Terms of Agreement between the Department of Health, the HSE and the IMO regarding GP Contractual Reform and Service Development

An Roinn Sláinte
Department of Health

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Seirbhís Sláinte Níos Fearr á Forbairt
Building a Better Health Service

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1. Service Development

1.1 Developing General Practitioner Services as Part of an Integrated Model of Structured Chronic Disease Prevention and Management

(See Appendix A1-A7, and Appendix E, Figure 3)

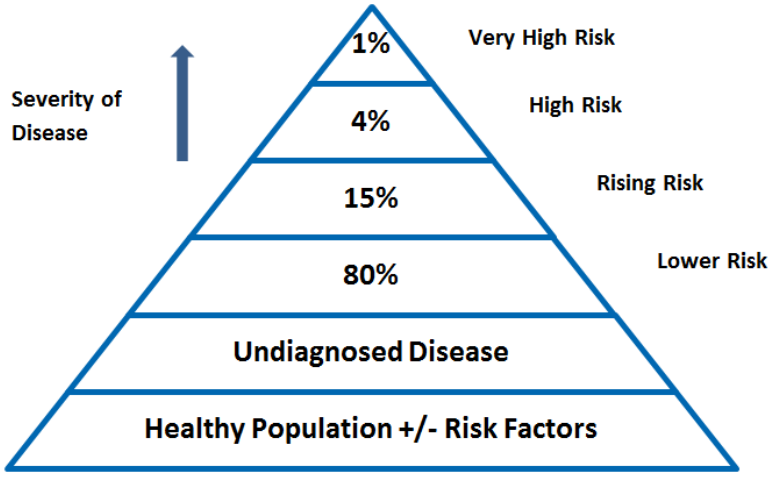
Work has been underway for some time on a range of building blocks to support the development of a more integrated model of primary care and community services which will involve General Practitioners and Primary Care Team staff working together as integrated multidisciplinary teams, at network level serving populations of on average 50,000.

Key background documentation:

1. Chronic Disease Prevention and Management Programme & Population Level Approach to Management of Chronic Disease.
2. Tom O'Dowd Report, A Future Together – Building a Better GP and Primary Care Service.
3. Development of Community Health Service networks – 96 at an average population of 50,000 to enable development of teams across general practice and primary care services.
4. Chronic Disease Integrated Care Programme Summary Model of Care 2017.

A population level approach to the prevention and management of chronic disease involves moving a step further upstream from the level of the individual, to assess whole-population needs with a view of targeting different interventions at individual risk groups. Internationally, approaches to chronic disease have been based upon the concept of the Population Health Pyramid. While there are variations on this Pyramid, they typically segment whole populations or cohorts within populations into a number of risk groups.

Figure 1: Population Health Pyramid



Prevention and Management of Chronic Disease in Ireland

The Health Service Executive have developed a number of policy frameworks, strategies, national guidelines and national programmes focused on chronic disease in the last decade with the objective of:

- Prevention of disease, case finding & improving patient access.
- Managing patient care in an integrated manner across service settings.
- Achieving best health outcomes and enhancing clinical decision making.
- Supporting the effective use of resources.

The Integrated Care Programme for the Prevention and Management of Chronic Diseases has identified 4 levels of service complexity (Figure 2). The central premise underlying this approach is that patients should be cared for at the lowest level of appropriate complexity, with all work underpinned by self-management support. Chronic disease prevention and management in General Practice is the basis of the model.

Figure 2: Levels of Service for Chronic Disease

A number of elements which will support the implementation of this model of care have already been developed, these include:

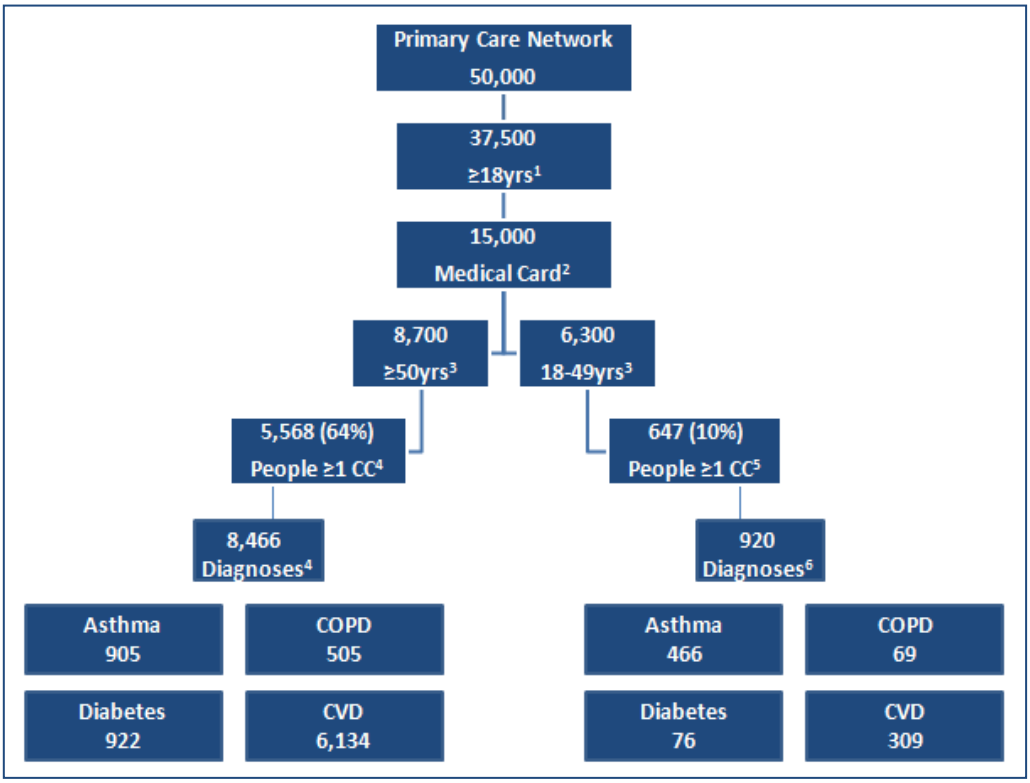
- A national framework for Making Every Contact Count (MECC) – focused on the primary prevention of chronic disease.
- A national framework for Self-Management Support (SMS) – supporting those living with chronic conditions to manage their own conditions.
- 24 'demonstrator sites' for specialist supports to General Practice (level 2) including those for diabetes, heart failure and respiratory disease.

Networks – Developing Multi-Disciplinary Teams Across General Practice and Health & Social Care Networks

In order to support the development of this approach, team working will need to be developed between general practice and the wider health and social care services at network level (as referenced in previous reports including, *A Future Together – Building a Better GP and Primary Care Service*. The development of this approach will also support the development of risk stratification of the population.

Each of these CHNs will include a population of approximately 50,000. To illustrate the approach, based on best available data, Figure 3 presents what is known about the burden of the chronic diseases below in adults with a medical card in an 'average' CHN population (a similar model for the entire population [medical card and non-medical card] is also available).

Figure 3: Prevalence of Chronic Disease in an 'Average' CHN Population with a Medical Card



1. Based on census 2016
2. Based on GMS/GPVC population aged 18+ as per PCRS 2017 as a proportion of total population aged 18+ in 2016 census
3. Based on GMS/GPVC population data as per PCRS 2017 in which 58% of the population aged 18+ were 50 years or older
4. Based on TILDA analysis of GMS/GPVC population as per PCRS 2017. For example, as per that analysis 10.4% of GMS/GPVC patients aged 50+ had a diagnosis of asthma
5. Based on QNHS, special module on health, 2010, and extrapolating prevalence of the chronic conditions and multimorbidity from those aged 50-64 in the TILDA study.
6. Based on QNHS, special module on health, 2010. This does not take account of differences in prevalence between the medical card and non-medical card population aged 18-49. No account of multimorbidity is taken in these calculations.

From the perspective of population level, chronic disease prevention & management, health service planning and resource allocation there are four critical deficiencies in the data as presented above:

1. It is based on national (or international) estimates and not on patient level records and it is based on (informed) assumption rather than fact.
2. At best it reflects the current situation, but is unable to provide any information about future utilisation (or 'risk').
3. It estimates multimorbidity in those aged 18-49 years; we have no study of how many people with one of the chronic conditions listed above also have one or more of the other conditions.

4. It takes no account of differences across CHNs. The figures above are very likely to overestimate the number of people with chronic disease in some, e.g. more affluent CHNs - which have a smaller GMS/GPVC population, and similarly underestimate the number in others, e.g. those with a greater number of older people with a medical card/GPVC.

The development of this approach will also support the development of risk stratification, and will improve service to the public as well as ensuring best utilisation of resource and maximising services for patients.

