Strengths
Weaknesses
Opportunities
Threats

analysis
of the

Model of Primary Care proposed in *Primary Care - A New Direction*

National Primary Care Steering Group – Services Sub Group

January 2004

Introduction

Under the Terms of Reference of the Services Sub Group of the National Primary Care Steering Group, one of the key tasks assigned to the group was:

"To examine the strengths, weaknesses, opportunities and threats in relation to the provision of integrated primary care in Ireland in line with the model set out in the Health Strategy"

This report describes the process and outcomes of the exercise.

Methodology

The SWOT Analysis commenced in January 2003 and was completed in October 2003.

From the outset, the Services Sub Group agreed that it was essential that the exploration of the strengths, weaknesses, opportunities and threats of the proposed model of primary care needed to be achieved through a process that was characterised by in depth discussion and agreed outputs with the full engagement of all participants.

With the approval of the Steering Group, in order to maximise input from all professions identified as members of the Primary Care Teams and Networks within *"Primary Care – a New Direction"*, a number of nominated professional practitioners joined the Services Sub Group and Task Force representatives in three (3) full day sessions.

These sessions took place in Tullamore and each one was facilitated by two facilitators from the National Partnership Forum.

Through brainstorming and discussion of issues at the first full-day session, 33 strengths, 51 weaknesses, 38 opportunities and 39 threats were identified.

These issues were grouped into themes, and prioritised, through further communications via email and teleconferencing. This process set the agenda for 2 full day detailed workshops.

These themes were:

1. Public / Private Mix
2. Cross / Inter-Referral and Teamwork
3. Person-Centred and Communication of Services to Client
4. Community Participation
5. Health Promotion
6. Human Resource Issues
7. Primary Care and the Wider Health System
8. Governance and Reporting Protocols
9. Flexible Services / Out-of-Hours Services

The following pages set out in summary the main strengths, weaknesses, opportunities and threats identified under each.

1. PUBLIC / PRIVATE MIX

Strengths:

- Uniform quality and uniform delivery of service
- Needs centred system
- Current mix of public and private service is valued
- Creates a benchmark for comparisons of service.

Weaknesses:

- "Gap" not addressed – charges could impact / penalise people who have genuine need but who are on low incomes, above medical card guidelines
- Paying for GP service but not for other services could be a major issue of inconsistency / inequity
- Imbalance of national distribution of resources, including imbalance between disciplines
- Private sector may develop more quickly and leave public service behind
- Demand Vs need – consumer may demand "entitlement" which is not needed
- Different contractual arrangements for different professions currently.

Opportunities

- To maintain balanced service while affording choice (based on need rather than demand) to everyone
- To include providers and service users as partners (self-governance, empowerment, efficiency)
- To broaden the range of services available based on need
- To introduce to the consumer and service provider a sense of relative cost
- To provide equitable access to services
- To implement best practice from public / private
- To develop consistent graded eligibility system and include those on low income without GMS entitlement
- To introduce deterrents against misuse of services
- To access private sector co-funding
- To review research on incentives to encourage appropriate attendance
- To create competition for delivery of service

Threats

- Return to a two-tier system
- Risk of GP delivering private practice outside of public facilities
- Scope for inappropriate use of services when provided free of charge
- Introduction of charges could result in poor compliance

2. CROSS / INTER-REFERRAL AND TEAMWORK

Strengths

- New model enables cross-referral
- Open channels for referral
- Computerised records
- Better co-ordination of services will lead to increased delivery of services
- Formalised teamwork – especially on single site
- Establishes ownership of patient's path through the system

Weaknesses

- Potentially increasing workload in primary care
- Dependency on quality of inter-professional relationships
- Absence of clear referral protocols
- Current practice of self-referral to certain professions not supported by model
- Difference between formal referral protocols already in place and what actually happens during day-to-day practice
- Eligibility issues, including matters such as referral by GP of public patients in Private Nursing Homes to other professionals in Primary Care Teams
- Lack of clarification / inflexibility regarding the division between network and team to facilitate inter-referral
- Quality control / integrity of information stored electronically (i.e. the concept that if it is recorded on computer, it must be true)

