Summary Report on Primary Care Conference
Galway, 23rd and 24th October 2002.

Introduction

This document provides an overview of the proceedings of the Primary Care Conference held in Galway on the 23rd and 24th October, 2002.

The conference was organised by the Primary Care Task Force, Department of Health and Children and was intended to inform and facilitate discussion amongst the stakeholders about the implementation of the strategy document "Primary Care *A New Direction"*. The objectives were to facilitate debate between the interests involved in the implementation of the Primary Care Strategy and to help develop ideas on the key themes and issues which will arise during the implementation process. The contents of this summary report include a report on the workshops, outlining the issues discussed and the possible approaches suggested to address the challenges. The report addresses each of the four workshop themes discussed, viz.

i. Teamworking
ii. Operational Issues
iii. Integration and Quality
iv. Community Involvement

A wide range of issues was discussed in the workshop sessions and we have attempted to reflect these in a comprehensive way. At the same time, in order to ensure that the report authentically reflects the nature and flavour of the deliberations, the workshop material has not been rewritten into a "prose" format.

We wish to thank the keynote speakers, the facilitators from the National Partnership Forum, the delegates and all who contributed to the planning and implementation of the conference.

This report on the Primary Care Conference has been prepared by the Primary Care Task Force, Department of Health and Children.

Overview/Key Themes

This section of the report highlights certain key issues which arose in one or more workshop groups or in the plenary discussions and which are central to the successful implementation of the Strategy. These are as follows**:**

Eligibility and Enrolment

Questions were posed as to who is eligible for the services provided by the primary care team. Approximately 70% of the population are private patients and do not currently have ready access to many of the services to be provided by the health board members of the primary care team. The intention is that both private and public patients will have access to the full range of services provided by the team. It was recognised that to succeed, the focus must include the "well" population, not just those presenting for treatment.

Questions were also raised as to whether a voluntary enrolment arrangement will succeed. What incentive would there be for a person to enrol with a team? The view was expressed that the delivery of an improved and integrated service by the primary care team could of itself serve as an incentive to people to enrol. Some concerns were expressed that this could have the effect of undermining existing GP practices.

Access issues

An issue of concern to many participants was whether all services would be free of charge at the point of delivery and whether private patients would be charged for the services of team members. It would be necessary to devise an equitable system to enable access for this section of the population.

"Enrolment versus list" issue

A central concern is that while general practitioners' patient lists may be drawn from a wide and not geographically defined area, health boards' community services are organised on geographical lines. Therefore a GP may currently, especially in an urban setting, have patients from several community care services areas, and consequently he/she may be dealing, for example, with several public health nurses. In order for the primary care model to work successfully, it will be necessary to arrive at enrolment

arrangements whereby the team members are clearly delivering services in a co-ordinated manner to the same population.

Community Participation

The importance of involving the community in the planning and delivery of services was a theme not just in the workshops dealing with this specific topic, but in the others too. It was evident that some healthcare professionals may have concerns about the process and the potential for tension to be generated between the community and the professionals. The process must therefore produce a meaningful outcome with benefits for all parties. It should also aim to make progress on the basis of mutual trust and respect.

Accountability and Gatekeeping

The question was raised as to whether patients will wish to have a personal relationship with a particular team member, rather than the team as a whole. In order to provide a quality service, some felt that there would need to be a clear accountability structure, so that patients would not "fall between" team members, none of whom was ultimately responsible for their care as a whole. The development of the "key worker" concept was seen in the workshop sessions as providing the basis for addressing this issue. The view was expressed that professionals need to recognise each other's areas of expertise, to have professional confidence in each other and be willing to cross-refer to other team members as appropriate. This raises issues also about the use and sharing of patient information, which is essential to the effective functioning of the primary care team.

The implementation projects provide an opportunity for the definition of the roles and responsibilities of the team members to be explored and developed. There is an opportunity to be innovative in this regard.

Primary and Secondary Care Linkages

The refocusing on primary care which is fundamental to the Strategy requires that secondary care be seen as complementary, not superior to, primary care. The provision of an integrated service will require the development of the necessary structures and linkages to ensure appropriate and continuous care as patients pass from one sector to another.

The Change Agenda

There was a general recognition that the process of change on which the successful implementation of the Primary Care Strategy depends must be a gradual one. It must be co-ordinated and supported through interdisciplinary training where appropriate, the gathering and sharing of information and ongoing contact between the professional and other interests involved. It was recognised also that there is a need for improved linkage between health services policy and the education of healthcare professionals. There must be recognition also that, irrespective of the issue of finance, there is potential for the realignment of existing services and relationships so as to move towards the model described in the strategy.