GP Contract

The Programme has established the bundle of conditions that should be covered for the Prevention and Management of Chronic Disease by General Practitioners and the prevalence of those conditions within the population.

A Chronic Disease Management Programme for GMS/GPVC patients will commence in January, 2020 and will be rolled out to adult patients over a 4-year period with a target uptake rate of 75%. The Programme is comprised of three components:

1. Opportunistic Case Finding.
2. An annual Preventive Programme for patients at high risk of cardiovascular disease or diabetes.
3. A Structured Treatment Programme for those diagnosed with the Chronic Diseases included in the Programme.

It is projected that in the order of 431,000 patients will participate in one of the three components of the Programme comprising of: 250,000 patients, with one or more diagnosed chronic conditions, who will participate in a Structured Treatment Programme; 120,000 patients who will participate in Opportunistic Case Finding and a further 57,000 high-risk patients receiving an annual preventive consultation with their GP. The first phase of the Programme will target patients over 75 years with the Opportunistic Case Finding and Preventive components of the Programme commencing in Year 2. The chronic diseases included are:

- Diabetes Type 2.
- Asthma.
- Chronic Obstructive Pulmonary Disease (COPD).
- Cardiovascular Disease including;
    - Heart Failure,
    - Ischaemic Heart Disease,
    - Cerebrovascular Disease (Stroke/ Transient Ischemic Attack (TIA)),
    - Atrial Fibrillation.

1.1.1 Structured Management of Chronic Disease

1.1.1.1 Bundle of conditions

The chronic diseases and conditions focused on in the Structured Prevention and Management of Chronic Disease Treatment Programme are:

- Diabetes Type 2.
- Asthma.
- Chronic Obstructive Pulmonary Disease (COPD).
- Cardiovascular Disease including;
  - Heart Failure,
  - Ischaemic Heart Disease,
  - Cerebrovascular Disease (Stroke/TIA),
  - Atrial Fibrillation.

1.1.1.2 Details of the CDM Treatment Programme

In order to support patients in managing their chronic disease there are two scheduled reviews with the GP in a 12 month period, preceded by a practice nurse visit. These reviews are made up of a number of elements including:

- Patient education.
- Preventative care.
- Medication review.
- Physical examination.
- Scheduled investigations, e.g., HbA1c for patients with diabetes.
- Individual care plan.

A patient centred approach requires that patients and their clinical providers work in partnership and ensures that patients are supported and empowered to be involved in their own care.

Based on the models of care for the various chronic diseases developed by the National Clinical Programme and the existing Cycle of Care for diabetes, there will be two scheduled reviews in a 12 month period. Before each GP visit, the patient will visit the practice nurse to have blood drawn for the necessary tests so that the results are available for the next review.

Each scheduled review will require 2 visits: a visit to the GP and to the practice nurse. The practice nurse visit will enable detailed education and review of the patient centred care plan and will include phlebotomy necessary for the programme. Subsequently, a clinical examination, medications review and an overall care plan will be reviewed by the GP. The practical result of this is that a GP or practice nurse develops a care plan with each patient registered on the Chronic Disease Programme.

This care plan will take cognizance of the clinical aspects of the patient's condition and their own goals for what they wish to achieve. The formulation of the plan will be an opportunity to support patients in learning about their own disease, the steps they can take to improve their own self-management, and the supports which may be available to them. It will help them to increase their awareness of a deterioration of their condition, how to recognise it and how to manage and respond to it through the development and implementation of an action plan if this should occur.

From the diagnosis of a chronic disease and the Registration/First Visit, the care planning process will begin with the development of a care plan following a discussion and an agreement with the

patient. This care plan is regularly reviewed and updated to reflect the current health and wellbeing of the patient as well as their future wishes and expectations.
The scheduled reviews will be planned so they are of optimal value to the patients and the practice team. For instance, if the patient is having a consultation visit with the GP, any planned investigations will be carried out prior to this consultation so that the information is available for joint decision making with the patient, e.g. by patients being called by the practice nurse for a structured visit including phlebotomy prior to the GP consultation visit.

In the first year, a person is registered to the "Structured Management of Chronic Disease Programme" with their GP and there are 4 structured visits to the GP Practice, in a 12 month period. These visits comprise of:

- 1 Registration/First Visit.
- 2 structured visits including phlebotomy with the practice nurse.
- 1 additional structured visit with the GP.

Each subsequent year, there will be 4 structured visits to the GP Practice in a 12 month period comprising of 2 structured visits with the GP and 2 structured visits including phlebotomy with the practice nurse.

1.1.1.3 Target Population of Proposal

The GMS and GP Visit Card population of 18 years of age and over is 1,419,867 people. This is:

- 68% of the GMS and GP Visit Card population.
- 30% of the total population over 18 (*GMS/GP Visit Card Population as of March 2018, Census 2016).*

A net target figure of 1,397,187 takes account that the Chronic Care Programme is a surgery based programme of care which will be delivered in GP centre(s) of practice only.

Prevalence rates – (*information based on TILDA for those over 50, ESR data, QNHS Data and Scottish Prevalence for some conditions).*

- The prevalence level is 10% for those aged 18 to 49, a total population of 60,223.
- The prevalence level is 31% for those aged 50 +, a total population of 253,689.
- When adjusted for prevalence & the addition of those diagnosed as part of Opportunistic Case Finding, the total target GMS/GP Visit Card population is 338,053.

- When adjusted for prevalence the total target GMS/GP Visit Card population for the CDM Treatment Programme is 338,053.

- It is anticipated that there will be a 75% uptake level, therefore the expected activity level is 253,540.

1.1.1.4 Phased Introduction of Structured Management of Chronic Disease

Ramp up in line with the following parameters:

- Phasing of multi-annual funding.
- GP & GP Practice capacity.
- Anticipated uptake rate of 75% of target population.
- Opportunity for increased investment in other areas including podiatry, dietetics, diagnostics, and rapid access clinics. Additional capacity for non-practice based diagnostic referral will need to be made available to each GP Practice e.g. spirometry, echocardiography etc. Community Healthcare Organisation Specialist Nurse and Allied Health Professional resources will also be required to support GPs in each locality and this requirement has been factored into the Sláintecare report.
- On-going monitoring and adjustment to Programme as required in relation to matching of uptake and resources available.

1.1.2 Prevention of Chronic Disease - Opportunistic Case Finding

The principle behind the early detection and diagnosis of cases is that they can be effectively managed from an early stage thus preventing some of the complications and the burden of uncontrolled or sub-optimally controlled chronic disease. There are significant levels of undiagnosed and hence untreated chronic disease in the population. The Programme will include case finding and an annual preventive visit for patients identified with high risk of cardiovascular disease or diabetes.

1.1.2.1 Bundle of conditions

The chronic diseases and conditions focused on in the Treatment Programme are:

- Diabetes Type 2.
- Asthma.
- Chronic Obstructive Pulmonary Disease (COPD).
- Cardiovascular Disease including;
  - Heart Failure,
  - Ischaemic Heart Disease,
  - Cerebrovascular Disease (Stroke/TIA),
  - Atrial Fibrillation.

The Preventive Programme focuses on patients at high risk of:

- Cardiovascular Disease.
- Diabetes.

The Opportunistic Case Finding Programme will identify those at high risk of cardiovascular disease or diabetes for entry to the Preventive Programme and those with undiagnosed listed Chronic Disease for the Treatment Programme

1.1.2.2 Details of Opportunistic Case Finding

Opportunistic case finding means that a systematic approach to the identification of cases is not taken, but that on an opportunistic basis i.e. when a patient attends for another issue, risk criteria can be applied and appropriate tests/assessments carried out to identify those with chronic disease or those at high risk of chronic disease.

The 2016 European guidelines on cardiovascular disease prevention in clinical practice acknowledge that assessing cardiovascular risk in all adults is not practical and that case finding those at relatively low risk is not effective. They recommend that individual countries set age cut off points based on available resources.[1]

The setting of lower and upper age cut off points for opportunistic case finding strikes a balance between:

1. Identifying as many individuals as possible who may benefit from additional management of high risk or the diagnosis of undiagnosed disease.
2. Using limited resources as effectively as possible.
3. Potential benefit gained by treating individuals previously unidentified.