Opportunities

- To make cross/inter-referral easier for team members, especially if they work on one site
- To ensure referrals are made appropriately and are person-centred
- To ensure that "collusion of anonymity" does not occur (i.e. GP refers to specialist A, Specialist A refers to Specialist B, etc. and nobody takes responsibility for tracking the patient)
- To ensure that person referred to another service is referred back to primary care team when appropriate (i.e. referral, treatment and referral back)
- To ensure the appropriate return of patients from secondary to primary care
- To develop shared electronic records
- To develop protocol whereby other primary care staff may refer directly to specialty
- To train team members to recognise appropriate/inappropriate attendance or referral
- To define key worker for care groups / service users
- To provide enhanced results/outcomes through easier access to other services (e.g. diabetes)
- To develop appropriate shared care within primary, secondary and tertiary care
- To take back the care of chronic illness from acute services
- To ensure more appropriate referral occurs by increased understanding of roles within the team and other community-based professions
- To disseminate and share information
- To provide more co-ordinated delivery of services
- To learn from each other
- To provide inter-professional training (and for professionals to keep each other updated on their own profession)

Threats

- Cross/inter-referral may not be as effective if team is not based on a single site (not full consensus)
- Lack of good integrated ICT and record systems
- State of the art ICT systems will not be implemented
- Lack of resources or uncertainty about how this will happen
- Not clear who will manage the team and network members
- Team may be in place before service required is agreed through needs assessment

- GP surgeries close to the implementation project losing patients to the Primary Care Teams

3. PERSON-CENTRED / COMMUNICATION OF SERVICES TO CLIENT

Strengths

- Recognition of person-centredness as key element in model
- Will direct services and resources where they are really required
- Comprehensive, longterm and contextualised relationships with the same generalist in primary care
- Increased scope of appropriate services available
- Model visualises that the team sponsors and captures the needs within its own area
- Expectations from services may not be as high when people are more informed
- Supports self-care
- Holistic, embracing health and social well-being
- Builds a strong connection between the team / network and the community / inhabitant

Weaknesses

- Will add time to service user interactions / consultations if done well
- Not everyone might agree with results of individual person-centred needs analysis (e.g. family, carer, neighbour, etc.)
- Person's permission / co-operation for needs assessment may not be forthcoming
- Very little reference in model to person whom the model is built around
- Confusion may arise as to how a person's needs are established

Opportunities

- To empower people to make informed decisions and to address the determinants of health and well-being
- To enable provision of personalised flexible care packages
- To develop appropriate methods of comprehensive needs assessment, incorporating a triangulated approach (combining person, community and population health)
- To learn to communicate appropriately (understandable language, etc)
- To promote linkages to other areas (e.g. social welfare, etc.)
- To enshrine the right to refuse treatment in the model (except where serious threat to self or others exists)
- To increase population health information / knowledge in order to look after the individual comprehensively
- Can potentially avail of significant levels of existing information held by professionals (including GP consultation history)
- For professional to carry out opportunistic needs assessment (i.e. difference between individual who comes in for help and individual who is called in for, e.g. immunisation)
- To provide continuity of care, which is a key element of person-centredness
- To provide a wellness-centred model as opposed to an illness-centred model of primary care
- To introduce single, common methods of access to services
- To address non-service issues such as transport, accessibility, etc.
- To configure teams/networks based on local needs assessment
- To provide customer service training for the team and network members
- To educate the consumer regarding appropriate use of services
- Can bring in the "best" of private sector consumer philosophy/policies

Threats

- Unrealistic expectations from the individual may be raised but unable to meet all needs
- Provider led culture could remain dominant
- Those with greatest need may feel exposed / threatened by consultation on health needs

4. COMMUNITY PARTICIPATION

Strengths
- Recognises need for and importance of the consumer view in planning, delivery and monitoring of services
- Supports person-centredness
- Supports population health approach

Weaknesses
- Model does not allow for education and capacity building of the community in relation to participation (information, knowledge, etc.)
- Danger of tokenism if engagement is merely symbolic
- Strategy suggests 'consumer panels' alone as a means of community participation (suggest that this is a legacy view – strategy is built on the principle of quality – a quality system is dynamic therefore other models of connectivity are possible besides consumer panels if they have potential for greater value add)