Teamworking Workshop

Effective teamwork is the cornerstone of the integrated primary care model. It is recognised that an ongoing commitment to change management is necessary to support effective multidisciplinary teams.

Session one of the workshop focused on the patient and the two workshop groups assigned were asked to:-

a) Identify the challenges for the patient in a service provided by multidisciplinary teamworking within primary care. How can each of these challenges be overcome?

b) Identify the opportunities for the patient in a service provided by multidisciplinary teamworking within primary care.

The issues discussed by the groups can be summarized as follows:-

Challenges	Suggested Solutions
• **Access** – Point of contact to team. • Location of team/new premises? travel and distance from patient	• One central contact number. GP or Key Worker? • Services available locally, in health centre, GP practice and in patients home
• **Eligibility** – How do I pay/are all services free of charge? • **Equality** – Service available to enrolled population of team only?	• Free care for all. • Increase eligibility thresholds.
• **Information/Communication** – • How do I find out about team & services provided? • Loss of personal relationships with service provider • Continuity of care • What information/data is gathered, shared and held? Do I want the information shared/confidentiality? • Is it there where/when required? • Confusion in roles of service providers for patients	• Local media, information material, posters, signage etc • Patient empowerment, concept of added value, link person/co-ordinator • Key worker concept • Establish policies, protocols and procedures and ensure appropriate people have appropriate access as required. Informed consent. • Shared access to records with patient access control. • Information and internal organisation
• **Community Involvement** – • How can the community influence the	• Community development approach to consultation and

team? • How do other community based services interact with the team	involvement. Advocacy for vulnerable groups. • Community development approach in overall direction and planning of team. Community needs assessment with client involvement

Opportunities for Patient: **- The opportunities identified for the patient in a service provided by multidisciplinary teamworking within primary care included the following;**

Enhanced service, local, integrated, holistic and person centred, accessible, advantages in providing more care locally, 'one stop shop', faster access to a wider range of services, seamless service, opportunities for group work, health promotion, etc

Session two of the workshop focused on the service provider and the two workshop groups were asked to:-

a) Identify the challenges for the service provider working in a multidisciplinary team environment. How can each of these challenges be overcome?

b) Identify the opportunities for the service provider working in a multidisciplinary team environment.

Challenges	Suggested Solutions
• **External macro factors** – roles, resources, accountability, culture change, governance, contracts	• To be addressed through communication and negotiation at national level
• **Provider Roles** - Understanding the roles of team members • Different work methods/practices, domiciliary care/clinic based care • A variety of perceptions about primary care • Patient seeking a preferred team member or/from different teams? • Charges for services provided • Recognising the community as part of the team • Accountability	• Regular contact will facilitate development over time • Provision of community based information and communications technology systems • Clarify what is meant by primary care. Seek a shared and agreed understanding • Inform patients about team services and team concept and approach to care • No fee charged at point of service • Use established processes to select community representatives for accountability back to sector

• Accommodation • Staff Recruitment/Retention	• Urgent needs assessment to establish requirements • Incentives i.e. (Dublin weighting), Training
• **Evaluation –** How are service, and patient outcomes measured?	• Agree systems and indicators. Look at other models which have addressed this matter
• **Implementation of Primary Care Strategy** - Lack of consensus about practical implications	• Build on existing strengths in the system and develop around local needs. Resource disciplines to tease out practical implications.

Opportunities for Service Provider: - The opportunities identified for the service provider working in a multidisciplinary team environment included the following;

• **Services**	• Patient centred care, more appropriate care to appropriate persons, integration of services, co-ordination and cohesiveness, holistic approach, timely intervention, reduce waiting lists, move towards universal health provision, collective evaluation, standardise services, achieve best quality, possibility of increased resources, less duplication, quality information, devolving care from secondary care, cost efficiencies etc
• **Staff**	• Increased work satisfaction, support of team members, sharing workflow, access to and shared expertise, better understanding of what each service can provide, retain staff, staff development and growth, better teaching/ education opportunities for students, opportunity to influence change within the organisation, provide feedback on the implementation of the Primary Care Strategy
• **Community Needs**	• Teams better fit community needs, more holistic needs assessment, opportunity to involve consumer/community in a meaningful way, potential to target & highlight issues/needs in the community

Conclusion

The image of the 'pizza' was proposed to describe the model required;

Pizza: - base is the same
topping different
individual slices
different slices

and the approach required was to take one slice forward at a time.

