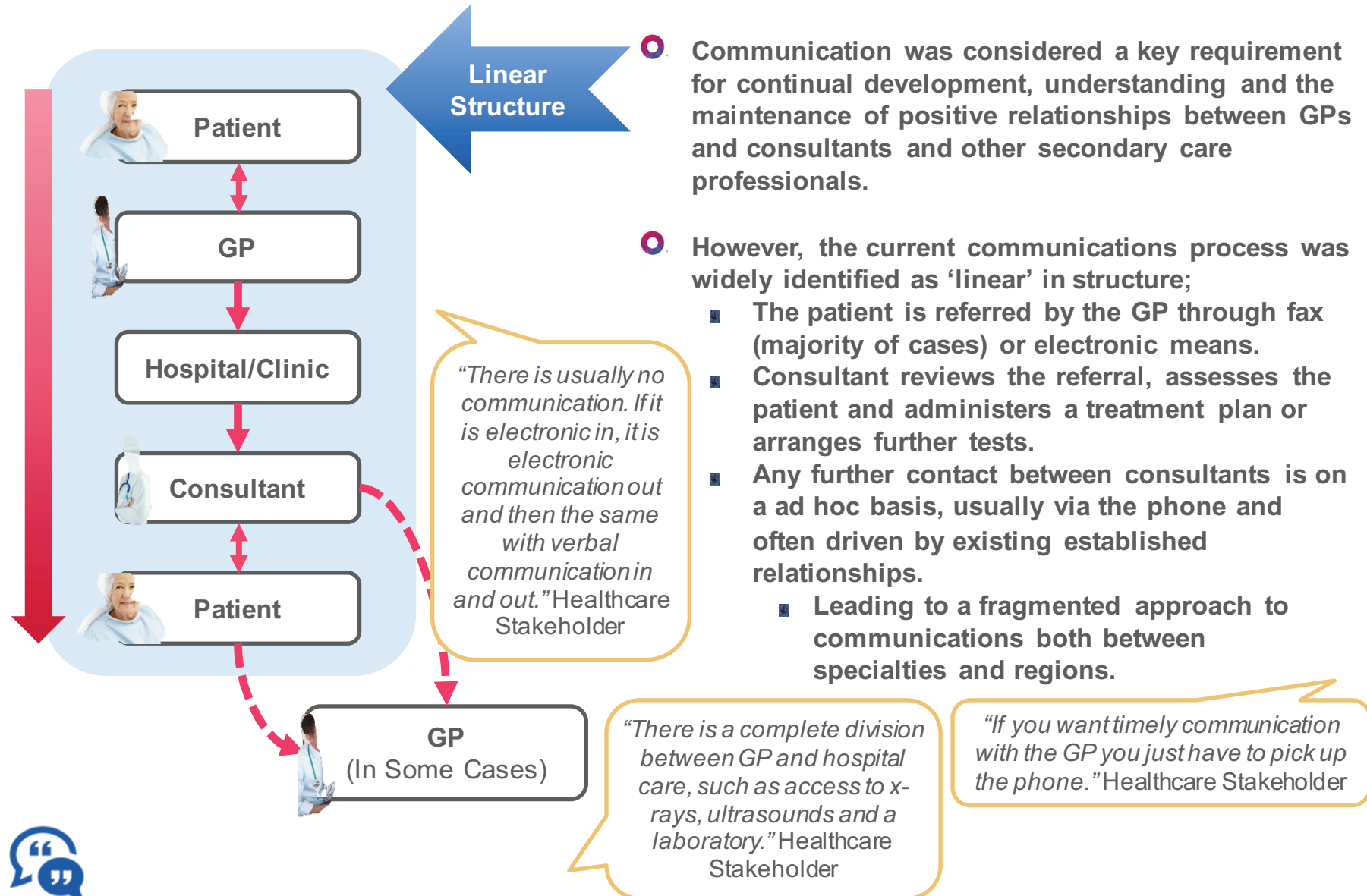
Echo was also referenced by several GPs as another initiative that was perceived to have worked well in Ireland...

- ✓ **Teleconference set-up for consultants to share information/ knowledge with primary health care providers on complex cases to enable continued care at a primary level.**



## 2.5 Communication Structures

# Overview of Current Communications Structure – I





# Overview of Current Communications Structure – II

- Once patients have been referred by the GPs, the responsibility of care shifts towards the consultants and it can be difficult for patients then to revert back to their GPs on a day to day basis.
  - GPs may be unaware of medications/ procedures patient has been administered, especially in emergency situations.
  - Therefore, no one source will have a full patient history unless the patient discloses all contacts.
- In addition from the consultants perspective communication can break down from the GP side, if there is no established relationship with the GP and if the consultant is referring back to a larger practice they can be left unsure if their written referral has been received and actioned by the relevant GP.

- Overall, the lack any standardised systems or processes to ensure communication or updates on patient status between GPs, consultants and other primary care workers was considered negative for patient care in the long run.

*"At the moment its very poor there is no standardised pathway for communications between GPs and PHNs, it is all at a very individual, very local level."* Healthcare Stakeholder

*"You often get an incoherent report, badly hand written. You get it back 3-4 days after you've got the prescription. Basically bad and incoherent communication is a huge problem."* GP, Urban

*"Continuity can break down from a GP side – sometimes I will write back to the GP and I just cant be sure if they know the patient and will see the patient."* Healthcare Stakeholder

*"Sometimes the GP might not even have what we want on file. We'll then have to go to the hospital. As I said, very cumbersome."* Healthcare Stakeholder

*"We wouldn't routinely notify a GP every time one of their patients comes in to the emergency department."* Healthcare Stakeholder



# Overview of Current Communications Structure – III



*“The interactions between GPs and Pharmacists, tends to be, broadly speaking very local, very ad hoc, and focus on very particular patients.” Pharmacist*

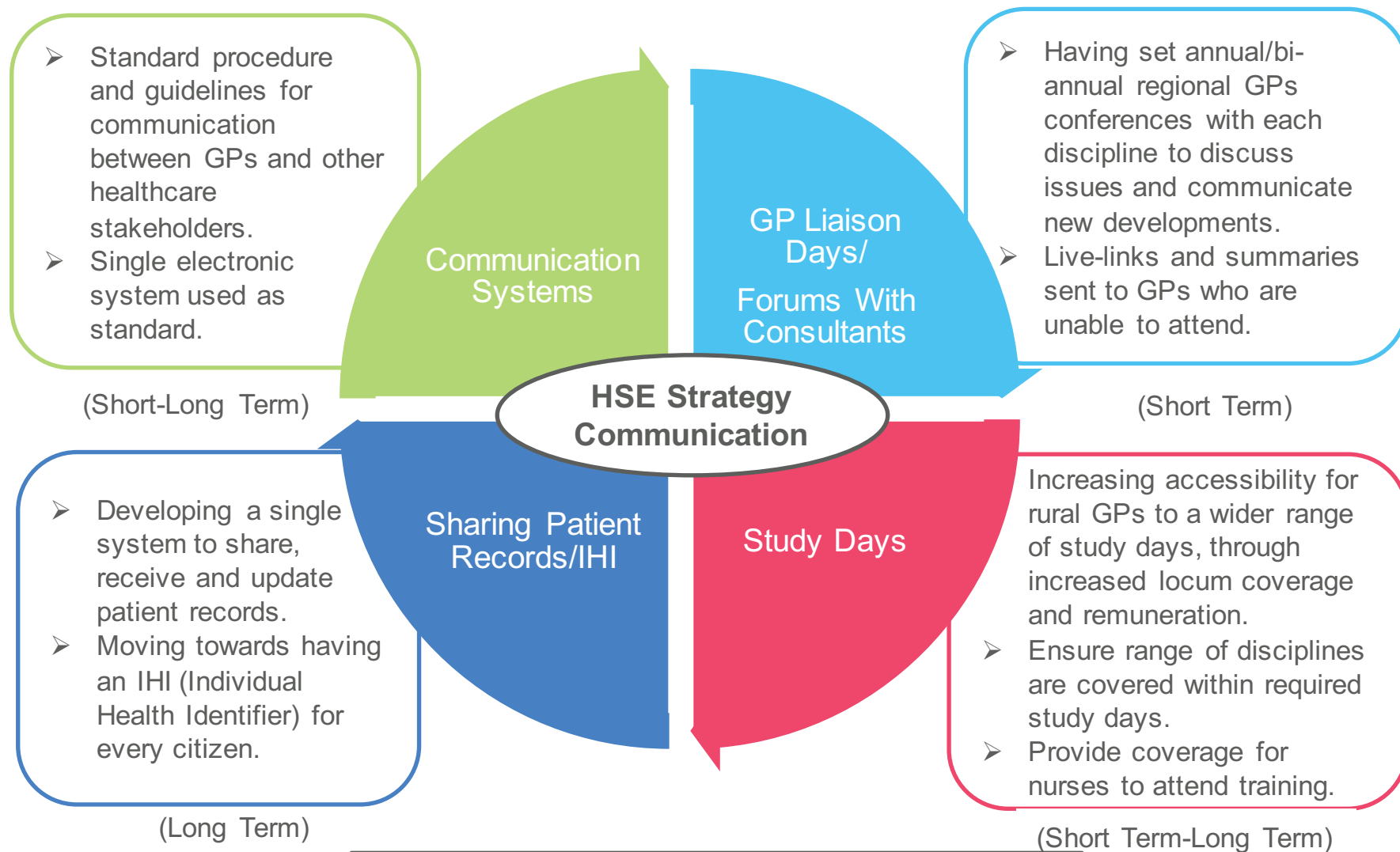
*“What was striking was that what you notice on a local level is a very good relationship between pharmacist and their local GP.” Pharmacist*