Opportunities
- To ensure full and meaningful community participation in addressing issues of equity and access
- To ensure community is part of the development and ongoing implementation of the system
- Significant / central role for communities in planning, delivery and monitoring of services
- For genuine and active community involvement
- For the community to mould the service to suit local community need
- To improve communication between health providers and communities and to get health messages to the community
- To provide a better designed service
- To strengthen governance through strong community participation
- To deal with the issue of democratic deficit through community participation
- To ensure community role in priority setting
- To encourage and support vibrant community involvement in service delivery, complement provider services

Threats
- What is popular is not necessarily what is required (this is an issue of communication?)
- What becomes popular becomes political (system is to de-politicise – again issue of communication?)
- Key marginalized groups may not be represented – e.g. he who shouts loudest gets heard (may not be articulate, etc)
- Wider community (silent majority) may not be represented / may not make their own views known (challenge of creating focus groups)
- Some issues more 'popular' than others
- How to reconcile the conflicting views of different groups (this is a CORE issue)
- How to prioritise conflicting demands

5. HEALTH PROMOTION

Strengths

- Strengthens health promotion and should lead to population health based approach
- Person / service-user will be pivotal in service delivery
- Model proposing broader view of health – looks beyond health as merely 'absence of illness'
- Looks at prevention and how people can maintain good health
- Primary Care Team model provides for multi / inter-disciplinary targeted health promotion based on assessed community need
- As per the strategy, Primary Care Team model will be facilitated and funded to develop and expand cross-sectoral activities, which can promote and protect the health of families enrolled with them (e.g. health promoting schools or workplaces and linking to community development projects)
- Integral element in health of community

Weaknesses

- Does not ring-fence resources for health promotion so health promotion may be the first to suffer in the event of funding restrictions
- Strong on health promotion in general but weak on the evidence to support it

Opportunities

- To provide supports to enable all people to address the determinants of health and well-being
- To target all groups in the community
- For health professionals to carry out opportunistic needs assessment with the service user
- To develop community-based, innovative approaches
- To tap into existing resources in the community (as part of partnership with community)
- To make health promotion integral to the roles of all professionals and central to team / network ethos – "a way of working"
- To provide training for team and network members on concepts and principles of health promotion
- To increase public awareness of the importance of health promotion – maintaining wellness and preventive healthcare
- To tap into developing expertise to measure effectiveness of current health promotion practice and to provide training for staff on evaluation techniques for health promotion, guiding more effective health promoting work at primary care level
- For more co-ordinated multi/inter-disciplinary evidence-based health promotion approaches and systems
- To develop measurement / evaluation tools for health promotion initiatives (both local and global)
- To develop a partnership between media and health
- To track impact of health promotion delivery systems

Threats

- It takes a long time to measure/evaluate the effect of health promotion initiatives
- Behaviour change takes time
- Need for appropriate measurement of health promotion initiatives
- Need evaluation of some of the global health promotion initiatives already implemented

6. HUMAN RESOURCE ISSUES

Strengths

- Wide range of multi-disciplinary team members available to work with each other (well trained, experienced – holistic care)
- Team configuration based on needs assessment (right professionals employed)
- Greater knowledge and support of each others' roles
- Everybody clearly understands their role

Weaknesses

- Shortage of health professionals (leave time, training time) – potential gaps in service elsewhere
- Indicates a mix of employment / working relationships – health board directly employed staff, contractors and their staff, and staff/volunteers in community and voluntary sector (need for flexible and innovative working relationships not specified in model)

Opportunities

- For more satisfying work, leading to higher retention levels
- To develop public / private mix from discipline viewpoint (multiple contracts)
- To amalgamate some roles – providing better / more integrated services for individuals/families
- To engage other health professionals (e.g. community health workers, acupuncturists) so as to deliver holistic care
- To develop inter-disciplinary training models
- To ensure that those delivering inter-disciplinary primary care training courses are from a broad range of disciplines to reflect the team / network membership, including input from the community involvement perspective – this needs to be resourced from a time and financial viewpoint
- To make good the gaps that exist in some undergraduate training i.e. public health, health promotion, community development
- For personal and career development for team members
- For parity of opportunity with acute services / providers
- To give team development / teamwork specific attention
- To map competencies relative to health and social care requirements and multi-disciplinary team
- To play to professional strengths / more appropriate use of personnel
- Focus change management to person rather than service, to work in the new environment there will be a shift from old practices and this change will have to be well managed in order to achieve success
- To develop new roles (health promotion, etc.)
- To expand current roles
- To develop new contracts – new opportunities (e.g. new public services contracts)
- To look at models for broader development of practice nurse role
- Primary care model that can influence a comprehensive Primary Care Human Resource planning – service providers and education providers
- Flexible contracting to open up more opportunities
- Broaden horizons in relation to recruitment
- Better contract will enhance performance management