Internationally countries with case finding programmes tend to start at 40 or 45 years of age, in Ireland people over 45 years of age have been selected as the appropriate cohort. It was considered that this age group was appropriate as significant under diagnosis of risk factors, particularly hypertension is prevalent from the mid-40s on, particularly in more deprived populations such as the GMS/GPVC population at which this Programme is targeted. It was not considered appropriate to limit the upper age of the Programme as it should be recognised that case finding identifies both individuals at high risk of cardiovascular disease and individuals with undiagnosed disease e.g. atrial fibrillation, hypertension, heart failure and diabetes. While some authors in the literature suggest that the "time to benefit" from interventions for the prevention of disease in high risk individuals over 75 years of age is limited, there is strong international evidence that patients over 75 years of age significantly benefit from the diagnosis and appropriate treatment of previously undiagnosed blood pressure and atrial fibrillation. [2][3][4][5][6]

Analysis of TILDA data suggests that there are approximately 30% of over 75 year olds in the population who have undiagnosed hypertension, the treatment of which would make significant reductions in the incidence of stroke and myocardial infarctions nationally, both of which are conditions which place a huge burden on both individuals and the health service. The HIQA HTA on atrial fibrillation recommended case finding in older age groups and this was likely to yield a reduction in the incidence of strokes of 160 per annum. The HTA considered case finding in older age groups to be cost effective.

The National Clinical Programmes for Stroke and Heart Disease recommended that all patients over the age of 45 with the risk criteria suggested should be included in the Case Finding Programme.

To incentivise the identification/early detection of patients requires payment for the GP to opportunistically assess patients – i.e. risk assess and carry out specific tests**.** The case finding payment is based on the number of patients with the risk criteria found, invited for assessment and assessed.

If patients are diagnosed with chronic disease on opportunistic assessment then they enter the Chronic Disease Management Programme and there is a treatment fee for these patients. The GP returns data on the number of patients identified with various risk criteria, the number assessed and the number newly diagnosed.

[1] 2016 European Guidelines on cardiovascular disease prevention in clinical practice. European Heart Journal (2016) 37, 2315–2381
[2] Crossan, C. et al. Cost effectiveness of case-finding strategies for primary prevention of cardiovascular disease: a modelling study. Br J Gen Pract 2016
[3] Treating hypertension in the very elderly—benefits, risks, and future directions, a focus on the hypertension in the very elderly trial. European Heart Journal (2014) 35, 1712–1718
[4] HIQA. Health technology assessment (HTA) of a national screening programme for atrial fibrillation in primary care. August 2015
[5] 5 Effectiveness of preventive primary care outreach interventions aimed at older people: meta-analysis of randomized controlled trials. Ploeg J1, Feightner J, Hutchison B, Patterson C, Sigouin C, Gauld M. Can Fam Physician. 2005 Sep; 51:1244-5.
[6] 6 Effect of health risk assessment and counselling on health behaviour and survival in older people: a pragmatic randomised trial. Stuck AE1, Moser A2, Morf U3, Wirz U3, Wyser J3, Gillmann G4, Born S1, Zwahlen M4, Iliffe S5, Harari D6, Swift C7, Beck JC8, Egger M4.PLoS Med. 2015 Oct 19;12(10):e1001889. doi: 10.1371/journal.pmed.1001889. eCollection 2015 Oct.

The following are the risk criteria for the patients who the GP could select for assessment as these patients tend to have a higher prevalence for Chronic Disease:

- Current smoker.
- BMI ≥ 30 approx. i.e. obese.
- History of gestational diabetes.
- Dyslipidaemia (HDL less than 0.9 or triglycerides greater than 2.82) (previously recorded)
- Moderate or severe chronic kidney disease ([eGFR less than 60 mL/min/1.73 m2], [previously recorded]).
- History of severe Mental Illness.
- Irish Travellers, Roma, African & Asian Ethnicities (given high incidence of CVD in in this population cohort).

GPs will return data on patients assessed and the numbers allocated to each of the 3 pathways. The data return for this is included in Appendix A5. This will be integrated into the clinical record. This would be subject to audit if necessary.

Operationalisation of Opportunistic Case Finding

Development of Resources

1. A case finding consultation template has been developed and will be available in all GP software systems (Table 1).
2. GPs must ensure all staff are aware of the system of Opportunistic Case Finding – develop information resources for practice staff and patients including information on consent.

Implementation of programme in GP practice

1. The practice will identify all of their patients already diagnosed with the conditions listed in the Treatment Programme, at the commencement of the Chronic Disease Contract.
2. The practice will also identify all of their patients with diagnosed hypertension and categorise them with the NICE criteria of:

    a. stage 1 hypertension (≥ 140/90), QRISK < 20% and no target organ damage.
    b. patients with stage 1 hypertension with target organ damage or QRISK ≥ 20%.
    c. hypertension stage 2 (≥ 160/100).

    The latter 2 groups should be enrolled in the Preventive Programme. In order to identify these in the GPs cohort of diagnosed hypertensives it may be necessary to review their record for level of blood pressure, do a QRISK assessment and ideally take blood for renal function tests, and urine for protein and haematuria at their next visit. If blood is taken it should also be sent for HbA1c, FPG and BNP levels to rule out other chronic disease and a pulse rate and rhythm should be examined.

3. Patients with (a) low risk stage 1 hypertension and no target organ damage will not currently be included in the Programme. These patients are considered low risk as they are already diagnosed and under the usual care of the GP, however this will be reviewed after the first 5 years of the Programme, when the data available will allow better Programme targeting.
4. In the year following the introduction of the Treatment Programme, the Opportunistic Case Finding Programme should commence.
5. When the Opportunistic Case Finding Programme commences, as patients present to the GP or practice nurse, patients that fit the risk criteria profile are offered a case finding assessment.
6. When a patient attends, their informed consent is obtained using an agreed consent process. This includes informed consent for the case finding process, treatment options if appropriate and data sharing for on-going care, evaluation, planning and quality improvement.
7. GPs should utilise agreed case finding assessment consultation template for screening appointment. (see Table 1).
8. Appendix A1 gives the details of the data returns for the “high risk” cohort that should be returned to the HSE.

Table 1

History										
Age	Sex	Current Smoker	QRISK Variables*							
		Yes								
		Yes								
		No								
Assessment Tests										
BMI	Height	Weight	Waist Circumference	Pulse Rate	Pulse Rhythm	Blood Pressure***	Peak Flow	Heart and Lung Examination	Spriometry*****	ECG*****
Blood Tests (Taken in Practice or Referred to Local Service)										
HBA1c ****	FPG ****	Lipid Profile**	FBC	Natriuretic Peptide (**** ie. on loop diuretic)	Renal Function Tests					
					Creatinine	U&E	eGFR			
Proteinuria	Haematuria									
Calculate QRISK score following test results and examination										

* Enter all the variables known, risk prediction accuracy will improve with more variables, additional QRISK variables may be added as the calculator is updated by UK Authorities.
** Individual with familial hyper-cholesterolemia should not be risk scored, as many will show a low score but in fact they need referral to specialist care.
*** Patients with hypertension with a QRISK of ≥20% or patients with hypertension stage 1 (≥140/90) with target organ damage or hypertension stage 2 (≥160/100), should be enrolled in the high risk Preventive Programme.
**** if clinically relevant.
***** If clinically indicated and available.

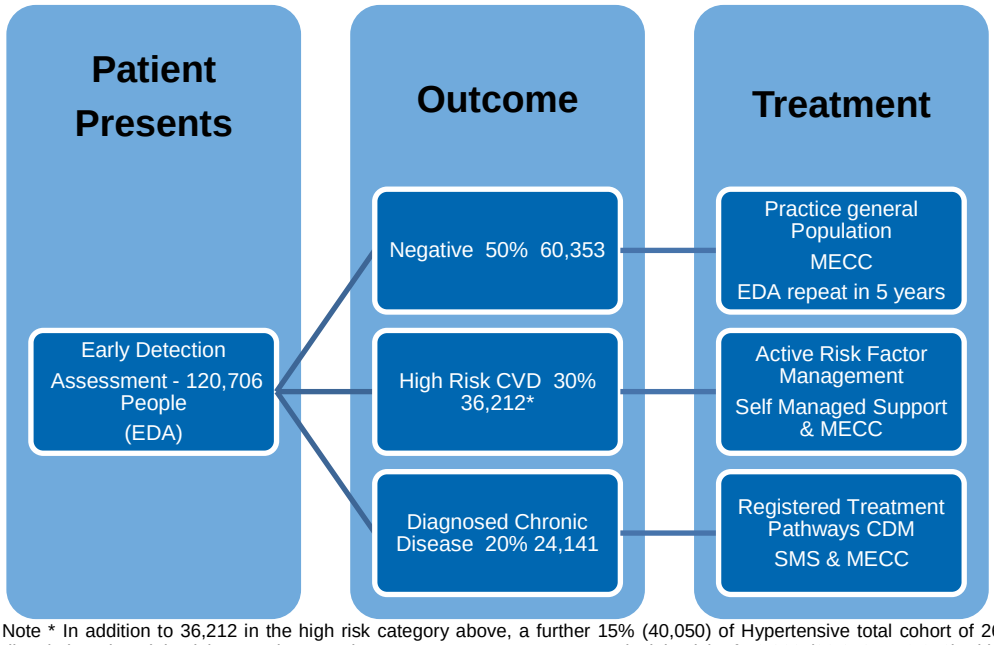
1.1.2.3 Target Population of Proposal

The GMS/GP Visit Card population of 45 years of age and over is 911,049 people.