*“The Pharmacist gets through the GP on the phone normally and they just deal with that issue and move on.” Pharmacist*

- Both Pharmacists interviewed were widely positive about the current relationship between GPs/ practice nurses and Pharmacists.
  - Access is possible where appropriate, usually involving a phone conversation for patients with more complex medicine needs.
  - This is especially important in more rural areas where patients have less alternative options available and GPs get more ongoing interaction with the same Pharmacists.
- Pharmacists also signpost and refer patients to GPs where needed, especially where more complex needs present.
- However, no direct, formalised communication currently takes place between Pharmacists and GP practices.



# Overview of Ideal Communications Structure



The benefits and possible feasibility of these initiatives will be discussed on the following slides.



# Ideal Communications Structure: Communication Systems – I

- Standard procedure and guidelines for communication between GPs and other healthcare stakeholders.
- Single electronic system used as standard.

(Short-Long Term)

Communication Systems

*“IT infrastructure in hospitals. It’s creaking at all levels. They don’t have a standard one so it’s very hard to put in a reliable communication link with GPs.” GP, Urban*

*“I think the communication pathway is two way. GPs also need to communicate in with specialist, not just one way. In each large hospital there should be a specialist, such as radiology, so there could be a point of contact for GPs to discuss with.” Healthcare Stakeholder*

- Currently there is a huge variation in the IT and communications services provided to GPs.
  - Largely dependent on investing in their own systems/processes to move towards electronic system.
- Subsequently this variety in service means there is no standardised procedure for communication, and GPs may have to use multiple electronic mail/information systems.
- Frustration evident amongst some healthcare stakeholders, such as Public Health Nurses, who regularly deal directly with GPs.
  - Have to work out the way each individual GP works and then contact them accordingly.

*“GPs are already up and running because they pay for these things themselves, it is the hospitals that are running behind. Definitely more funding is needed for them to catch up.” GP, Rural*

**A single, standardised communication process between GPs and consultants would aid in streamlining referrals and patient information sharing processes.**



# Ideal Communications Structure: Communication Systems – II

- Standard procedure and guidelines for communication between GPs and other healthcare stakeholders.
- Single electronic system used as standard.

(Short-Long Term)

Communication Systems

*"Some GPs are real technophobes and aren't for changing. You have to fit in with their way of doing things."*  
Healthcare Stakeholder

*"The phone is so important! I won't stop using the phone."* Healthcare Stakeholder

- Overall, there is a preference for the movement towards a single, standardised communication system and process.
- Ideally this would be largely electronic for updates or simple queries.
- However, still important to have the option of direct contact via telephone for urgent situations.
  - Personal relationships between GPs and other healthcare stakeholders still seen to be important to ensure quality care for patients.
  - Formalised structures should not remove the ability to pick up the phone to discuss a patient.

# Ideal Communications Structure: Communication Systems – III

- Standard procedure and guidelines for communication between GPs and other healthcare stakeholders.
- Single electronic system used as standard.

(Short-Long Term)

Communication Systems

*“What all expressed was a need and a wish to formalise that relationship between patient and GP without losing that relationship. In having a more formal transfer of information back and forth if you’re taking electronic healthcare records or the way they can transfer.” Pharmacist*

*“There would have to be a shared care protocol between GP and pharmacists, the main factor is transforming the information back and forth. It’s happening informally at this stage.” Pharmacist*

*“Technology and electronic health records and the pharmacy having appropriate access to that are seen as being very important.” Pharmacist*

*“Health link should be extended out to pharmacies, so they can securely communicate.” Pharmacist*

- Formalising the communication procedure between Pharmacists and GPs is also seen as a potentially positive initiative, allowing for easier transfer of information back and forth.
- This ideally would include an inclusion of Pharmacists on the Healthmail system in order for easier transfer of information for patients.
- The inclusion of Pharmacists on an e-Health system, offering greater access to their medication history, and the ability to update any reported reactions to medication, etc. is also considered beneficial for GPs and other healthcare stakeholders.

# Ideal Communications Structure: Case Studies - eHealth

## Healthmail

- Healthmail enables secure emailing of clinical information at the point of care.
- Used in addition to any existing email addresses or communication services.

- Majority of GPs and healthcare stakeholders are aware of Healthmail. However varied exposure to and use of the system.
- Technology adopters have embraced the secure mailing, however, as not all GPs and consultants are registered this is again driving inconsistencies of approach.
- Some GPs are opposed to adopting it due to the monitoring requirements – need to ensure the mailbox is managed which adds to existing administrative burdens.
- However, Healthmail is in line with the overall demand for consistent and technology based solutions.
  - Needs to be more widely adopted and/or enforced?



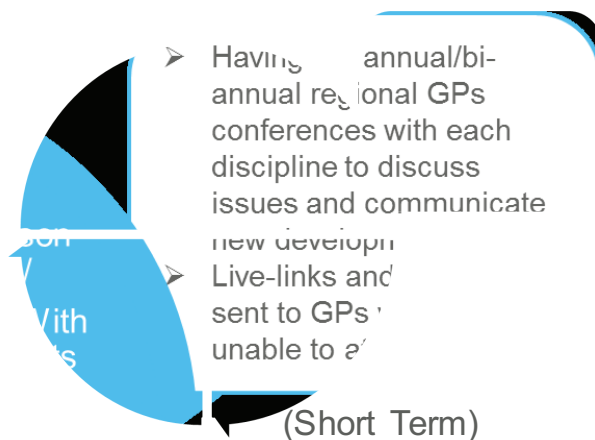
## Healthlink

- National messaging system linked to multiple communication projects.
- Enables the transfer of messages and information in real time via a secure network.

- Use of and exposure to Healthlink vary by region and speciality.
- Many GPs and healthcare stakeholders reference smaller scale communication systems in place.

*"Ideally you would email by a secure link. Now that we have Healthmail it makes things a bit easier." GP, Urban*

# Ideal Communications Structure: GP Liaison Days/Forums With Consultants



*"I think integrating GPs into the local hospitals is a good thing. The meetings should be accessible for GPs to attend."* Healthcare Stakeholder

- Currently there are GP liaison days and forums being conducted on an ad-hoc basis – largely dependent on individual department initiatives.
- However, difficulties with funding of and access to locum coverage, particularly in rural areas can impede GPs from attending and participating in these discussions.
- In general the majority of GPs and consultants would like to see a shift towards a more open and accessible means of communication on a more national level.
  - Consultants would like more accessibility to a wider GP audience to introduce new ideas or procedures.
  - GPs would like the opportunity to share issues and information with consultants.

Scheduled regional conferences throughout the year by all key relevant disciplines. Providing; an incentive/ appropriate supports in order to encourage GP attendance, live coverage for GPs who cannot attend and summaries of key topics and action points would be beneficial to engage with GPs nationwide.