Operational issues Workshop

In session one the two groups assigned were asked to address:-
What are the opportunities and challenges posed by the following commitments on certain operational issues?

The four operational issues addressed were Enrolment, Access and Referral, Geographic versus List and Governance and Accountability.

In session two of the workshop the groups were asked to address:-
How can the challenges be overcome?

The issues discussed by the groups can be summarized as follows:-

Enrolment

The strategy states *"The entire population will be encouraged to enrol with a team of their choice and with a doctor within that team. The benefits of enrolment will be explained to individuals so that they can make an informed decision on whether to take the opportunity. Enrolment will also serve as an important tool for health Boards and other public policy makers in undertaking needs assessments. The system of enrolment will be flexible…The benefits of enrolling with a team will include better continuity of care* (Primary Care Strategy *A New Direction*, Action 7., P.36 and P.25)

Opportunities of Enrolment

Enables population health approach to planning, Improves needs assessment, Defined population provides denominator

Opportunities to gain access to 'hard to reach' segments of population

Inclusive of everyone

Enables ongoing relationship/proactive approach by GP and service provider

Can encourage continuity and a family approach

Receiving commitment by patients to team

Gain for consumer - access to a range of services, Enables better response to needs

Potential to give choice to person

Improves communication within network

Level of enrolment will be single greatest indicator of population satisfaction with primary care strategy

Sharing information and producing better information

Opportunity to address issues re data protection and confidentiality

Enrolment - Challenges	Overcoming the challenges
• More people could be lost to the system (due to voluntary nature of same) • People may not like the system • Could heighten/create a sense of inequity with people who cannot enrol	• Information to stakeholders • Persuade people that it's good for them, its advantages etc • Personal exchanges –person to person • Give multiple choice of where to enrol i.e. GP

• Enrolment process for prisons, nursing homes etc • Needs of travellers, commuters, students etc • Geographically dispersed locations should not be disadvantaged because of their size • GPs may feel they have no choice • Personality clashes between team members • Control issue – people enrolling with more than one team • Huge administrative issue – costs etc. • Demoralise existing community care staff • Idea of common record could be disincentive for people to enrol • How to inform communities and sell the vision • Interface between PC Team and specialists • Do patients enrol with the doctor or the team? • Gender issues i.e. female GP for female clients	surgery, health centre, pharmacy, online etc • Target certain groups • Engage with local communities

Access and Referral

The strategy states that "*Individuals will be able to self refer to any given member of the primary care team or network as appropriate. There will also be a system of triage and referral at the point of access available for those who wish to use it. This will ensure that people can be linked with the most appropriate professional for their needs"* (Primary Care Strategy *A New Direction*, P.25)

<u>Opportunities - Access and Referral</u>

Improved access - making access to care as local as possible, Access to services not normally available, Tele-triage with access to electronic patient records, Self referral for patients, Improved choice , better intra-team referrals, Potential and opportunities for earlier intervention

Appropriate use of resources

More empowering

Supports whole system health promotion concept

Increases opportunities for prevention

Access and Referral - Challenges	Overcoming the challenges
• The choice has to be informed • Need for education of local population • Will all team members accept self referral • Self referral may overload the services • Will the patient self refer appropriately, Establish process for self referral, Can system facilitate access to all team members on the same day? • How will self referral work if team do not have all the team members/professions available • Service must respond to needs of local community • If basis of team is geographic, it eliminates choice • Need for generalist first contact • Need for referral pathway from network to team • Self referral to any member of team leads to issues re medico - legal insurance • Issues around professional territorialism • Keeping health promotion and population health model to forefront • Need for education around role definition of different professions • Team approach needs time • Management of change • Communication	• Keeping health promotion and population health to the forefront • Multidisciplinary nature of team – must be the business of every team member, Teams need a plan, Needs Assessment to include community involvement and Prevention and Health Promotion services free at point of use • Health Promotion token on enrolment • Ensure holistic service • Point of contact to team Generalist? Co-ordinator? • Access and referral to/from Team and Network, members need to agree how to overcome this challenge and establish procedures etc