This is 45% of the GMS/GP Visit Card total population, is 53% of the total population over 45 and 20% of the total population.

When adjusted for prevalence of 31% and those already captured under the CDM Programme structured visits and the anticipated uptake level of 75% the target population for the opportunistic screening is 120,706.

1.1.2.4 Case Finding Process



Note * In addition to 36,212 in the high risk category above, a further 15% (40,050) of Hypertensive total cohort of 267,000 will go directly into the High Risk Annual Preventive Treatment Programme. Total High Risk of 76,262 (36,212 + 40,050) with an uptake of 75% leaves 57,196 on the High Risk Annual Preventive Treatment Programme.

This flow diagram describes how early detection by the GP can divide his/her patient population into 3 groups; general population, high risk population and population diagnosed with chronic disease.

- The patients for active management by the high risk preventive programme comprise those patients not diagnosed with one of the selected chronic diseases for the Treatment Programme but who have either QRISK3 **≥** 20% stage 1 hypertension with target organ damage, stage 2 hypertension, pre diabetes or BNP greater than 34 pg/ml or NT pro BNP **≥** 125 pg/ml.
- Patients opportunistically diagnosed with a chronic disease move into the treatment programme as described in this document.
- Opportunistic case finding should not be done on the same individual patient more frequently than every 5 years.

High Risk Preventive Programme

Interventions for High Risk Group:

- High risk patients should be enrolled in the High Risk Preventive Programme and receive an annual GP and practice nurse visit.
- The GP should review the patient's medications and perform any appropriate blood tests.
- All patients should be given health promotion advice, advice on lifestyle modification and have risk factors and interventions recorded.
- All high risk patients should be actively managed and have self-management supported by an annual visit to the practice nurse and a personalised care plan agreed and documented.
- Patients diagnosed with pre diabetes should be referred to the Diabetes Prevention Programme for pre diabetic education.

Active Risk Factor Management

Patients who have been identified at high risk of CVD require active management of their risk factors. This would take place by the GP/practice nurse agreeing a self-management plan with the patient, agreeing their goals for improvement. The GP/practice nurse would explain the importance of improving their risk factors and make the appropriate referrals to support services for smoking cessation, harmful alcohol treatment and weight management as appropriate. The GP/practice nurse would also refer the patient to local community support services for exercise, weight management, or pre diabetes structured education as appropriate. An annual review of risk factors would be carried out by the GP/practice nurse where medications will be reviewed and the self-management plan would be reviewed and additional support or referrals made. Appropriate medical treatment e.g. for hypertension, smoking cessation, blood lipids etc. would be prescribed and appropriate blood tests would be carried out.

The format of the patient centred personalised care plan has been agreed. (Appendix A2)

1.1.2.5 Phased Introduction of Opportunistic Case Finding

Capacity restraints in General Practice will necessitate both a phasing in of the Chronic Disease Management Programme and a requirement to register the most vulnerable patient-cohorts initially. Phasing in the Programme, in a sustainable manner, will be achieved through facilitating older populations of patients initially, with the entire population being entered into the Programme within 4 years. Starting with the over 75 population in the first year, will not over-run capacity and will support patients, who are most affected by acute exacerbations of chronic diseases and acute hospital admissions.

The Chronic Care Programmes are surgery based programmes of care and will only be delivered within the GP's centre(s) of practice.

Ramp up in line with the following parameters:

- Identification of patients already diagnosed in the practice with chronic disease in year 1.
- Case finding programme to commence in year 2, following the above.
- Phasing multi-annual funding.
- GP & GP Practice capacity.
- Anticipated uptake rate of 75% of target population.
- Data feedback on numbers tested and results of testing.
- On-going monitoring and adjustment to programme as required in relation to matching of uptake and resources available.

Agreed Phasing

- Assume 75% Programme uptake.
- 2020 start with 75+ on Programme.
- Opportunistic Case Finding to commence in Year 2.

Agreed Phasing Option – CDM Programme Phasing Oldest to Youngest

Practice Nursing Additional Capacity :	2020	2021	2022	2023	Total
Sequencing Assumption	30%	45%	25%	0%	100%
Additional Hours / WTE	74	111	62	-	247
Opportunistic Case Finding 45 +	**2020**	**2021**	**2022**	**2023**	**Total**
Ago Cohorts		**75+**	**65-74**	**45-64**	
Opportunistic Case Finding GP Registration		**28.7%**	**29.5%**	**21%**	**100%**
Opportunistic Case Finding No of People	-	34,670	35,580	50,456	120,706
Annual GP FEE - HIGH RISK	-	28.7%	29.5%	21%	**100%**
No of People 40%	-	16,428	16,859	23,909	57,196
CDM - DIAGNOSED 20%	0%	14%	29%	29%	100%
No of People	-	5,201	5,337	7,568	18,106
CDM Programme - all conditions	**2020**	**2021**	**2022**	**2023**	**Total**
18-49 - all conditions					
GP Visits %	0%	0%	80%	20%	100%
GP visits people	-	-	36,135	9,032	45,167
50-64 - all conditions					
GP Visits %	0%	0%	100%	0%	100%
GP visits people	-	-	42,640	-	42,640
65-74 - all conditions					
GP Visits %	0%	70%	30%	0%	100%
GP visits people	-	47,607	20,403	-	68,010
75+ - all conditions					
GP Visits %	55%	45%	0%	0%	100%
GP visits people	43,789	35,828	-	-	79,617
Total People with completed GP visits	**43,789**	**83,435**	**99,178**	**9,032**	**235,434**
Total CDM (incl those diagnosed from OCF)	**43,789**	**88,636**	**104,515**	**16,600**	**253,540**
Total CD & OCF/Preventative Program	**43,789**	**139,734**	**156,954**	**90,965**	**431,442**

1.1.3 Treatment Programme and Data Returns

1.1.3.1 Chronic Disease Practice Register, Diagnosis and Registration Visit

At the commencement of the contract, GPs will identify all their existing patients who have been diagnosed with one of the listed diseases in the Treatment Programme. Informed consent for entry into the Programme should be sought and for sharing of data for a number of functions. This consent will need to be recorded and returned to the HSE. The patient will then be registered with the Programme on the chronic disease register which the GP has established. Subsequent to this when each new patient is first diagnosed they should be entered onto the register, informed consent for entry into the Programme and sharing of the data should be sought, recorded and returned. The HSE is required to establish data governance, analysis and feedback of information to facilitate this, in line with Data Protection requirements.

The Registration/First Visit will encompass registration of the patient and the first scheduled review. Registration will include a history, behavioural risk factor assessment and brief intervention as appropriate undertake a comprehensive clinical examination, do the necessary diagnostic testing and commence the development of a Care Plan. The Registration/First Visit will contain all the elements of a scheduled review as set out in Table 2 below. This information then populates the database or clinical information system including test results, findings from a clinical examination, lifestyle behaviours and information on the provision of brief interventions, education and appropriate referral. At this Registration/First Visit the development of a Care Plan in partnership with the patient will be initiated. For patients with co-morbidities clinical information relevant to all co-morbidities will be recorded on the clinical information system. The management of patients with co-morbidities is more complex and therefore will require more resources including time than patients with single morbidities.

1.1.3.2 Scheduled Care Reviews

To support patients in managing their chronic disease there are two scheduled reviews in a 12 month period.

Registration on the Programme will be part of the initial first visit as outlined above. These reviews are made up of a number of elements including patient education, preventative care, past medical history, physical examination, and scheduled investigations. It is also important that the care planning process, in partnership with the patient, is initiated from Registration/First Visit and that with each review the care planning process is continued with the Care Plan being updated and agreed. It is envisaged that each of the twice yearly scheduled reviews will require a visit to the GP and a visit to the practice nurse. The data return of the scheduled review, whether it is completed by the GP and/or the practice nurse should be returned from the GP Management System on completion of the review. This will be uploaded from the GP clinical systems automatically on a monthly basis.

The literature suggests that the care and management of patients with more than one chronic disease, i.e., with multi-morbidity, is more complex and can present with a number of challenges. In order to optimise management of these patients, there is more consultation time with the General Practice team. This can be done by extending the consultation times or by increasing the number of consultations. The contract will need to support this approach through incentives for increased consultation time associated with multimorbidity. The Clinical Programmes Models of Care includes elements that will be carried out with each review.