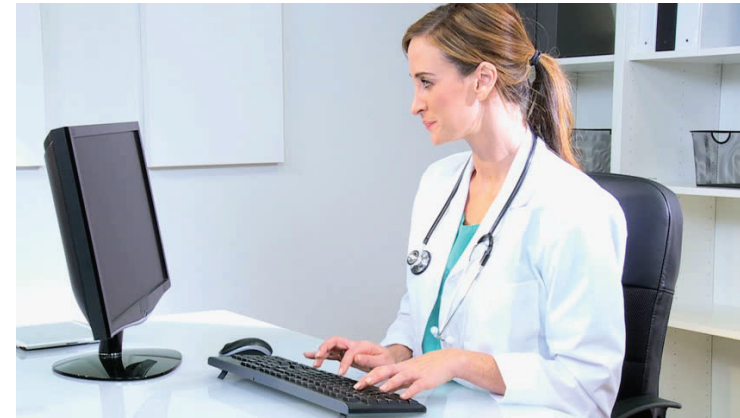


# Ideal Communications Structure: Case Studies – Discussion Board

## Discussion Board

- Provision of a private and secure discussion board for medical professionals within the nursing home speciality.
- Health care specialist/ directors are invited to join.
- Monitored by a health care specialist.
- Currently offered in Canada.

- **Forum for discussing key issues affecting the speciality e.g. infection control advice, new ideas/ practices with GPs, consultants and other health care providers.**
- **Aids in knowledge sharing across the country rather than just within certain areas of regions.**



*"It encourages professionals to share and discuss best practice."* Healthcare Stakeholder





# Ideal Communications Structure: Pharmacist Liaison Days



*“On a local level, where there were one or two GPs and a pharmacist, they held meetings and patient care meetings, on a regular basis to discuss general and patient care that they have experienced with patients. It seemed to work very well. Something more formalised like that in urban areas would be beneficial. It started as a cost containment strategy but they found improvements in quality and safety of prescribing medicines.” Pharmacist*

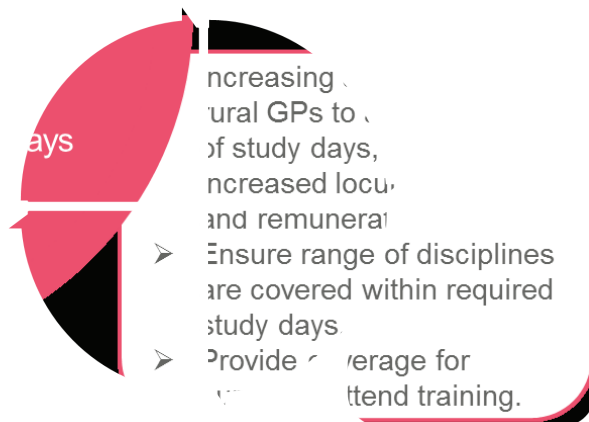
*“There is very little in the way of structured or coherent interaction between the pharmacy profession and the GP profession. There isn't a whole lot of integration or team work there. There is only local collaborative relationships.” Pharmacist*

*“To actually discuss patient care it would have to be at a local level, between pharmacist and GP.” Pharmacist*

- Local level initiatives that currently take place on an ad-hoc basis, involving on-going patient care meetings between Pharmacists and GPs were also considered very positive from a Pharmacist perspective, especially in terms of building a relationship.
- Formalising or incentivising this contact was considered a positive way to improve quality of care for patients, especially those with more complex needs.
- In addition, it was seen as a positive opportunity to update GPs on new medications and alternative prescriptions available.

*“I think there is an interest among pharmacists of having more coherent contact.” Pharmacist*

# Ideal Communications Structure: Study Days



(Short Term-Long Term)

*"GPs come to hospitals then each department give a little talk on their area, I take part in this."* Healthcare Stakeholder

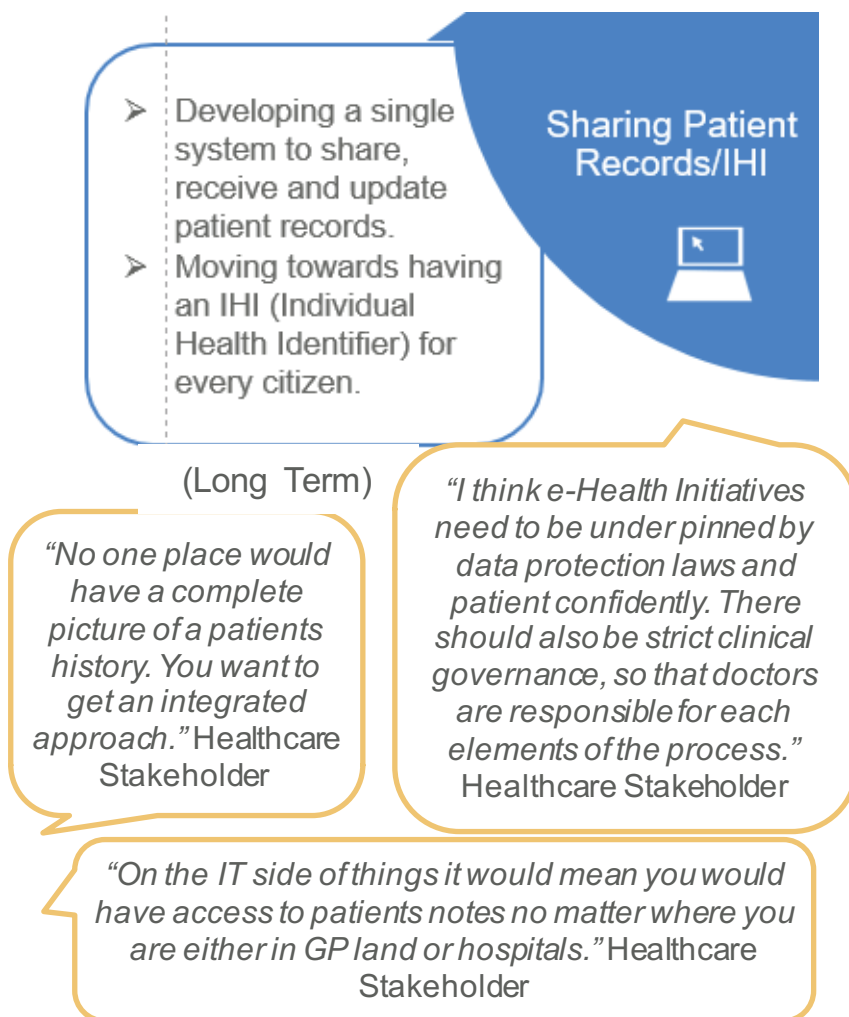
*"You cant always get to the training that you'd like to, it's a lot of time out the surgery."* GP Rural

Greater access to locums and compensation for distance travelled for rural GPs would make study days more accessible, allowing them to partake in a greater range of study options. Possibility of providing coverage or incentive for nurses to complete would also aid in increasing the range of services they could provide.

- GP study days are currently a key forum for consultants to interact with GPs.
  - Provides GPs with the opportunity to brush up on medical skills in specific areas.
  - Allows consultants to share new ideas and procedures with GPs.
  - Creates a better understanding and appreciation of processes between primary care and hospital care.
- However, as previously highlighted it is difficult for GPs in more rural areas to secure a locum to attend, and usually have to do so at a cost to themselves.
  - Further to travel and locum payment does not fully cover time missed.
- Locum coverage is also not covered for nurses to attend study days.
  - Limits opportunity to up-skill.



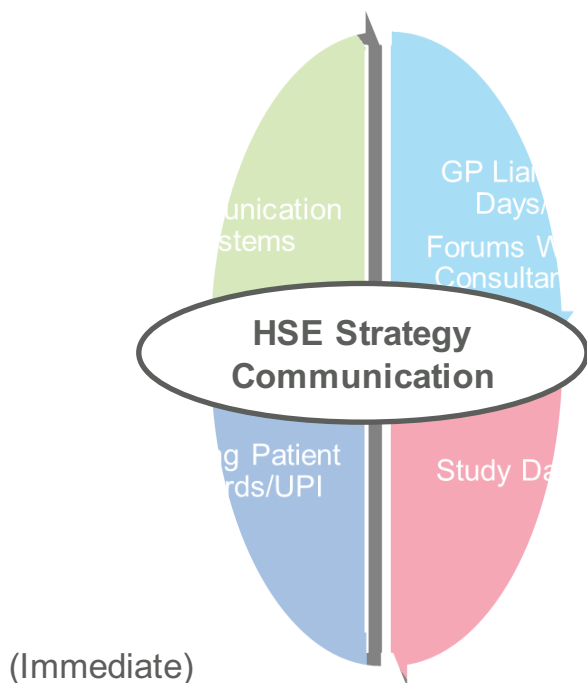
# Ideal Communications Structure: Sharing Patient Records/IHI



- The Individual Health Identifier is considered an important initiative that will be a very positive move for GPs, consultants, other healthcare stakeholders and patients.
  - ✓ Allow access to complete patient history, allowing for more compressive understanding of needs.
  - ✓ Saves time on back and forth between consultants and GPs.
  - ✓ Beneficial for emergency and out of hours situations, e.g. flag any pre-existing conditions, etc.
- However, there was significant concern raised around patient confidentiality and data protection.
  - Important that access and patient protection measures are considered before an IHI was introduced.
- Recommended that the GP act as 'gatekeeper' to information to ensure confidentiality.