Geographic versus List

The strategy states that "*The population to be served by a team will be determined by encouraging GPs to join together their existing lists of enrolled individuals and families, with certain geographic considerations. This geographic focus will strengthen the capacity of the primary care team to adopt a population health approach to service delivery. In the implementation projects..*"team members" *..will be aligned around the resultant general practice lists to provide care to these expanded population groups. Currently general practice populations do not automatically align with community care*

catchment populations. However, with some flexibility, it should prove possible to agree a basis on which common catchment populations for a combination of both can emerge. Various models of teamwork will be introduced during the implementation projects" (Primary Care Strategy *A New Direction,* P.35)

Opportunities of Geographic versus List

Improved population health approach for planning, Improved identification of epidemiological issues, Patient centred, Facilitates community involvement, More likely to capture families, Facilitates inclusion of marginalised groups, Better service for all in the area, it is a good idea

Geographic versus List - Challenges	Overcoming the challenges
• If a person chooses not to enrol, what happens? • Communication • Existing mismatch between choice system and geographic system • Focus on geographic should be at network rather than team level • How do you form manageable teams • System of enrolled and non enrolled patients complicates issue of record keeping • Need for review, demographic changes	• Communications- • Information and Communications Technology • Common Patient Record • In large geographic areas, provide a number of small teams to give more choice to clients

Governance and Accountability

The implementation projects will require a variety of approaches to Governance and Accountability. These arrangements will also include reporting arrangements

Opportunities - Governance and Accountability

Defined roles and responsibilities, Opportunity for standardised framework on Governance and Accountability, Possibility of allowing community involvement in Governance and Accountability, Improved harm minimisation and risk management, reduce clinical errors, Increased coordination will result in administration support,

Opportunity for creativity in what providers do

- Review roles and responsibilities in view of needs assessment
- Greater transparency around performance
- Building quality into the system
- Monitoring and evaluation

Governance and Accountability - Challenges	Overcoming the challenges
• Leadership • Getting inter-professional and community agreement on Governance and Accountability • Need for education on all sides • Too much bureaucracy – huge potential problem • Dual system for managing staff (and employing staff) • Financial - potential loss of income • Who is the employer? Is there a conflict of interests? • Issues around levels of responsibility and roles • Who is the fund holder? • Relationships - employer - employee - professional • Line management versus professional accountability • Change management – how to manage the change successfully	• Mission Plan • Service Plan • Operational Policies • Performance Indicators • Starting Point – Develop a common understanding of: - Governance and Accountability - Monitoring and Evaluation • State Registration of Professions • Bureaucracy – Well designed electronic systems - Paperless • Quality and Performance

Integration and Quality Workshop

The Strategy states *"**There will be greater integration between primary and secondary care**.*
The interface between primary and secondary care will be advanced through a number of initiatives, designed to improve integration. Services will be organised to provide the most appropriate response to initial needs, and thereafter may reduce pressure on hospital services. Integration initiatives aimed at enhancing communication and exchange between primary and secondary care, should be locally agreed but within a national framework to be developed by the National Primary Care Task Force. They will include:

• *Referral guidelines and protocols for consultant care and diagnostic services*

• *Discharge plans agreed between the hospital and a key primary care worker*

•*Integrated care pathways, facilitated by key workers*

•*Individual care plans for certain people, appropriate to their needs*

• *Shared care arrangements for specific health conditions."* (Primary Care Strategy A New Direction Action 10, P.37)

The two groups assigned to this workshop theme were asked to address:-

What are the opportunities and challenges posed by the above?

How should the integration and interface agenda be progressed?

The matters discussed by the groups can be summarized as follows:-

Opportunities - Challenges	Suggested Solutions
Definitions • What do we mean by secondary care • What do we mean by primary care • Need to explore the wider dimension.	**Definitions** • Need to ensure that secondary care is not just seen as acute services but also recognises the other care groups i.e. childcare, disability, mental health etc. • Primary care should include community integration • Primary Care should have stronger emphasis on health prevention and promotion. There should be integrated screening programmes
Structures • Poor **discharge planning** resulting in beds being blocked within the hospital	**Structures** • There is a need to link the work of the National Medical Manpower Task Force and the work of the Primary Care Task Force. • **Planning** of services needs to be done across the primary and secondary care sectors and not in