The regular scheduled reviews should include specified elements which are set out in **Table 2.**

The elements are set out in sections:

1. **Identification and demographic details.**
2. **Clinical Assessment;**
   2.1 Medical assessment,
   2.2 Risk Factors,
   2.3 Symptoms,
   2.4 Social Assessment.
3. **Physical Examination.**
4. **Investigations.**
5. **Referral to Specialist Services.**
6. **Care Planning.**

During a review process each of these sections will be included. Under each section there are a number of elements for review. Any changes in these elements for example demography, medication, medical history will be recorded and the records updated. It is envisaged that although for specific conditions the physical examination may have a different focus there are some common assessments that will be carried out such as calculation of BMI (as overweight and obesity are risk factors or impact a number of the chronic diseases).

However, for each condition there may be differences in the investigations that will be carried out and whether they need to be done annually or more frequently. The frequency of these investigations depends on a number of factors including:

- The evidence of the value of the result in managing the chronic disease – for some investigations, it is important to have recent results to effectively manage the condition.
- Whether it is the first registration visit.
- Whether the value was raised at the first or preceding review.

In **Table 3** below the agreed appropriate investigations for specific conditions are listed. These investigations and their frequency are based on Models of Care developed by the National Clinical Programmes. The request and results from these investigations should be recorded on the clinical information system. These results and their trends can be used to support quality improvements in the design, planning and delivery of services for patients with chronic disease.

The scheduled reviews will be planned so they are of optimal value to the patients and the practice team, for example, if the patient is having a consultation visit with the GP any planned investigations will be carried out at the practice nurse visit prior to the GP consultation so that the information is available for joint decision making with the patient.

Table 2: Elements of Scheduled Care Reviews

1. Identification and demographic details:

- Patient GMS Number
- Patient ID
- Patient Name
- Patient Address
- Date of birth
- Age
- Sex
- Ethnicity
- Primary diagnosis
- Co-morbidities
- Disease register status

2. Clinical Assessment:
(Including new/updated results)

2.1 Medical assessment

- Past medical history including mental health
- Medication review include inhaler technique if relevant
- Vaccination (influenza and pneumococcal)
- Self-management review including self-monitoring of weight, exercise, salt, alcohol, smoking, medication adherence

2.2 Risk Factors : Make Every Contact Count
(See Appendix for risk factor status and health behaviour change intervention descriptors)

- Smoking status and intervention
- Alcohol status and intervention
- Body mass index status and intervention – overweight and underweight
- Nutrition/diet status and intervention
- Physical activity status and intervention

2.3 Symptoms
(Clinically appropriate assessment)

- Respiratory Symptoms : Dyspnoea, breathlessness,
- exercise tolerance,
- Cardiac symptoms: including exercise induced
- Peripheral vascular disease symptoms
- Eye symptoms
- Mental Health symptoms

2.4 Social Assessment

- Family
- Community

3. Physical Examination
(Clinically appropriate examination)

- Pulse rate and rhythm
- Blood pressure
- Weight
- Height
- Waist circumference
- Heart and lung auscultation
- Foot and lower limb examination

4. Investigations:
(Clinically appropriate)

5. Referral to specialist services

- Retinopathy screening programme
- Structured education programme/ respiratory and cardiac rehab
- Smoking cessation
- Alcohol/drugs addiction services
- Dietician
- Podiatry
- Mental health services

6. Care Planning

- Agreed updated Care Plan

Table 3: Investigations

	Investigations for Treatment Programme					Investigations for Preventive Programme
Investigations: *(If clinically appropriate)*	**Diabetes**	**COPD**	**Heart-Failure**	**A Fib**	**IHD**	**HTN BP**
Respiratory Function: spirometry		Diagnosis				
Cardiac Tests: ECG	Registration/First Visit /Annual Review (if clinically indicated)	Registration/First Visit /Annual Review (if clinically indicated)	Registration/First Visit	Registration/First Visit /Annual Review (if clinically indicated)	Registration/First Visit /Annual Review (if clinically indicated)	Registration/First Visit /Annual Review (if clinically indicated)
Cardiac tests : ECHO			Registration/First Visit/Review Annually	Registration/First Visit /Annual Review (if clinically indicated)		Registration/First Visit /Annual Review (if clinically indicated)
Urinalysis: micro-albuminuria	Registration/First Visit/Annually if previously raised		Registration/First Visit/Annual Review			Registration/First Visit /Annual Review
Haematuria						Registration/First Visit /Annual Review
Renal function tests: urine albumin to creatinine ratio (ACR)	Registration/First Visit/Annual Review		Registration/First Visit/Annual Review	Registration/First Visit/Annual Review		Registration/First Visit /Annual Review
Blood Tests						
HbA1c	Registration/First Visit / All Scheduled Reviews		Registration/First Visit			
FPG	Registration/First Visit					
Lipids profile	Registration/First Visit /Review Annually – Review twice yearly if previously raised	Registration/First Visit/Annual Review	Registration/First Visit/Review Annually	Registration/First Visit/Annual Review	Registration/First Visit/Annual Review	Registration/First Visit /Annual Review
Renal function tests – including serum creatinine, eGFR (estimated glomerular filtration rate) if clinically relevant	Registration/First Visit /Review Annually – if previously raised, review twice yearly	Registration/First Visit /Annual Review	Registration/First Visit /Annual Review	Registration/First Visit /Each Review	Registration/First Visit/Annual Review	Registration/First Visit /Annual Review
Full blood count	Registration/First Visit	Registration/First Visit	Registration/First Visit /Annual Review	Registration/First Visit /Annual Review	Registration/First Visit	Registration/First Visit
Thyroid function tests	Registration/First Visit	Registration/First Visit	Registration/First Visit	Registration/First Visit		Registration/First Visit
Liver function tests	Registration/First Visit	Registration/First Visit	Registration/First Visit	Registration/First Visit /Annual Review		
Natriuretic Peptide	Registration/First Visit /Annual Review		Registration/First Visit	Registration/First Visit	Registration/First Visit	Registration/First Visit
U/E +	Registration/First Visit	Registration/First Visit	Registration/First Visit	Registration/First Visit / Each Review	Registration/First Visit / Each Review	Registration/First Visit

5. Data Recording and Returns

The completion of the data return in respect of the chronic disease programme is essential to the success of the Programme and to facilitate appropriate analysis and planning of services.

The data returns set out in the Programme, are subject to the tests underpinning the data being available to the individual GP in his/her area, and the non-availability of any test to a GP shall in no way impact on the GP's entitlement to participate in the Programme of care and to be paid for such participation. The GP shall return all of the required data available to him/her and the non-availability of a specific piece of data shall not be a barrier to the rest of the data being returned.

All parties agree that the system will allow for auto population of data from the clinical systems for the purposes of the minimum dataset and the patient care plan.

For each scheduled review data and information is collected and recorded. **(Appendix A1: Minimum dataset)** This data will be required for the clinical management of the patient and should be entered onto the GP's own clinical systems. Some of the information recorded will be required to be returned to the HSE as part of the contractual requirements while other subsets may be provided to the HSE to support and inform quality improvements, service design, planning and risk stratification, (indicated in Appendix A1). A system of quality assurance will be introduced to ensure that this Programme is being provided in the most effective and clinically appropriate manner and is accessible to the target population across the spectrum of severity for each of these conditions. It will be necessary to use the clinical data returned to refine the assumptions that underpin the target groups in the contract and make them more accurate. This will require adjustment of the clinical model, by agreement, to ensure that it is as effective as possible in improving population health.

Suitable restructuring of the GP clinical systems will be required to facilitate the establishment of standard disease registers using this common dataset, which are an integral part of the GP clinical systems. In addition the systems should support the easy transfer of the required data to the HSE.

6. Development of a Care Plan

A patient centred approach requires that patients and their clinical providers work in partnership and that patients are supported and empowered to be involved in their own care. The practical result of this is that a GP or Practice Nurse develops a Care Plan with each patient registered on the Chronic Disease Management Programme. This Care Plan will take cognizance of the clinical aspects of the patient's condition and their own goals for what they wish to achieve. The formulation of the plan will be an opportunity to support patients in learning about their own disease, the steps they can take to improve their own self-management, and the supports which may be available to them. It will help them to increase their awareness of a deterioration of their condition, how to recognise it and how to manage and respond to it through the development and implementation of an action plan if this should occur. From the diagnosis of a chronic disease and the Registration/First Visit the Care Planning process should begin with the development of Care Plan following discussion and agreement with the patient. This Care Plan is regularly reviewed and updated to reflect the current health and wellbeing, of the patient as well as their future wishes and expectations. The HSE has developed a Care Plan Template in partnership with GPs to provide a standardised approach **(Appendix A2)**. This will be electronically held in the GP clinical system and appropriate fields populated from the system. Nurse prompts will appear on the system. A paper updated version can be printed for the patient to be taken away after each nurse visit.