# Ideal Communications Structure: HSE Strategy Communication



- Overall, it was considered essential that strategies, short and long term plans for development and new initiatives for primary care were better communicated and shared by the HSE with GPs and healthcare stakeholders.
  - Contribute towards a greater understanding of HSE actions and plans for the future.
  - Create a more open environment for discussion and development.
  - Aid in the creation of joined up thinking and processes across disciplines.
  - Provide a greater understanding of the timelines that will be involved in the implementation of new initiatives.

- In addition, GPs feel that clearer communication of GPs current funding model needs to be shared with the public and supported by the HSE.
  - Address the misconceptions that they feel are present regarding their practice income versus their personal income.

*"Needs to be more consultations with GPs before there is any changes." Practice Manager*

*"there's a misconception that we are high earners and privileged, that we get paid for every single visit. It's not true. It doesn't help that the HSE publish the figures every year." GP, Urban*

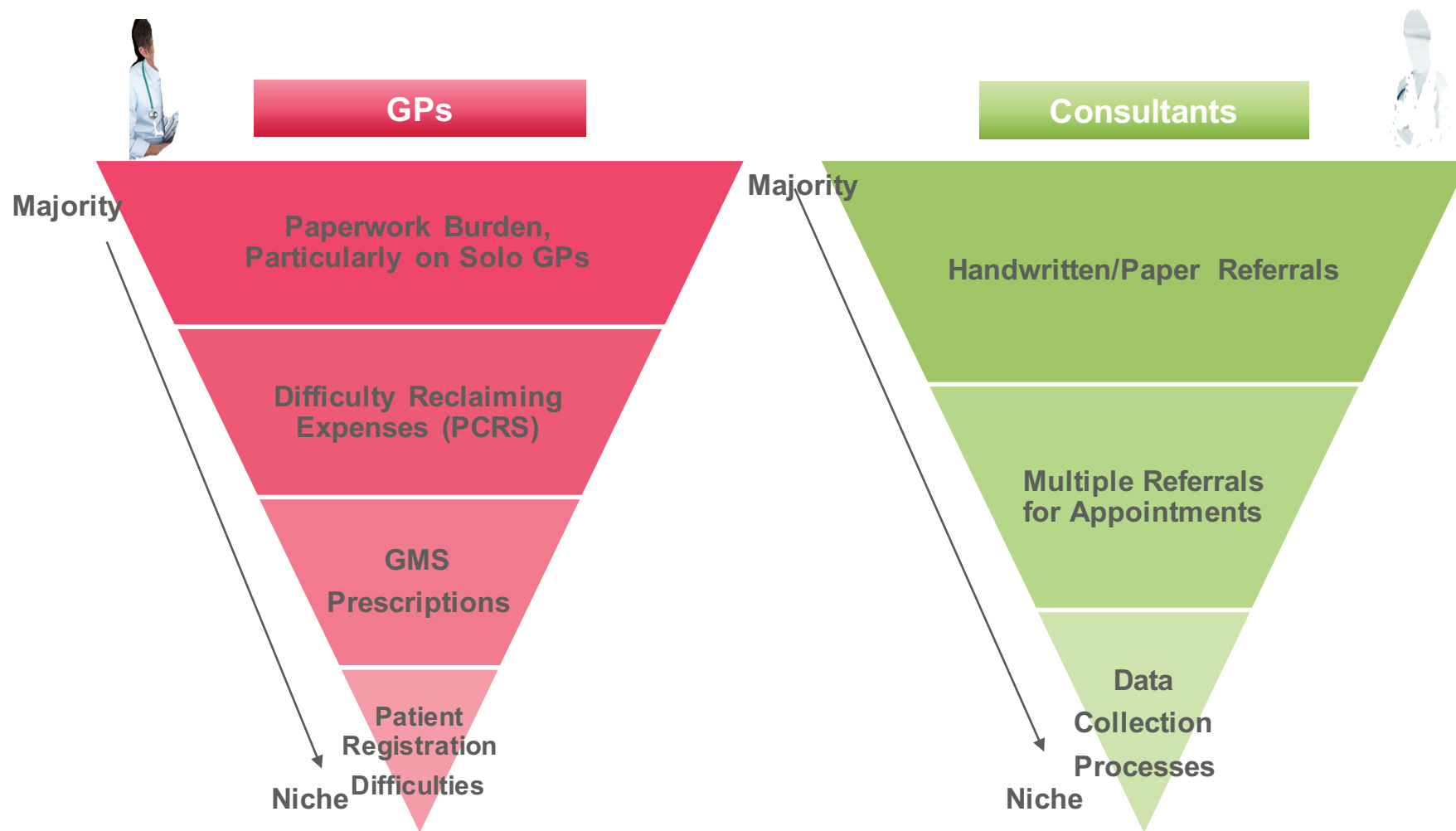


**Greater clarity and communication of short and long term strategies across all areas will garner trust and encourage co-operation.**



## 2.6 Administrative Procedures

# Overview of Key Administrative Issues

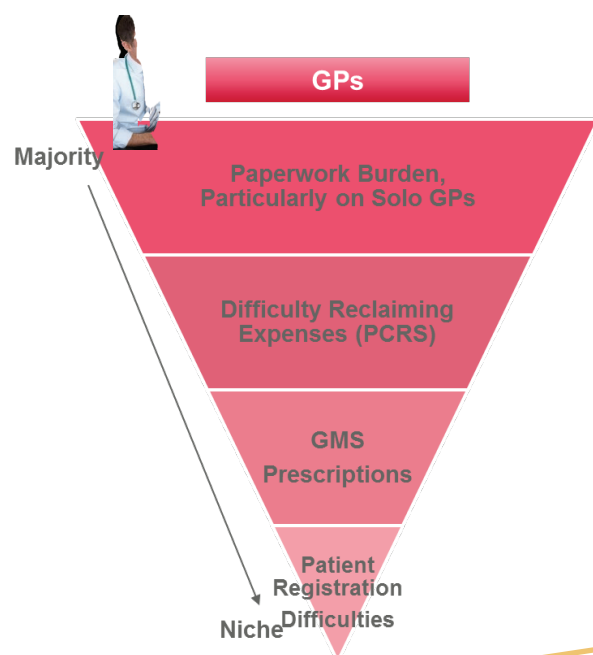


The following administrative issues for both GPs and consultants will be discussed in greater detail overleaf.





# Key Administrative Issues: GPs – I



## Paperwork Burden, Particularly on Solo GPs

- Overall there is huge pressure on GP practices with regards to the administrative workload.
  - Huge variety of paperwork required to complete, e.g. referrals, prescriptions, school/work doctors notes, social welfare forms, patient information, MC1/MC2 forms, medication lists for patients in nursing homes, etc.
- Without the potential for funding for a practice manager, administrative duties can be a burden for solo GPs.
  - Receptionist can be too busy to deal with administration on a regular basis.

