Policy Brief
Interdisciplinary Team Working in Ireland: *A New Direction* 16 years on.

Executive Summary: The 2001 Primary Care Strategy '*A New Direction'*, presented a vision for Primary Care Team (PCT) working in Ireland. Despite this, interdisciplinary team working is not a routine way of working in Irish primary care. This research investigated the levers and barriers to implementation of the 2001 strategy. General practitioners and other primary care professionals from three HSE areas took part in an on-line survey and interview study. The analysis showed that the idea of interdisciplinary team working makes sense to participants and most were currently involved in a PCT. There were examples of successful team working, however, there was strong consensus that the full and adequate functioning of PCTs is hampered at this time. This is due to a lack of resources for general practice staff participation in teams, a lack of training for health professionals to work together and the damaging effects of the HSE staff moratorium on the primary care system. Furthermore, current HSE metrics about interdisciplinary team working are too narrow. These need to be broadened to capture PCT processes and outcomes but, also, other forms of interdisciplinary working that have been developed by committed and responsive primary care professionals based on the needs of their local communities. Finally, there needs to be better engagement and communication between HSE management and front line staff in primary care, particularly about the new Community Healthcare Organisation (CHO) structures and issues about equity and consistency of primary care service delivery.

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Background

Internationally, primary care is the cornerstone of healthcare planning and reform and there is an emphasis on interdisciplinary team working (WHO, 2008). Despite these policy imperatives, it has been challenging to implement interdisciplinary team working as a *routine* way of working in a number of developed countries, including Ireland (Phillips and Bazemore, 2010; O'Sullivan, Cullen and MacFarlane, 2014). However, there is a lack of research about levers and barriers to implementation. The aim of this research was to analyse levers and barriers to implementation of interdisciplinary team working in Ireland by examining:

1. Interdisciplinary team working promoted by the 2001 Primary Care strategy, that is HSE Primary Care Teams (PCTs),
2. Other forms of interdisciplinary working, initiated by primary healthcare professionals to respond to local needs, that is 'bottom up' innovation.

This research offers a comprehensive exploration of what kind of interdisciplinary practices are working well in primary care settings in Ireland at this time and why.

Methods

The research was conducted in HSE West, HSE South and HSE Dublin-Mid Leinster between 2014 and 2017 (see Appendix I). It involved:

- An online survey with GPs and HSE Primary Health Care (PHC) professionals which received 569 responses (71 GPs, 498 HSE staff),
- An interview study with forty one qualitative in-depth interviews with GPs and Primary Health Care (PHC) professionals and HSE management.

Principal findings about levers and barriers to implementation of interdisciplinary team working in Ireland

- The majority of participants in the survey and interview study understand and support the policy imperative for interdisciplinary working in primary care to enhance patient care. Interdisciplinary working makes sense to them ***(lever),***
- The majority of participants in the survey and interview study were taking part in HSE PCT clinical meetings in their area ***(lever),***
- The majority of participants in the survey and interview study considered that there is a lack of progress with the implementation of PCTs in the HSE in general. There is considerable frustration about this ***(barrier),***
- Participants provided some positive examples from their own specific experience of PCTs, including respectful interdisciplinary team working and successful management of patient referrals for those in urgent and complex situations ***(lever),***
- There was a notable absence of discussion about community participation in PCTs ***(barrier),***
- There was a strong view across the survey and interview study that more resources are needed to realise the full potential of PCTs ***(barrier):***
    - GP attendance is considered pivotal for effective team meetings and is disrupted by lack of payments for GPs to attend PCT meetings
    - There are no resources for practice nurse participation in PCT meetings
    - The lack of resources in the primary care system means that PCT meetings focus on urgent referrals rather than on the broader aspects of primary healthcare i.e. health promotion and disease prevention

- HSE PCT clinical meetings are administratively resource intensive. This is challenging for service providers who are dealing with increasingly complex patient needs in a system with diminished resources since the recession
- Staff need training to work effectively together across disciplines.