7. Enabling Measures

- GP Clinical Systems will need to be enhanced to support CVD risk calculation and the care plan record.
- GP Clinical Systems will need to be enhanced to enable the minimum data set to be auto populated and to be recorded and data to be returned.
- GP systems will be developed to support GPs to proactively identify the cohort of patients requiring complex care and information to enable quality improvement.

- Data governance will be established in line with GDPR requirements.
- Individual patient consent for early detection, treatment and data sharing for various necessary functions will need to be collected by the GP at registration. The HSE will develop the consent method and materials.
- Supports to practices to enhance diagnostic ability and practice nurse capacity will be required (it is estimated that over 247 additional practice nurse WTE's will be required to serve the GMS/GPVC population identified with chronic diseases).
- Additional capacity for non-practice based diagnostic referral will need to be made available to each GP Practice, e.g. spirometry, echo cardiography, etc. CHO Specialist Nurse and allied health professional resources will also be required to support GPs in each locality.
- Communications to the public and development of materials about the new programmes will be developed by the HSE.

1.2 Enhanced Special Items of Service

(See Appendix E, Figure 4)

Summary

The following Special Items of Service have been agreed:

1) Therapeutic Phlebotomy for Haemochromatosis

- Current admissions of GMS/GPVC patients to the acute setting and OPD will be treated in General Practice. It is estimated that 7,000 – 8,000 GMS males require venesection treatment annually each requiring an estimated 3 visits per patient per year equating to 24,000 venesections per year freeing up approximately 12,000 hours of acute nursing/phlebotomist time annually.

2) Involuntary Admissions to Acute Mental Health Facilities

- There are approximately 2,000 involuntary admissions to acute mental health facilities annually.

3) Virtual Clinics

- Virtual weekly consultation for heart failure patients between GPs and Consultant Cardiologists to discuss patient with heart failure and agree/amend care plans for these patients. These clinics will divert patients from acute settings and OPD waiting lists.
- Currently there is a pilot in the Carlow/Kilkenny area. On-going monitoring of the demonstrator project has shown a 95% decrease in referral for admission and an 87% decrease in referral to OPD of these patients.
- Under this new service item GPs will be able to participate in a weekly Virtual Clinic facilitated by a Consultant Cardiologist to discuss eligible patients with heart failure and agree/amend care plans for these patients. The Special Item will initially commence in the clinic in the Carlow/Kilkenny area with a view to extending it to a further 3 locations by 2022. It is estimated that the 4 Clinics when fully operational will provide 17,500 virtual clinic slots per year. GPs will receive a fee of €100 for each eligible patient reviewed at a virtual clinic subject to an overall cap of 6 patients per virtual clinic. GPs who do not have a patient scheduled for review may participate in the virtual clinic for CME/Training purposes, no Special Item fee will be associated with attendance for CME/Training purposes.

Special Items of Service	Expected Activity Level
Summary	
Therapeutic Haemochromatosis	24,000
Involuntary Admissions	2,000
Virtual Clinics (4 Virtual Clinics)	17,500

1.2.1 Therapeutic Phlebotomy for GMS/GPVC Patients with Haemochromatosis

Domain	Elements associated with each domain
Principle Description	• Hereditary Haemochromatosis is an inherited iron load condition and is the most common genetic disease amongst Caucasians, especially those of Celtic origin and is particularly prevalent in Ireland. Ireland has the highest levels of this condition in the world, with research showing that approximately 1 in 83 people are predisposed to develop hereditary Haemochromatosis. [7] The treatment for the management of Hereditary Haemochromatosis is by phlebotomy venesection. If not treated appropriately Haemochromatosis can cause serious health implications.
Strategic Alignment	• A Strategic Framework for Reform of the Health Service 2012 – 2015. • Sláintecare- primary care expansion and transition from acute to primary care setting. • CHO Report- to deliver better more integrated and responsive services to people in the most appropriate setting by developing primary care services, while at the same time developing and implementing standardised pathways and models of care. • Corporate Plan- Development of a new GP Contract, strengthening primary care services, improving access to hospital, outpatient and community services and reducing wait times. • Capacity Review 2018- Increase in primary care capacity including GP Workforce and Practice Nursing.
Impact on Health System – Evidence Based	• Estimates of prevalence in the Irish population suggest that approximately 1.2% of the population amounts to approximately 55,000 patients have the condition many of whom will require treatment by venesection.[1] • Changes to admissions in acute setting and OPD as condition can be readily treatable in General Practice but currently being treated in Hospitals.
Patient Impact – Evidence Based	• The defined target population of patients would be predominately aimed at men, aged between 40 and 65 years. The prevalence rate of Haemochromatosis in Ireland is estimated at 55,000. Of this figure approximately 20,000 are women who do not require venesection and another 15,000 males who, while having the condition, will not require venesection. In addition, it is estimated that there are approximately 5,000 patients whose condition may remain undiagnosed. That leaves 15,000 patients requiring venesection of which it is estimated that between 7,000 and 8,000 will be GMS/GPVC patients with an average of 3 visits per patient per year. • Improvement of patient experience as large numbers of patients may no longer have to travel to Secondary Care for treatment for this condition. Currently patients have the inconvenience of having to travel considerable distances for treatment that could be carried out in their own GP practice. • By moving to a community based setting providing positive outcomes, it can allow necessary flexibility for patients, who require life- long treatment. It eases hidden costs for the patient – allowing patients to access this treatment at suitable times.

[7] Therapeutic Phlebotomy for patients with Hereditary Haemochromatosis Model of Care, June 2016

Feasibility of Implementation – Evidence Based	• The diagnostic criteria and therapeutic approach are well documented. The ICGP has a reference guide on this subject. It is sufficiently common that many large practices would have 10-40 patients (GMS/GPVC and private) so most practices might wish to undertake the procedure. On the other hand single handed GPs might not wish to engage and consideration should to given to the option of inter-referral (e.g. via GPreferral.ie). • This condition is readily treatable in General Practice, but in the main is currently being treated in the more expensive secondary care sector. It is estimated that there will be approximately 24,000 venesection per annum which equates to approximately 12,000 hours of nursing/phlebotomist time. By moving this from Hospital to primary care it can free up capacity for more acute/complex patients. • Enablers such as provision of consumables (blood bags etc.) need to be standardised. • Provision for dealing with clinical waste needs to be standardised. • Links to be established with the national blood transfusion services to allow for blood taken from patients with Haemochromatosis could, where logistically feasible, be made available for the public good.
Interface & integration with other initiatives / other models of care Evidence Based	• Alignment with best practice in the HSE. • Therapeutic Phlebotomy for Patients with Hereditary Haemochromatosis Model of Care June 2016. • Clinical Governance for treatment and on-going monitoring should be tailored to suit patients' needs and in accordance with established safe clinical standards. • Community Healthcare Organisation Report- alignment of service provision for integrated care at Community Healthcare Network and Primary Care Team level.
Area(s) that proposal will impact on	• Changes to Service Delivery will occur by diverting patients from acute to primary care setting. • Due regard needs to be had to the opportunity gains for acute hospital system as a result of transitioning this activity to primary care. • Changes to Work Practices will free up nursing hours and space in the hospital setting. • This service enhancement will be accessible to patients who are eligible for free GP care.

1.2.2 Involuntary Admissions to Acute Mental Health Facilities

Domain	Elements associated with each domain
Principle Description	• A patient with a mental illness may require admission to a psychiatric hospital or unit voluntarily, or may be committed as an involuntary patient. • The vast majority of admissions are voluntary but there are some 2,000 annually that require involuntary admission.
Strategic Alignment	• Since the introduction of the 2001/2011 Mental Health Act, there is an opportunity to streamline arrangements in respect of involuntary admission, which will better reflect the model of service provision outlined in A Vision for Change, National Mental Health Policy. • Corporate Plan- Development of a new GP Contract, strengthening primary care services.
Patient Impact – Evidence Based	• There are approximately 2,000 involuntary admissions per annum of which 1,200 occur during out of hour's periods and 800 occur during normal

	surgery times.