*"I have reduced to a 4 day week but I spend the 5<sup>th</sup> day all day on paper work. A lot of time is taken up by paperwork and you try get the quick ones done when you are seeing the patient but you know that some are going to take much longer."* GP, Rural

*"The paperwork and admin is a challenge. Forms get brought into us without any notice and we have to deal with them as best we can. I had one from the school recently looking for a 4 page document with every medication the child might be on."* GP, Urban

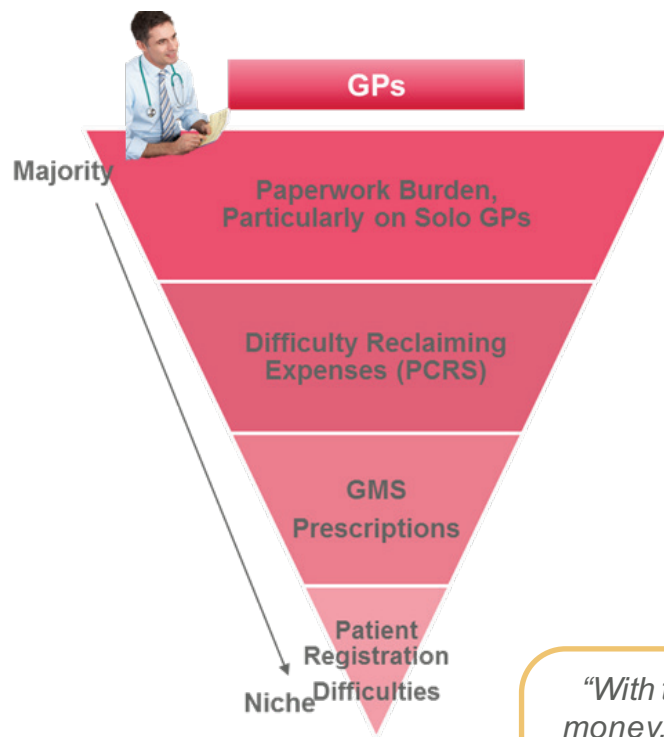
*"People just want all these letters from the GP and we just cant provide it."* GP, Rural

**Any opportunities to streamline the administrative process for GPs, or to increase funding for solo/rural GPs to access a practice manager would aid in freeing up GPs time, and present a more attractive workplace for trainee GPs.**





# Key Administrative Issues: GPs – II



## Difficulty Reclaiming Expenses

- Widespread dissatisfaction with claims process across GPs interviewed.
- Key issues with PCRS are;
  - Complicated, lengthy and varied claims process.
  - Length of time taken for reimbursement.
  - Need to follow up on payment as no update given, and subsequent difficulty getting through to appropriate person.
  - Misplacement or rejection of forms on minor or inconsistent technicalities.

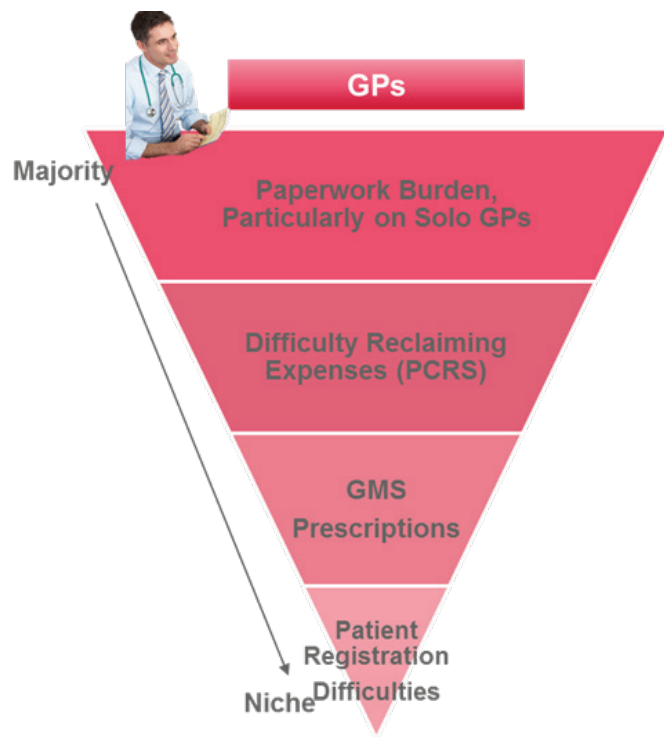
*"With the PCRS we are owed money, trying to get someone to deal with me, I've been writing to them for 2 years now and no reply or answer. I find them very difficult to deal with."* Practice Manager

*"Honestly the PCRS seem to reject a certain amount for no reason, no matter what. You have to reclaim and reclaim and you don't get anywhere and sometimes you have to reclaim and it can take up to five years."* GP, Rural

**A review of the PCRS processes felt to be essential as part of the contract negotiations. Efficiency of administrative and funding processes essential to build trust and ensure provision of care.**



# Key Administrative Issues: GPs – III



## GMS Prescriptions

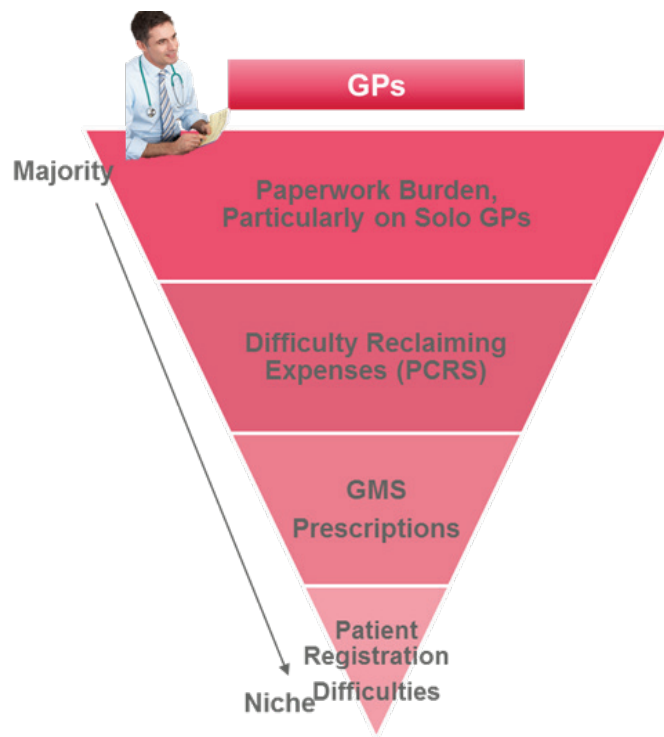
- GP requirement to transcribe any consultant prescriptions on to GMS prescription paper considered archaic and costly – in time and money.
- In smaller practice GPs are having to transcribe prescriptions.
  - Wasting time that could be spent on patient care.
- GMS script printers are considered costly to maintain, and require pre-printed paper which needs to be stored by GPs.

*"GMS Prescription paper needs to be scrapped. Doctors should use only one universal script for all patients - the medical card number on the prescription should be sufficient." GP Urban*

**Overall consensus prescriptions should have a universal format with a unique reference number. Whilst GP approval of prescriptions from consultants is important to ensure continuity of care this should be approved either via an online process or a signature.**



# Key Administrative Issues: GPs – IV



*"There is so many layers of democracy which has tripled the work, that we need to do for the nursing homes. Most of which is paper work." GP, Rural*

## Difficulty Registering Patients

- Problems registering nursing home patients mean that GPs are not getting paid for the patient visits they are covering.
  - Anecdotes of forms being lost and need for them to be re-submitted.
  - Registration procedure introduced by HIQA considered to add to paperwork and GPs administrative workload.
  - Some experienced issues getting in contact with someone from the HSE to discuss difficulties.
- Considering high volume of visits required due to lifestage (some patients needing a weekly visit), this is considered a huge strain on GP resources.

Preference for a streamlined process to register long term nursing home patients and greater accessibility to contact person within HSE to deal with difficulties.