- There was frustration among the majority of participants in the interview study that HSE metrics for PCT working are limited to quantitative information about the meetings e.g. how many meetings took place, who was in attendance and how many patients were discussed ***(barrier),***
- There are many examples in the survey and interview study of other forms of interdisciplinary working that were initiated locally (see Appendix II). These include services for health promotion (e.g. mother and toddler groups, programmes to support healthy eating on a limited budget) and chronic disease management (e.g. care for people with chronic obstructive pulmonary disease). This kind of 'bottom up' interdisciplinary team working is not captured in the current HSE metrics about interdisciplinary working and participants regard this as a problem. This is important work in primary care and needs to be acknowledged and resourced ***(barrier),***
- Interview study participants explained that the recession has decimated resources in primary care in general and put increasing pressure on front line staff. Some 'bottom up' interdisciplinary services that were initiated at a local level have ceased to operate as staff are forced to 'fire fight' waiting lists in their respective disciplines ***(barrier),***
- There is a lack of clarity and consistency among front line staff about health system issues including the nature of on-going reforms (e.g. CHO area developments) and equity of service provision (e.g. uncertainty about whether public patient status or clinical need should be used to prioritise waiting lists) ***(barrier)***.

Conclusion

Interdisciplinary team working is integral to the delivery of comprehensive primary care in Ireland. This is acknowledged and understood by clinicians and management personnel working in primary care settings. While this represents important levers for implementation, there was a strong consensus among these stakeholders that interdisciplinary team working in primary care in Ireland will only realise its potential if there are more resources allocated to team functioning as well as the primary care system more broadly. A modified set of HSE metrics is also needed to capture the full breadth of interdisciplinary team working that is taking place and better communication is required between HSE management and frontline staff (GPs and other primary health care professionals) about healthcare system development options and decisions. These findings are supported by national and international research about interdisciplinary working in primary care (O'Sullivan, Cullen and MacFarlane, 2014; Kelly, Garvey and Palcic, 2016; O'Reilly et al., in press).

Recommendations

1. ***Increase the available resources for primary care***

- Revise GP contracts to provide resources to support GP and practice nurse involvement in HSE PCTs,
- Increase the resources for PCT staffing to:
  - Increase the current level of administrative support
  - Back fill posts for maternity leave sick, leave etc.
  - Develop new posts to meet the ever increasing complexity of patient and service user needs,
- Provide resources for training for general practice staff and primary health care professionals to work together in HSE PCTs,[2]
- Increase resources for PCT infrastructure so that physical space/ rooms are available for prevention and intervention work in primary care.

[2] The national curriculum on inter-professional education which will be launched in September for new graduates is relevant here

2. ***Modify HSE metrics about interdisciplinary team working***

- Provide administrative resources to support PCTs and to gather information for current HSE metrics about PCTs,

- Develop new metrics about the:
    - Quality of team working
    - Outcomes of team working
    - Nature of community participation being conducted in PCTs
    - Other forms of interdisciplinary work that are taking place by asking front line providers *"is there any other work you are doing which should be acknowledged as a whole system approach to interdisciplinary team working?".* The HSE excellence awards criteria could be used to gather these data.

3. ***Improve engagement and communication between stakeholders in management and 'on the ground'***

- HSE management should improve engagement and communication with GPs and other primary health care professionals 'on the ground' about healthcare system development options and decisions e.g. about the new CHO Structures and the impact on equity and consistency of service.

References

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APPENDIX 1

Description of the study sample

Survey sample[3]

There were 569 eligible responses including 71 GPs (response rate of 71 %) and 498 other healthcare professionals (response rate at most 22 % of HSE full-time equivalent posts). Respondents from the HSE in the main comprised OTs, Physiotherapists and SLTs (hereafter grouped together and called clinical therapists). While most occupations within the HSE were adequately represented in the sample, nurses were under represented. Of the 71 GPs who responded, 34 % were in rural practices, 41 % were in mixed urban/rural practices and 24 % were in urban practices, largely representative of all GP practices in Ireland. Response rates across the three regions were broadly similar.

Of those who provided valid demographic information (n = 427), respondents were predominantly female (82 %) and the majority (72 %) were aged less than 50 years. The majority of respondents (53 %) were 15 years or more post qualification. Of the 71 GPs, the majority (62 %) were male; aged 50 years or more (57 %) and were 15 years or more post qualification (67 %), representative of the GP profile in Ireland(23). 78 % of respondents reported that they were a member of a formal PCT.