1.2.3 Virtual Clinics

Domain	Elements associated with each domain
Principle Description	• The Virtual Heart Failure Clinic provides weekly opportunities for GPs to discuss heart failure patients on whom they wish to have specialist opinion from the Consultant Cardiologist. These are patients that the GP would otherwise refer to the OPD or to ED/AMAU for admission. On-going monitoring of the demonstrator project has shown that there has been a 95% decrease in referral for admission and an 87% decrease in referral to OPD of these patients. Patients have also been spared the requirement to travel. The Virtual Heart Failure Clinic is attended by the Consultant Cardiologist and a group of GPs. GPs present the patient's details at the Virtual Clinic instead of making the referral to OPD/ED/AMAU. GP time is required to prepare the case and to attend the clinic, which takes approximately 1 hour. In addition other GPs are encouraged to join the video group presentation for learning purposes. GPs attending for CME purposes do not attract a fee. • Currently the Virtual Clinic is being applied to the heart failure service. This demonstration project also serves to develop Virtual Clinic methodology between Primary and Secondary Care which can also be used in diabetes, asthma and COPD care. • Heart failure is a serious condition which deteriorates at a variable rate, the patient can be cared for in the community by GPs when in the stable state and this needs rapid access to specialist opinion to enable this. As patients start to deteriorate urgent specialist advice or intervention is needed to avert hospital admission. • Approximately 2% of the adult population suffer from heart failure, this prevalence rises to over 10% of those aged over 70, and the prevalence in the population is rising at approximately 4% per annum. Currently there are approximately 5,800 admissions for heart failure per annum with an average length of stay of 10.58 days. Hence this comprises 58,934 bed days used. 15.8% of patients are readmitted within 30 days. There are approximately 96,000 OPD visits for heart failure per annum. Currently waiting time for OPD referrals is on average 6 to 9 months, a 2012 national GP survey by the Heart Failure Clinical Programme and the ICGP showed that 89% of GPs found these waiting times a significant barrier to managing heart failure in Primary Care. • The Virtual Heart Failure Clinic provides rapid access to specialist opinion to support General Practitioners continue to manage heart failure patients in the community and to minimise OPD and referrals to ED/AMAU for admission. In addition it increases the confidence of GPs in their management of this complex condition.
Strategic Alignment **ICP CD**	• A Strategic Framework for Reform of the Health Service 2012 – 2015. • Sláintecare- primary care expansion and transition from acute to primary care setting. • CHO Report- to deliver better, more integrated and responsive services to people in the most appropriate setting by developing primary care services, while at the same time developing and implementing standardised pathways and models of care. • Corporate Plan- strengthening primary care services, improving access to hospital, outpatient and community services and reducing wait times.

	• Capacity Review 2018- increase in primary care capacity. • Integrated Care Programme for the Prevention and Management of Chronic Disease.
Impact on Health System – Evidence Based	• The research carried out by the National Clinical Programme on the pilot project in Wicklow/Wexford and in the demonstrator project in Carlow/Kilkenny has shown that for patients that the GP was intending to refer to OPD, presentation at the virtual clinic averted 87% of these referrals. For patients whom the GP was intending sending for admission to ED/AMAU, presentation at the Virtual Heart Failure Clinic averted 95% of admissions**.** • Survey of GPs using the service found that 94% of GPs said the Virtual Clinic improved their ability to care for patients in the community, 76% said that the clinic improved their confidence in accurately diagnosing heart failure.
Patient Impact – Evidence Based	• 95% of patients whom the GP would have referred for admission are spared this experience, as are 87% of patients who would have been referred to OPD. It has been calculated that approximately 60 kms average travel has been spared for each of these patients, allowing services to be provided closer to home.
Feasibility of Implementation – Evidence Based	• Stable heart failure can be managed in General Practice if adequate and ready access to specialist opinion and support is available to GPs. • The original pilot study and the "demonstration for scale up" project in Carlow/Kilkenny has shown that this project can be successfully implemented. • The Demonstration project has allowed the accurate estimation of the ancillary costs in community CNS requirements and hospital resource requirements to provide this service. • It is estimated that 17,500 number of consultations would be needed per annum. This would be ramped up by 4,375 per year over 4 years, with 4 clinics in place at the end of 2020, 1 existing and 3 new.
Interface & integration with other initiatives / other models of care Evidence Based	• Alignment with best practice in the HSE. • Community Healthcare Organisation Report- alignment of service provision for integrated care at Community Healthcare Network and Primary Care Team level. • Alignment with eHealth Strategy to support and enable GPs active participation in the eHealth space. • Alignment with HSE OPD Strategy. • Alignment with new Chronic Disease GP Contract. • Aligned with ICP CD model of Care.
Area(s) that proposal will impact on	• Changes to Service Delivery will occur by diverting patients from acute to primary care setting. • Changes to Work Practices will free up nursing hours and space in the hospital setting. • The vast majority of patients referred to ED or AMAUs with heart failure are currently admitted. • Currently GPs cannot access rapid specialist opinion on stable or deteriorating heart failure patients. This necessitates them referring unstable patients to the ED/AMAU where they are inevitably admitted and more stable patients requiring specialist opinion to OPD. The Virtual Heart Failure Clinic provides rapid specialist opinion so that GPs can manage stable heart failure patients in Primary Care.

2. Service Modernisation and Reform Measures

(See Appendix E, Figure 1)

2.1 Service Models: Overall Commitment to Change

The parties acknowledge the significant level of reform and modernisation that has taken place in General Practice since the Blueprint for General Practice was published in 1993 and the publication of the Primary Care Strategy in 2001. This includes the very high levels of computerisation in General Practice, introduction of free GP care at the point of service for, inter alia, under 6's and over 70's, introduction of versions of chronic disease management such as Diabetes Cycle of Care and Asthma Cycle of Care, provision of structured out of hours GP services, introduction of flexible shared contracts and open entry to GMS and extension of retirement age for GPs under the GMS scheme from 65 to 72 years. The parties also agree that further measures are required to underpin the delivery of a more integrated, efficient and effective General Practice service within a strengthened primary care setting. A fundamental review of the GMS and other publicly funded health sector GP contracts will take place early in the lifetime of this agreement.

Under this Agreement further Sustainable Reform and Modernisation Measures will be implemented on a phased basis over a 4 year period, commencing in 2019 as outlined in this document.

2.1.1 Implementing Community Healthcare Networks (CHNs) and associated operating model for Community Services (CHO)

An integrated care system is one which puts the patient at the centre of system design and delivery and is well organised and coordinated to manage costs. Community Healthcare Networks (CHNs) have been identified as the core unit of healthcare service provision and co-ordination within the community in order to ensure greater alignment of service provision for integrated care across care domains.

Each CHO is divided into Community Healthcare Networks (96 nationally) which are comprised of circa 50,000 population. CNH managers (Network Managers) will manage the delivery of primary care services and coordinate the integration of services within/outside CHNs and the acute hospital system.

Implementation of the networks will commence in 2019 with the establishment of nine learning sites involving the management of primary care staff by the network manager, working collaboratively with community nursing and GPs. In CHNs, the move to collaborative, multidisciplinary working that encourages primary and secondary care to be aligned in one system closer to the community, will facilitate a more streamlined coordinated transfer of care and improved service user experience.

Multidisciplinary teams convey many benefits to both the patients and the health professionals working on the team. These include improved health outcomes and enhanced satisfaction for clients, and the more efficient use of resources and enhanced job satisfaction for team members.

In the above context each GP Practice will cooperate with and support the implementation of Community Healthcare Networks (CHNs) and the associated operating model for community services (CHOs) in line with the terms of this agreement and the obligations outlined in the table below. At CHN level the GP lead will be part of a local management structure and team. This team will have responsibility and accountability for the management and delivery of primary care services within the network and the integration of other services required to support the CHN population. Heads of Discipline will continue to provide clinical governance The CHN will be led by a Network Manager working closely with the GP lead and the Asst. Dir. of Nursing.

There will be nine CHN GP Leads in the learning sites in the first instance and thereafter, following successful deployment of the model, in each of the 96 CHN's throughout the country, forming the core of health and social care community service provision across the country.

At CHO level a GP lead will be a member of the Community Services management team including any successor arrangements which arise in the context of the regional alignment of CHO's and hospital groups.

Therefore, this agreement will see enhanced and new roles and functions for:

- GPs within Networks.
- Lead GPs at CHN management level.
- Lead GP at the senior decision making level for community services in the current CHO structure, including any successor arrangements which arise in the context of the regional alignment of CHO's and hospital groups.

To support learning site process in the immediate term and support development of multidisciplinary team, five posts will be assigned to the network learning sites, the profile of these posts will be decided by the network leadership (including the lead GP) to ensure that the CHN is responsive to the needs of patients and service users.

Learning Site Selection

After undertaking a validation exercise with the Chief Officers alongside their Heads of Primary Care and local CHO PMO, a preferred selection has been made for the nine Learning Site locations, one per CHO. The criteria/characteristics used to validate the optimal Learning Site locations include the following:

- Demographic factors (e.g. population, rural/urban, cross-border, % over 65 years, % disability cases, socio-economic factors).
- Alignment to Acute Services.
- Primary Care Factors (e.g. Level of colocation with Primary Care Teams, management capability, GP engagement, professional & nursing engagement, resource levels).
- Home support factors (e.g. home support resource levels, home support teams, service provision).
- Mental health factors (e.g. alignment to mental health boundaries, acute impatient, service-user access to mental health services).
- Other factors including overlap with any other demonstration projects/pilot sites.