# Key Administrative Issues: Consultants – I



## Handwritten/Paper Referrals

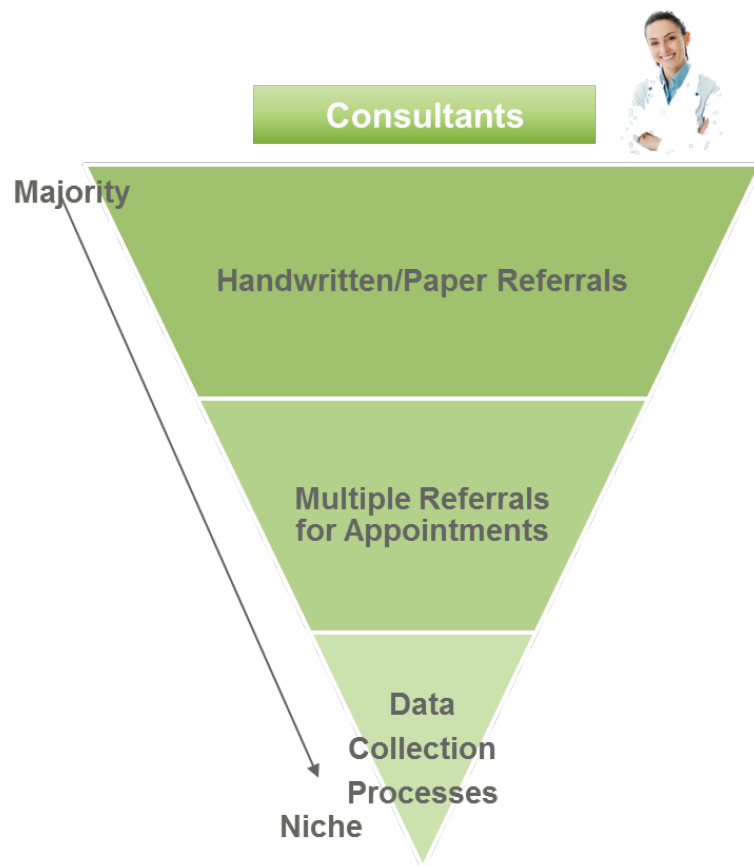
- Different approaches to referrals across GPs can add to administrative headache.
  - Some GPs email typed referrals, some are handwritten.
  - Others fax printed off typed or handwritten referrals.
- Difficulty deciphering handwriting can lead to mistakes in patient identification and/or creating the need to have an unnecessary follow up call with a GP.
  - Considered very frustrating for hospital/clinical administrative staff and consultants.

*"It can be so frustrating if you are not clear why a patient has been referred."* Healthcare Stakeholder

Preference for single, typed, electronic system to increase clarity of referrals and minimise and potential risk for misinterpretation.



# Key Administrative Issues: Consultants – II



## Multiple Referrals for Appointments

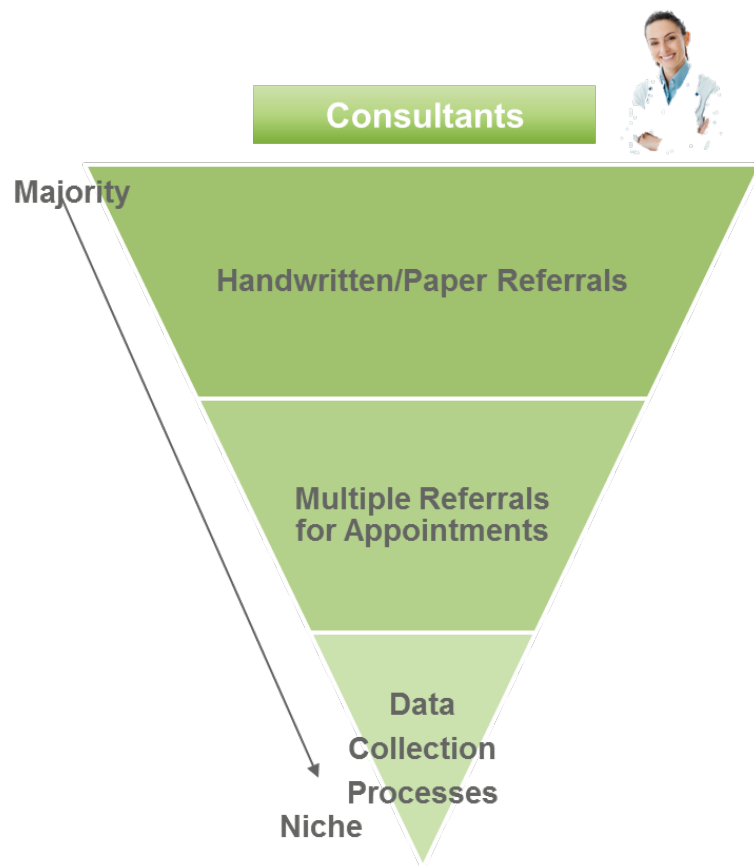
- Issue of GPs 'shopping around' for patient appointments was mentioned as an irregularly occurring, but concerning practice that has a negative impact on hospital/clinic administration.
- In some instances GPs were mentioned as requesting 2-3 appointment dates, and then choosing the best choice for patient.

*"GPs should be discouraged from shopping around and should develop a good strong relationship with one hospital."* Healthcare Stakeholder

A single electronic referrals process would minimise the opportunity for GPs to 'shop around' and reduce additional administrative burden on hospitals/clinics.



# Key Administrative Issues: Consultants – III



## Data Collection Processes

- Consultants dealing with chronic disease management referenced the importance of data collection at a primary care level.
  - Established coding system to ensure national figures are available for the number of patients GPs are treating for certain diseases, such as COPD and asthma.
- Reference to existing coding practices that are in place for some illnesses/ diseases (e.g. diabetes), but requirement for these to be rolled out more widely.
  - A greater understanding of the prevalence of certain disease will help to ensure necessary funding and supports can be put in place for their treatment and management.
- Again this would require a national system to be in place and the necessary resources allocated to GPs for coding and reporting to the HSE.

*"I think if GPs registered their COPD patients then we would know how many they had."* Healthcare Stakeholder





# Key Administrative Issues: Pharmacists

*"When doctors write a new prescription for patients they don't even put on the prescription what the reason for it is. That prevents pharmacists from doing all the safety checks that they are required to do on the medicine and makes it harder for them to see how a new prescription fits in with the patients existing medication profile or existing treatments." Pharmacist*

## Diagnosis on Script

- Pharmacists usually just receive a script with details of the medication without explanation of the condition or reasoning.
- As experts in medication, pharmacists would like to see reasons for medication being prescribed listed on the script.
  - This would allow them to substitute with appropriate alternatives or doses if necessary.
  - Especially as they are more likely to be familiar with all the medications a patient is on.



*"There are a number of areas such as contraception, flu vaccines etc. that pharmacists perform themselves in the pharmacy." Pharmacist*

## Inability to Prescribe

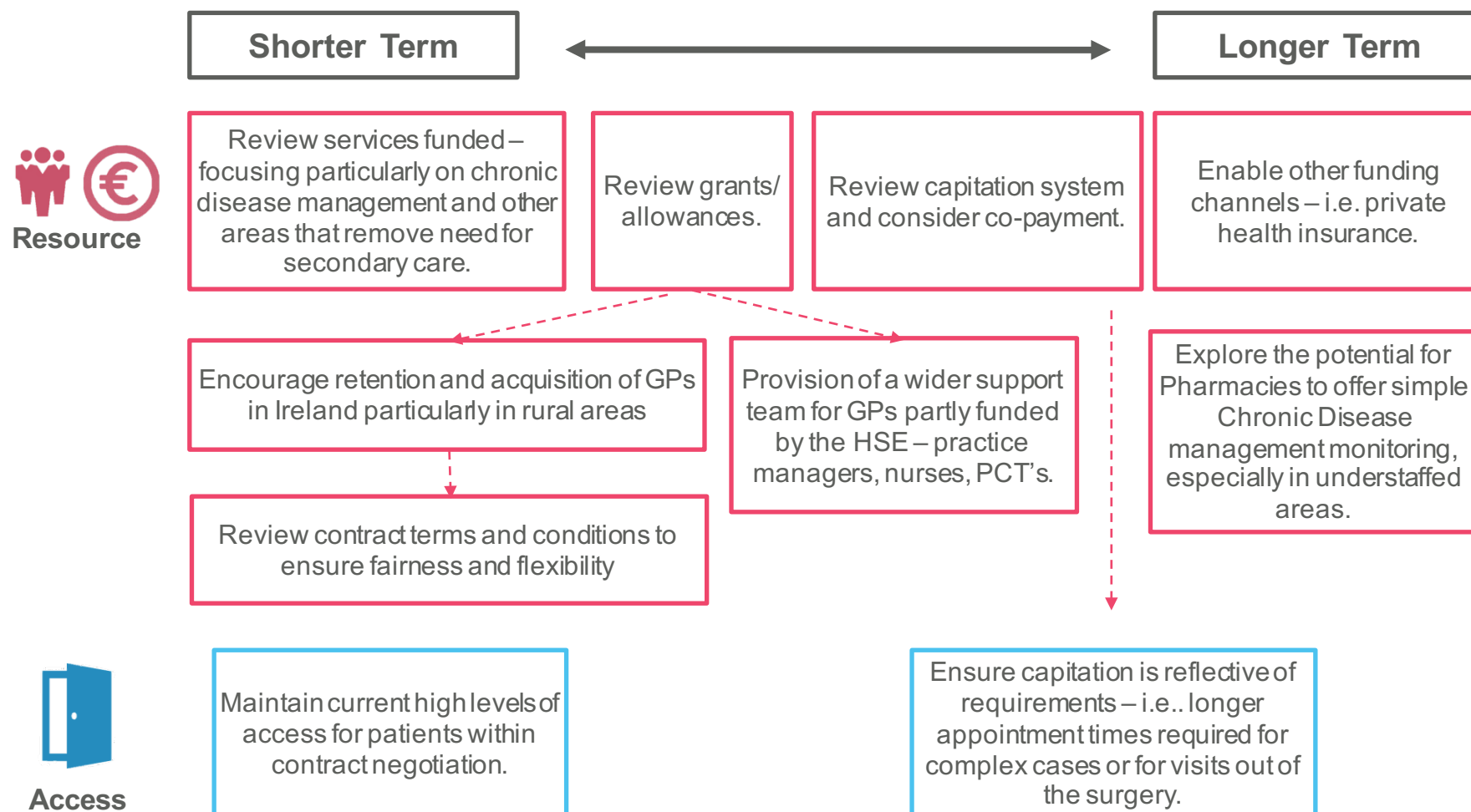
- The ability of Pharmacists to prescribe in certain instances, e.g. repeat birth control, etc., would be preferable for patients.
  - Saves the costs of having to attend the GP for a repeat prescription.
- However, this is something that would need to be further considered due to regulatory issues.