Threats

- Lack of required numbers of professionals (inadequate training places)
- Original core training may be an inhibitor to change for some disciplines (single service focus?)
- No multi/inter-disciplinary training for undergraduates
- Unrealistic expectations could lead to dissatisfaction / morale problems among professionals
- Lack of appropriate/adequate infrastructure to accommodate staffing levels
- Short-term contracts could lead to migration of staff to other areas (equitable contracting?)

- Service setting / focus – single Vs multi-professional training, or acute Vs community
- Lack of time for effective communication with other team members
- Lack of training resources, including time, spatial and financial
- Appropriate skills for management of change process
- Complex reporting relationships – e.g. independent contractors Vs public employees
- Professional accountability, supervision and mentorship
- Professional pathways (career development)
- Blurring of professional boundaries
- Staff may not be attracted to work in primary care
- Current gaps in services/professionals may continue e.g. 1) employment ceilings, 2) not a level playing field to start with – some professions are more established in the community than others
- Hanley Report – poor emphasis on primary care
- Restrictions or barriers to training / recruitment (e.g. regulatory practices)
- Lack of ICT – necessary to support interdisciplinary collaboration
- Out of hours – expectations within current employment levels/contracts
- Balance between generalist and specialist complementary roles in PC Network and PC Team

7. PRIMARY CARE AND THE WIDER HEALTH SYSTEM

Strengths

- Primary care can deliver 90-95% of all health and social services
- Not a fully prescribed model – will enable new professions in future
- Pilot sites will show where some of the practical problems will arise
- Every person in the community will have access to a broad multi-disciplinary team
- Allows expansion of services that are delivered within the community by the multidisciplinary Primary Care Team
- Key worker concept
- Decreases the amount of visits for patients to other sites for services (i.e. many services may be provided on one site)

Weaknesses

- While the broad outline of the model of care is there, specifics for the on the ground day-to-day operations of a Primary Care Team are not there and this flexibility to adjust the health services to meet local needs could result in as many different models of care as there are Primary Care Teams
- As the models of care are not defined for the Teams, they are non-existent for the Networks. A model needs to be developed that can be adapted for particular needs
- Lack of baseline knowledge on catchment area

Opportunities

- To develop a comprehensive health service that is available to people when required
- To maintain a balanced emphasis between primary care and secondary care
- To provide a well developed primary care system that can ensure appropriate access to / use of secondary / tertiary care
- To develop Primary Care services as important focal points of health promotion and disease prevention and in turn interact with the community with the use of key workers to promote same

Threats

- Could some services be “lost” (e.g. services currently provided in hospitals)
- Lines of communication, etc. between the Primary Care Team and the Specialised Secondary Care Multi-disciplinary Team is unclear - clear systems are essential (e.g. within the Mental Health field)

- Unclear how the new system will dovetail what already exists in terms of community services and community care area structures – concern regarding how this will affect people already delivering community services
- Lines of communication between the Primary Care Team and Network are as yet unclear
- Definition of professional roles and responsibilities needs to be further defined allowing flexibility between roles

8. GOVERNANCE AND REPORTING PROTOCOLS

Strengths

- Existence of model enables the system to build a governance framework around it
- Enables quality assurance
- Enables value for money

Weaknesses

- Model is not explicit at all on governance issue – or on what is understood by governance
- Danger of duplication / triplication of reporting e.g. Team leader, clinical leader, line management
- In terms of reporting protocols, not clear how the network members are going to be managed/who they will report to, as they will be providing a service to 3-4 teams. Will there be duplication of reporting for them as well? Clarification needed on this issue.
- Governance could become 'red tape' – too much paperwork
- Integration between Primary and Secondary care will be only be possible if resources are allocated to facilitate improved discharge planner posts in the Acute Secondary care areas.