system or patients being discharged without proper structures in the community in place to support them. • Many stand alone **models of good practice** are in operation around the country but no process to allow the models expand nationally • No national agreed structure for **liaison** between the primary & secondary care to facilitate the process of integration • Currently families are not involved in the care process • **Out patient departments and Accident & Emergency** operational structures are not GP friendly • Services are planned around the service provider and not the patient. • **Lack of resources** within the community to facilitate shared care/ integrated care pathways i.e. nurse specialists	isolation of each other. There are currently, within the country, good models of practice where lessons can be learned. • Different professional groups (GPs / Consultants) within each sector to have an **agreed process** of working together • **Communities** should have a role in helping to inform the planning process • The need for a **dedicated liaison person** within the hospital to deal with all primary care issues should be addressed nationally. Accident & Emergency liaison nurse for GPs works well but is not available nationally and the nurses remit is only in association with A&E issues • **Model of best practice** throughout the country should be identified centrally in order to allow planners learn from the experiences of others • All new models/initiatives should be fully **researched** and by an independent and dedicated department e.g. clinical audit department. • **Discharge planning** requires planning on the day of admission in the case of an emergency admission and prior to admission in the case of an elective admission. • Discharge plans should be available to all parties involved in the care of the patient both in the hospital and in the community. • All relevant parties should be involved in the discharge planning process at an **early stage** and not on the day of discharge. • The provision of a **patient advocate** was considered an essential element to the process • The **patient** should at all times where possible be involved in the planning of their own care.
Funding • Funding does not **follow the patient** • Services provided in the community have a cost element for the patient, same services provided in the hospital are free • Hospital waiting lists encourage bad practice • Capitation system can be an incentive to refer patients to hospital	**Funding** • Funding should follow the patient • Need to move away from the culture of the hospital sector/Consultant sending out a message that they own the services and therefore control the services. It is believed that this has resulted from a background of the largest proportion of funding going into the acute hospital sector. • Funding should be agreed on the basis of the work to be done irrespective of the setting. In this way ownership of the funding is removed. It was suggested that each year primary care states what it requires from secondary care services. The secondary care services state what it can offer including research.

Communication • Lack of understanding of each others roles • Poor communication between organisation • Public need to be more educated on how to access the services at both primary & secondary level • Need for community group inclusion • Lack of appropriate information and communication technology and support structures, prevents appropriate sharing of information	**Communication** • Members of the new primary care model should be aware of the roles of each professional within the proposed structure. • Need for **mutual awareness** and understanding of the services provided by service areas • **More education** for the public, particularly in regard to the primary care services that are available to them and how they access these services. • **A good communication environment** will allow trust and respect develop. An example would be trusting the integrity of the information and course of action proposed in a GP referral to the Accident & Emergency department, in many cases it should be unnecessary to re-examine the patient • **Information Technology** has a role in underpinning improved communication. It will facilitate more efficient and effective flow of information among team members and between primary and specialist services. • All patients should have a **single identifier number** • **Confidentiality** issues need to be addressed with regard to information sharing • GPs should have Information Technology access to Outpatient Department Appointments and waiting list systems. • Standardised referral and discharge letters should be processed using Information Technology
Access • Unable to have direct community access to hospital services i.e. Diagnostic facilities • No national agreement on or provision of referral guidelines and protocols • Access to specialist's services is unduly difficult and leads to existence of waiting lists. • Minority groups who do not have GPs and tend to use Accident and Emergency services for primary care.	**Access** • The availability of a hospital based **liaison nurse** to facilitate direct access to hospital services was considered a key element to co-ordinating access to hospital based services. • The provision of **referral guidelines and protocols** which are drawn up and jointly owned by both primary and secondary care • Guidelines and protocols should be based on **best practice** • System should be **monitored** and an **evaluation** carried out which identifies the perceived benefits for the Public, Primary Care team and the Hospital team. • Where appropriate, **diagnostic services** should be available within the **community** where access is easier and the cost of the service to the state is cheaper. • GPs to have a greater role in the referral of patients to Specialist Services without having to always use Out Patient Departments and Accident & Emergency Departments to access service.

Community Involvement Workshop

The Strategy states *"Community participation in primary care will be strengthened by encouraging and facilitating the involvement of local community and voluntary groups in the planning and delivery of primary care services. Consumer panels will be convened at regular intervals in each health board. At local level, primary care teams will be encouraged to ensure user participation in service planning and delivery. Consumers will also have an input to needs assessments initiated by individual health boards. A greater input from the community and voluntary sector will enhance the advocacy role of primary care teams in ensuring that local and national social and environmental health issues, which influence health, are identified and addressed*." (Primary Care Strategy *A New Direction,* Action 19, P.39)

The two groups assigned to this workshop theme were asked to address:-

- **What is the purpose of engaging the community in Primary Care?**
- **What are the existing barriers to the implementation of a `Community involvement in Health` approach in the Primary Care system?**
- **What practical actions/steps can be taken to facilitate the involvement of the community in Primary Care?**