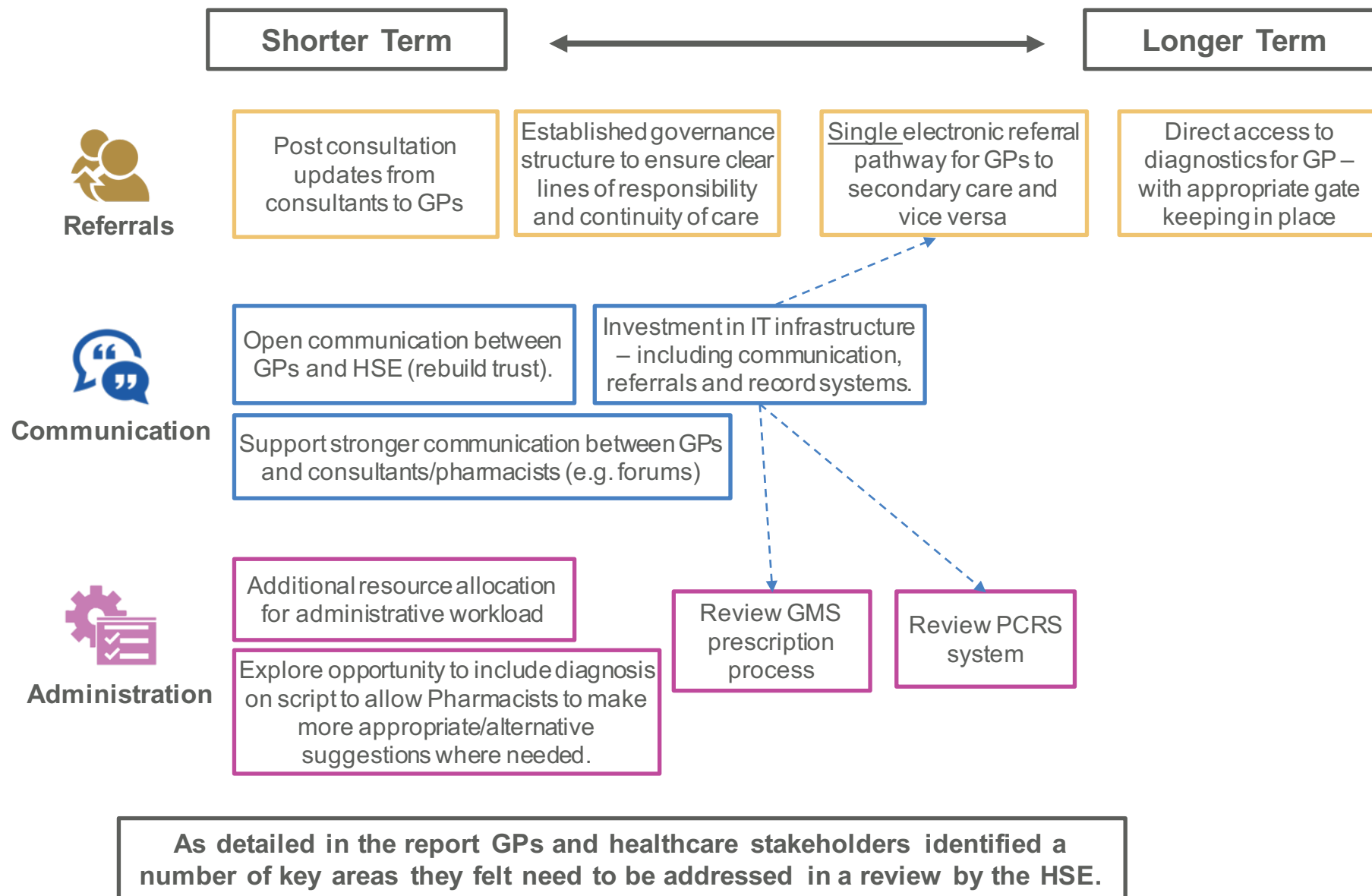
## 2.7 Service Providers Summary

# Summary of Recommendations - I



As detailed in the report GPs and healthcare stakeholders identified a number of key areas they felt need to be addressed in a review by the HSE.

# Summary of Recommendations - II





# Appendix 1 Quantitative Survey Questions

This survey was hosted on the HSE website between 24<sup>th</sup> November and 5<sup>th</sup> December 2016. It was open to all members of the public to complete.  
5085 responses were submitted.

## Profiling Questions

<b>Q.A</b> Before we begin can you please indicate which of the following brackets your age falls into? EXACT AGE GIVEN	18-24
	25-34
	35-44
	45-54
	55+
<b>Q.B</b> Are you male or female?	Male
	Female
<b>Q.C</b> Where do you live?	Dublin
	Rest of Leinster
	Munster
	Connacht/Ulster
<b>Q.D</b> Please indicate to which occupational group the Chief Income Earner in your household belongs, or which group fits best?  The Chief Income Earner is the person in your household with the largest income, this could be you. If the Chief Income Earner is retired and has an occupational pension please answer for their most recent occupation. If the Chief Income Earner is not in paid employment but has been out of work for less than 6 months, please answer for their most recent occupation.	Higher managerial, professional
	Intermediate managerial, professional
	Supervisory or clerical, junior managerial
	Skilled manual worker (e.g. Skilled Bricklayer, Carpenter, Plumber, Painter, Bus, Ambulance Driver, HGV driver, AA patrolman, publican)
	Semi or unskilled manual work (e.g. Manual workers, all apprentices to be skilled trades, Caretaker, Park keeper, non-HGV driver, shop assistant)
	Casual worker - not in permanent employment
	Student
	Housewife, Homemaker
	Retired and living on state pension
	Unemployed or not working due to long-term sickness
	Full-time carer of other household member
	Farmer 50+ Acres
	Farmer Less than 50 Acres

Note: MC = Multiple choice, SC = Single choice

<b>Q.E</b> Do you have children?	Yes
	No

<b>Q.F</b> In which of the following age groups do your children fall? <b>MC</b> <b>ASK ALL WITH CHILDREN (Q.E)</b>	Less than 1 year
	1-2 years
	3-5 years
	6-8 years
	9-12 years
	13 - 17 years
	17+ years

<b>Q.G</b> What is the highest level of education you have completed to date?	Primary school
	Currently in secondary school
	Completed secondary school
	Currently at third level
	Completed third level
	Prefer not to say
	No formal education

<b>Q.H</b> What is your main labour market status currently?	Full-time paid work (more than 30 hours)
	Part-time paid work (less than 30 hours)
	Retired
	Unemployed
	Student
	Full-time homemaker (looking after family)
	Other
	Don't Know
	Prefer not to say

<b>Q.I</b> Are you an employee or self-employed? <b>ASK ALL WHO WORK (Q.H)</b>	Employee
	Self-employed
	Prefer not to say