Opportunities

- To develop a governance model that is less intrusive and bureaucratic and is supported by regulation
- To retain flexibility to enable local-level responsiveness
- To harmonise all aspects of governance – managerial, clinical, professional
- To develop comprehensive governance framework which includes a whole health system and community approach
- To get away from working within hierarchical structures – good teamwork should promote good governance and good governance should promote good teamwork
- Potentially allows for improved delivery of services in a more cohesive and organised fashion through the team ethos towards care/support
- May facilitate better and more appropriate time management of individual staff members through appropriate referral of patients to team members
- Opportunity for interdisciplinary learning modules in relation to practice developments decided by the Team members
- Opportunity for the Team to deliver services that are more focussed on the individual community they care for – more person-centred and needs led services
- The Strategy for Nursing and Midwifery in the Community (NAMIC), which will be published early in 2004, will enhance the future development of Nursing and Midwifery within primary care services.

Threats

- Some team members may perceive a threat to their clinical independence
- People may be overloaded with 'non-real' work (e.g. administration, etc)
- Potential avoidance of the whole issue of governance
- A lack of common understanding of the term 'governance' – resulting in not developing a coherent, simple system of governance
- Who will decide what services can be disseminated to Primary Care from Acute services and why?

- Can the Primary Care Team cope with the added workload created by services being relocated in their domain?
- With extra workloads and possible increase in service users (through voluntary enrolment) of Primary Care Team, will same day access for patients still be guaranteed?
- Where professionals in the community have traditionally reported to a head of discipline, the concept of reporting to a team or network leader may be perceived as threatening to their professional development

9. FLEXIBLE SERVICES / OUT OF HOURS SERVICES

Strengths

- A broader health service available locally to meet local needs outside of regular office hours. (At present the only person available is a GP on-call. Routine planned appointments given outside regular hours to genuine patients who find it difficult to obtain time off for healthcare could significantly improve attendance and participation in a treatment programme resulting in an overall healthier person who should cost the health care sector less long term)
- More person-centred approach. More choice for people and service available when needed
- Reduces use of the secondary care system to deal with problems more appropriately dealt with in the primary care setting (i.e. currently post-natal queries/breastfeeding support requests received by the maternity hospitals at night and weekends from mothers in the community looking for out-of-hours support)

Weaknesses

- More demand on already limited human resources
- Staff safety, e.g. if only a very small number of staff are on duty at a specific location
- Cost of providing this service
- Current focus on the Primary Care Teams with a lack of direction for the Network

Opportunities

- People who work regular working hours will have more access to health and social services, in particular for screening / preventative measures as many people are reluctant to take time off for health care when they are not 'sick'.
- Appointments outside regular office hours would afford people the opportunity to avail of the health service required without requiring an employee to (a) seek time off or take annual leave (b) Inform anybody
- Greater and more efficient use of buildings, e.g. health centres, etc.
- With the introduction of extended working hours, working hours for many team members could become more flexible (this opportunity is dependent on provision of adequate human resources)
- To consider providing some services from alternative venues i.e. local community centres, local wellness centres
- To allow a wide range of services in the Network to be available at a time most convenient to the service user
- To source some services from private sector

Threats

- Lack of available human and financial resources
- Inappropriate use of the service outside regular hours by people who have ample opportunity to use the service during regular hours
- Services delivered out of hours may not be of the same standard as those delivered during normal working hours

CONCLUSION

This report has been accepted for adoption by the Primary Care Steering Group in 2004 and will be used to proof the *Draft Framework to guide service providers in the establishment of Primary Care Teams,* which is currently being finalised.

The report will also inform and proof the future work of the National Primary Care Steering Group and its Sub Groups.

The Primary Care Task Force will utilise the report to support the ongoing work of the Health Service Reform Programme.

It is visualised that the report can feed into and inform discussion and debate on very important issues in relation to the new Primary Care model , and will assist in the process of ongoing evaluation and quality assurance of progress being made.

The report can also support the wider modernisation agenda within the Health System.

The work of the Services Sub Group, the other Health Professional participants, and the Primary Care Task Force in completing the SWOT exercise in such a comprehensive way is gratefully acknowledged. Particular thanks is also due to the facilitation input of Seosamh O'Maolalai and Liz White from the National Partnership Forum, and to Catherine Devaney who organised the sessions and teleconferences and drafted the report.

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