The issues discussed by the groups can be summarised as follows**:-**

The purpose of engaging the community in Primary Care

It was agreed that the purpose must be clear and the following were the principal purposes identified:

To improve primary care services**,** Provide people-centred services – population health, Tailor services to needs, Increase responsiveness of team to needs of the community, To give people a voice - empowering individuals and communities, Enable the community to identify the needs in their own area, To involve rather than just consult communities - in a continuous process, Build contact between the community and the providers of services**,** Education of the community**,** To capitalise on the unrealised potential of such a process, To help to identify simple actions which can make a difference**,** To enable the importance of social issues to be appreciated.

What are the existing barriers to the implementation of a `Community involvement in Health` approach in the Primary Care system?
What practical actions/steps can be taken to facilitate the involvement of the community in Primary Care?

A wide range of potential barriers was identified. Questions were also raised about practical aspects of implementing this commitment.

It was recognised that the community has unrealised potential and that it can be helped and supported so as to take greater responsibility for its own health. Nonetheless there was a sense of the enormity of what needs to be done to give effect to this commitment. There was a concern that healthcare issues may be overwhelmed by other issues.

Barriers to `Community Involvement`	Actions/Steps to facilitate involvement of the community in Primary Care
	• The first principle was considered to be **"Do no harm"**.
Fears/Trust • Lack of trust of "the system" within communities • Fear of the unknown • Raising expectations and fear of not being able to deliver • Threat/fear of change • It's new – not been done before • Fear of narrow agenda of community groups • Might interaction be with existing community groups as opposed to users of the service? • Fear of tokenism and lip-service	**Fears/Trust** • Build trust of community – so that they will feel they are being listened to, Roles to be made clear at the outset • It will be necessary to have a process for selection of community representatives • Letting go – a need for openness by the parties to the process • The community must be enabled to have a sense of ownership, an understanding of what they are being asked to do and the potential benefits
Communication • Consumer panel – what is it? • Clarify whether all sectors would be represented on consumer panels • Systems communication (lack of a common understanding of what we want to achieve) • Capacity of system/individuals to take on board information from community/team respectively • Lack of understanding as to why and how community can/should become involved • Do communities not mobilise because communication with them was faulty? • Ability of community to relate to interest groups • Cultural differences • Extent of knowledge of staff of issues affecting those without a recognised voice	**Communication** • The nature and function of consumer panels must be made clear • There must be openness to different ways of working and realism about what can be achieved • Ensure that there is clear communication in terms of language used and the avoidance of jargon which may not be comprehensible to others • Formal meetings can intimidate individuals or the community generally - have informal meetings, go out to the community, simplify process • Move to the Team being seen as providing preventative services, not just treatment for illness – professionals, community and family support are there and should be used
Making the process work • Provider definition of need versus users' definition • How to give effect to the commitment in the Strategy • There is no one definition of "community" and one group took a wide view, while the other felt that given the primary care team model, the community should be those served by/enrolled with the team	**Making the process work** • Achieve a balance between providers definition of need versus users' definition • The process should build on strengths and learn from what works. It is important not to undermine what works now - keep it simple • Research effective models and utilise knowledge of others • There must be commitment to the process by the different interests • Involve a broad range of people in the process and sustain this.

the team. • Need for equal representation	• There should be parity of access of disadvantaged groups or individuals on consumer panels
• How do we develop communities to enable them to take part effectively in the process? • How to mobilise a community to engage itself in planning for healthcare • Have we hard examples of how to involve communities?	• Invest time and resources to engage people; accept it as a long-term process • The process of community involvement may regenerate a community spirit – through ownership/responsibility • Accountability – there should be a clear understanding in this regard • Establish what currently exists in terms of community development
Resources • Limitations on resources – funding and time	**Resources** • Capacity building will be needed • Buy in skills if necessary to support and facilitate the process
Other Agencies • Will health have to deal with non-health issues? • What means will there be to raise and address issues appropriate to non-health agencies?	**Other Agencies** • A broader perspective of determinants of health is more appropriate • A mechanism would be needed for bringing non-health issues back to appropriate agencies, as it was recognised that many of the determinants of health are outside the remit of the health system
Political issues • Politicisation of the system, Power (perceived) in political and administrative system – need to influence political process to progress the health agenda.	**Political issues** • Engage local politicians – use local community groups to reframe politicians' outlook – get broader health outlook back onto the political agenda.