<b>Q.J</b> Which of the following categories do you fall into?	Self-employed & professional
	Self-employed farmer
	Clerical & office employee
	Skilled manual worker
	Other manual worker
	Other occupation
	Prefer not to say

## SECTION 1: GP Usage

<b>P.1</b> Which of the following do you have? <b>SC</b> <b>ASK ALL</b>	Medical Card
	GP Visit Card
	None of these

<b>Q.1</b> Have you visited a GP or a GP out of hours in the past 12 months? <b>SC – ASK ALL</b>	Yes
	No

<b>Q.2</b> When did you last visit a GP? <b>SC</b>  <b>ALL WHO HAVE VISITED A GP IN THE LAST 12 MONTHS – (Option 1, Q.1)</b>	Within the last month
	2 – 3 months ago
	4 – 6 months ago
	7 – 9 months ago
	10 – 12 months ago



<b>Q.3</b> Thinking about your most recent visit to a GP was this visit for... <b>SC</b> <b>ALL WHO HAVE VISITED A GP IN THE LAST 12 MONTHS (Option 1, Q.1)</b>	Yourself
	Your child
	Someone else you are caring for
<b>Q.4</b> Do you have a family GP that you would usually visit? <b>SC - ASK ALL</b>	Yes
	No
<b>Q.5</b> Is the GP you most recently visited part of a group practice with 2 or more doctors or working alone? <b>SC</b> <b>ALL WHO HAVE VISITED A GP IN THE LAST 12 MONTHS (Option 1, Q.1)</b>	Part of a group practice
	Working alone
	Not sure
<b>Q.6</b> How easy, or difficult was it to find a family GP when you first looked for one? <b>ASK ALL</b>	Very difficult
	Quite difficult
	Neither easy nor difficult
	Quite easy
	Very easy

## SECTION 2: Most Recent GP Experience

<b>Q.7</b> Thinking about your most recent visit to a GP, how easy, or difficult was it to get an appointment when you wanted one? <b>ALL WHO HAVE VISITED A GP IN THE LAST 12 MONTHS (Option 1, Q.1)</b>	Very difficult
	Quite difficult
	Neither easy nor difficult
	Quite easy
	Very easy

<b>Q.8</b> Was this appointment urgent or routine? SC <b>ALL WHO HAVE VISITED A GP IN THE LAST 12 MONTHS (Option 1, Q.1)</b>	Urgent (e.g. unexpected illness/injury/medical emergency)
	Routine
<b>Q.9</b> How quickly were you able to get an appointment with the GP? SC <b>ALL WHO HAVE VISITED A GP IN THE LAST 12 MONTHS (Option 1, Q.1)</b>	Within 24 hours
	Within 2 – 3 days
	Within 4 – 6 days
	After a week
	After more than a week
<b>Q.10</b> Did you request a home visit for this appointment? SC <b>ALL WHO HAVE VISITED A GP IN THE LAST 12 MONTHS (Option 1, Q.1)</b>	Yes
	No
<b>Q.11</b> Did you receive a home visit? <b>IF YES AT Q10 – REQUESTED A HOME VISIT</b>	Yes
	No
<b>Q.12</b> Still thinking about this most recent visit to the G.P, how would you rate each of the following aspects of your experience. SCALE: 1 (Very poor) – 7 (Very good)  <b>ASK ALL NOT RECEIVING A HOME VISIT (Q.10/Q.11)</b>	Waiting room facilities
	Seating available
	Time waiting to see GP
	Cleanliness of surgery
	Health information provided (e.g. explanation of treatment, provision of medication/treatment guide and/or direction towards further information).
	Suitable discretion used by staff in reception regarding personal details/ condition

<b>Q.13</b> Following your appointment with the GP how well, or not, did you understand each of the following: SCALE: 1 (Very poor) – 7 (Very good) <b>ALL WHO HAVE VISITED A GP IN THE LAST 12 MONTHS (Option 1, Q.1)</b>	The condition/ illness that the GP diagnosed
	The treatment plan provided
	How to take any medication prescribed
<b>Q.14</b> Were you given time to ask questions about your condition or the treatment prescribed? SC <b>ALL WHO HAVE VISITED A GP IN THE LAST 12 MONTHS (Option 1, Q.1)</b>	Yes
	No
	Didn't have any questions to ask
<b>Q.15</b> Thinking about your overall experience with this visit to the GP, how satisfied were you with the service? <b>ALL WHO HAVE VISITED A GP IN THE LAST 12 MONTHS (Option 1, Q.1)</b>	Very dissatisfied
	Quite dissatisfied
	Neither/ Nor
	Quite satisfied
	Very satisfied
<b>Q.16</b> How would you rate the value for money you feel you received on your most recent visit to the GP. <b>ASK ALL WHO PICKED OPTION 3 AT P1 – PAY FOR GP, AND ANSWERED 1 AT Q.1</b>	Very Poor Value for Money
	Quite Poor Value For Money
	Quite Good Value for Money
	Very Good Value for Money
	Not Applicable/Didn't Pay

### SECTION 3: Access

<b>Q.17</b> Has the cost of a GP visit <u>ever</u> made you decide not to make an appointment? <b>SC</b> <b>ASK ALL</b>	Yes
	No
	Can't remember
<b>Q.18</b> Have you ever had to take time off work to attend a GP appointment? <b>SC</b> <b>ASK ALL</b>	Yes
	No
	Can't remember
<b>Q.19</b> Thinking about your normal routine when would be <b>most</b> suitable/ practical for you to have a routine GP appointment? <i>Please select one-time frame from the following</i>  <b>ASK ALL</b>	Monday – Friday between 8am – 10am
	Monday – Friday between 10am – 1pm
	Monday – Friday between 1pm – 2pm
	Monday – Friday between 2pm – 5pm
	Monday – Friday between 5pm – 6pm
	Monday – Friday between 6pm – 7pm
	Saturday/ Sunday
<b>Q.20</b> If you urgently needed GP services at the weekend, or outside of normal working hours, would you know how to access this service? <b>SC</b> <b>ASK ALL</b>	Yes – know how to access this service
	No – not sure/ do not know how to access this service
<b>Q.21</b> Have you ever had to access a GP service at the weekend, or outside of normal working hours? <b>SC</b> <b>ASK ALL</b>	Yes
	No
<b>Q.22</b> Thinking about the out of hours GP service you accessed most recently, how would you rate it on the following criteria. SCALE: 1(Very poor) – 5 (Very good) <b>ASK ALL ACCESSED GP SERVICES OUT OF HOURS</b> <b>(Option 1, Q.21)</b>	Location of GP service
	Availability of home visits
	Appointment availability
	Opening hours

## SECTION 4: GP Service Range

<b>Q.23</b> Do you have any of the following conditions? <b>MC</b> <b>ASK ALL</b>	Asthma
	Diabetes
	COPD (Chronic Obstructive Pulmonary Disease)
	Heart Disease
	None of these (SC)
<b>Q.24</b> Thinking about the main/ majority of the care you receive for your condition; here do you receive this care? <b>SC</b> <b>ASK ALL HAVE ONE OF THE CONDITIONS (Option 1, 2, 3 or 4, Q23)</b>	At the GP surgery
	At the hospital
	Other location
<b>Q.25</b> Has your GP ever talked to you about any of the following. <b>MC</b> <b>ASK ALL</b>	Vaccinations
	Smoking
	Diet
	Exercise
	Other lifestyle changes
	None of those (SC)

Questionnaire continued on next page.

<b>Q.26</b> Which of the following services are you aware of your GP offering. <b>MC</b> <b>ASK ALL</b>	GP Consultation
	Practice Nurse Consultation
	Child Vaccines
	Travel Vaccines
	Women's Health Services
	Men's Health Services
	Blood Pressure Monitoring
	Diabetes Testing and Monitoring
	Blood Tests
	Healthy Lifestyle advice – e.g. quit smoking, lose weight, stress management
	Maternity and Post-Natal Care
	Dressings and Wound Care
	Palliative Care
	Minor Surgery
	Scheduled check-ups for people with long-term conditions
	STI Testing (Sexually Transmitted Infection Testing)
Methadone	
None of these (SC)	
<b>Q.27</b> In addition to the services just listed what other services would you like your GP to offer? <b>ASK ALL</b>	Open response



Building a  
Better Health  
Service

Seirbhís Sláinte  
Níos Fearr  
á Forbairt