[3] *from* Tierney E, O'Sullivan M, Hickey L., et al., 'Do primary care professions agree about progress with implementation of Primary Care Teams: Results from a cross sectional study', *BMC Family Practice*, 2016, 17(163), 1–23

Demographics of respondents to survey (n=569)[3]

Characteristic	n	% of total responses	% of valid responses^
Age group			
≤ 35	106	18.6	25.1
36-49	197	34.6	46.7
≥50	119	20.9	28.2
Not given	147	25.8	
Gender			
Female	344	60.5	81.5
Male	78	13.7	18.5
Not given	147	25.8	
Occupation			
Occupational therapist	77	13.5	18.0
General practitioner	71	12.5	16.6
Physiotherapist	63	11.1	14.8
Public health/registered general nurse	63	11.1	14.8
Speech and language therapist	49	8.6	11.5
Manager	25	4.4	5.9
Dietician	18	3.2	4.2
Social Worker	13	2.3	3.0
Psychologist /Counsellor	12	2.1	2.8
Other occupations[2]	36	6.3	8.4
No occupation given	142	25.0	
Years since qualification			
1-5	32	5.6	7.7
5-10	76	13.4	18.3
10-15	89	15.6	21.4
15+	219	38.5	52.6
Not given	153	26.9	
HSE Region			
HSE West	174	30.6	42.2
HSE Dublin Mid-Leinster	143	25.1	34.7
HSE South	95	16.7	23.1
Not given	157	27.6	
Member of a formal primary care team			
Yes	388	68.2	78.1
No	109	19.2	21.9
Not applicable/not given	72	12.6	

^ % of responses excluding not given home help, community pharmacist, community worker, dentist, primary care facilitator, community doctor, general practice administration staff, general practice nurse, community welfare officer, area medical officer

Interview study sample

Location	N	Demographics
CS Site 1 **Private GP- Led interdisciplinary team with self-employed clinical staff**	**N=10** 2 GPs 2 Physiotherapist 1 Practice Manager 1 Office Manager 1 Dietician 1 Podiatrist 1 Primary Care Development Officer 1 Operations Manager	Male=2 and Female=8 Age range 27-55 years
CS Site 2 **HSE PCT**	**N=8** 2 Public Health Nurses 1 Centre Manager 1 Social Worker 1 Physiotherapist 1 Clerical Officer 1 GP 1 Occupational Therapist	Male=2 and Female=6 Age range 29-65 years
CS Site 3 **HSE PCT**	**N=19** 5 GPs 3 Physiotherapist 3 Public Health Nurses 1 Assistant Director Public Health Nurse 2 Psychologist 1 Occupational Therapist Manager 1 Occupational Therapist 1 Speech and Language Therapist 1 Home Help Coordinator 1 Primary Care Development Officer	Male=5 Female=14 Age range 28-52 years

Forty-one interviews were conducted with 39 individuals. The majority were female. The participants represented a cross section of health care professionals working on PCTs and a private GP led team. The age range was 27-65 and there was representation of a range of experience of working in primary care settings in Ireland.

APPENDIX II

Examples of 'bottom-up' interdisciplinary innovations in Irish primary care

reported in the survey and interview study

Design and delivery of educational events in the community for preventive care and health promotion:

Social worker, Dietician and Public Health Nurses working together on a *Healthy Eating on a Budget* programme for patients of their PCT, which was located in a deprived area,

Public Health Nurses, Occupational Therapists and Physiotherapists working together on a *Falls Prevention Programme* for older people,

Psychologist, Psychiatrist, GP, community youth worker, local business people and Garda Liaison Officer working together to deliver a *Youth Mental Health* programme to provide counselling support and foster positive mental health initiatives for young people.

Development of integrated care plans for people with complex health needs:

GPs, Public Health Nurses, Assistant Director of Public Health Nursing, Occupational Therapy Manager, Occupational Therapist and Physiotherapist working together to create new *community based services for people with dementia*,

Nurses, Dietitians, Physiotherapists, Occupational therapists, Speech and language therapists working together to plan care for patients after hospital discharge,

Joint Public Health Nurse, Physiotherapist and Occupational therapist visits to clients in their homes to support them and their carers, for example joint visits to people living with MS.

Advocacy on behalf of patients:

GP and Public Health Nurse liaising with each other, and with social services, for example Meals on Wheels services, to support older people to live in their homes.