The Learning Sites will represent a diverse array of demographics, rural/urban environment and services delivered.

Technology

In preparation for a national roll-out of a primary care ICT management system, the HSE will implement a technology pilot in two of the nine Learning Sites. Implementing a technology solution with a limited number of clinicians and patients will help to:

- Gather and refine detailed requirements for a primary care management system
- Identify and streamline business processes to be supported by technology
- De-risk a national roll-out by identifying potential implementation/transition risks for mitigation

As with any pilot, the scope must be limited enough to be feasible while broad enough to provide meaningful insight. The scope of the technology pilot is outlined below:

- Patients: Between five to ten identified complex cases or frequent users of primary care services.
- Staff: Primary Care professionals (including GPs) providing services to the identified patient group, primary care administrative staff in the selected Learning Site(s), the Network Manager in the selected Learning Site(s).
- Processes: Staff to staff communication, shared case notes, appointment scheduling, referrals, care planning/assessment.

To support implementation of the technology pilot, a number of GPs are identified in the network and by agreement will participate to contribute a GP perspective and advice on how the IT solution should be configured to best meet the needs of a multidisciplinary team, including GPs who undertake participation will be supported.

The identified GPs would also be asked to:

- Provide input and advice on patients being selected for the pilot as required.
- Attend one workshop to identify business processes to support care of selected patients.
- Attend a training module in using tool for identified processes to identify the effectiveness of the tool or how it might be adjusted to make it more effective.
- Participate in one de-brief session to evaluate pilot.

In the event of this project progressing to implementation there will be further discussion with the IMO.

Learning Site Evaluation

CHNs are critical to the delivery of coordinated and integrated care in the community and evaluation of the implementation of the new operating model in learning sites is essential to ensure that the model can be improved based on the learning from this initial implementation. Qualitative measures (such as staff interviews, observation, and service users feedback) and quantitative measures (such as existing metrics, delivery against objectives) approaches will be used to extract learning from the learning sites. Monitoring of activity in learning sites will be conducted throughout the implementation phase. Outlined below is an indicative list of the type of activity envisaged in this process, the detailed arrangements will be agreed with the IMO following appointment of an evaluation team and will focus on the following:

- To have devolved operational authority for CHNs vested in the Network Managers, improved multidisciplinary case working approach and complex case management across networks.
- Ensure ease of navigation for service users and fair and equitable access to Primary Care Services.
- Improved Interface between Primary Care Network Staff and Other Care Groups.
- Structured GP engagement and collaboration within CHNs.
- To enable local communities to become actively involved in co-planning services and promoting positive health and wellbeing.
- To identify enabling requirements across ICT, Estates, Finance etc. to support the full roll out of CHNs.
- Enhanced clinical supervision by Heads of Discipline.

It is also agreed that a structured process of engagement between the HSE and the IMO will take place periodically throughout the learning site process to enable feedback and as a confidence building measure during the learning site implementation phase.

Guidance – GP Involvement in Community Healthcare services

- Set out in **Appendix B** attached, are guidance documents which outline the broad approach envisaged in respect of:
    - Multidisciplinary working including the holding of clinical meetings.
    - Service planning & management.
- It is envisaged that this guidance will support GPs and other professionals in implementing the network model.

Support and "Go Live Process"

It is recognised that the role out of the learning sites will require a period of mobilisation and induction of all team members which will be supported by the HSE, a number of the key components of this process are outlined below:

- Appointment Network Manager & GP lead.
- Induction.
- National workshop targeted at GP Leads and Network Managers and other key stakeholders
- Local team building – roles responsibilities etc.
- Structured support process by HSE.
- National document agreed with IMO will provide context and background for GPs and teams in the development of the process.
- Detailed arrangements to apply will be agreed in that process.

It is intended that the new structure and additional local level decision making and cooperation will enhance the service experience for both GPs and patients. The participation and cooperation of GPs under this agreement is as listed below. Any additional workload other than that which is outlined

below or within the confines of the GMS or other publicly funded contracts is not encompassed by this agreement.

GP Cooperation & Participation Required – Community Healthcare Network

- **GP Community Healthcare Network Lead will provide leadership in the following areas to:**
  - Clinical Leadership.
  - Planning, performance & quality assurance.
  - Service delivery and improvement.
  - Communications.
  - Job Description Attached.

- **GPs in Community Healthcare Networks will actively support the implementation of the CHNs and the GP Lead Role including:**
  - **Participation in Planning of services**
    The GP Lead will participate in the planning and prioritising of CHN services in line with the population needs. The establishment of CHNs will facilitate and support the local identification of needs, and service planning and decision making.
    In order to facilitate local planning, area needs and decision making a bi -annual planning workshop led by the GP lead and attended by the local management team will be held. A GP from each practice in the CHN should attend this meeting at a minimum, building relationships with the HSE professionals on the Network Management Team. Such meetings shall be scheduled by the GP Lead being cognisant of the working commitments of local GPs.

    Participation in Planning of Services - 2 workshops per year for 2 hours per workshop

  - **Multidisciplinary Working & Care Planning**

    The Network Manager will lead multi-disciplinary team management and ways of working. The Network Manager, in conjunction with the GP Lead will support this care planning process as required including providing advice and guidance, re: prioritising resource to meet the determined needs, analysing trends in such cases and responding directly or seeking support of other services to do so.

    GP Involvement will involve:

    1. Referring any patients designated as a complex case and requiring discussion at a clinical team meeting (see Criteria for Referral to Clinical Meeting) to the appropriate Clinical Coordinator.
    2. Attending clinical team meetings and discussing their relevant cases, approximately one hour a month per GP or GP Practice. In exceptional cases where the GP is unable to attend for any reason the GP should discuss with the case manager.
    3. Giving clinical input where required.
    4. Ensuring that their own clinical notes are updated in accordance with the care plan.
    5. Where the GP sees it as necessary given his/her relationship/knowledge of the patient the GP may agree to act as a Key Worker.
    6. Ensuring that the Clinical Coordinator is aware of any relevant updates in the patient's case note discussed at a clinical team meeting.

    Multidisciplinary Working & Care Planning - Attendance at equivalent of 1 clinical meeting per month for 1 hour (per GP or per GP practice)

  Protocol for GPs practicing across different CHNs
  While GPs may attend any of the bi-annual CHN planning workshops relevant to their patient's geographic location, they should attend two planning workshops per annum of the CHN in which their main practice premises is located.

  - Recognising the professional duty of GPs to care for all their patients regardless of CHN location, GPs will attend 12 clinical meeting of 1 hour duration per annum.
  - Where a GP Practice has patients in multiple CHN areas, the relevant CHN clinical co-ordinators will liaise with each other to run meetings at an agreed time within the scope of the 12 meetings.
  - Where there are competing meetings which cannot be coordinated the GP shall not be

obliged to attend more than their obligation but will continue to liaise with clinical co-ordinator as per current professional practice.

- **Referrals and prioritisation**
  GPs will participate in the use of standardised integrated care referral pathways across CHNs and/or with acute hospital services particularly those focused on clients with complex needs and/or chronic disease. This will be underpinned by the development of waiting list management processes.

- **Population Risk Stratification**
  HSE Public Health & Clinical Programmes will provide guidance and support in relation to appropriate methodology of population risk stratification. GPs will be required to support the identification of clients either from a medical condition perspective or from indicators of levels of dependency e.g. frailty. This will be achieved in a number of ways:

  - Opportunistically as clients access services of GPs and have agreed medical conditions or other characteristics.
  - Clients who emerge through the multidisciplinary team meetings and where it is deemed appropriate.

Anticipated out comes of GP involvement in CHN

- Coordinated multidisciplinary care approach to care provision.
- Improved service user and Contractor experiences.
- Improved integration of community healthcare services and integration between community Healthcare and acute hospital services.
- GP involvement in the management process within the CHO Operating Model.

GP Cooperation & Participation Required

Community Healthcare Networks:

- **GP Lead Role:**
  - Clinical Leadership.
  - Planning, performance & quality assurance.
  - Service delivery and improvement.
  - Communications.

- **Network GPs:**
  - Participation in Planning of Services - 2 workshops per year for 2 hours per workshop.
  - Multidisciplinary Working & Care Planning - Attendance at equivalent of 1 clinical meeting per month for 1 hour (per GP or per GP practice).
  - Referrals and prioritisation / linked to ICT e-referrals.
  - Population Risk Stratification - in line with the nationally accepted population health “pyramid” used in identifying high risk approx. 4 % high risk and 1% very high risk which includes client groups such as chronic disease and also frail elderly**.**

2.1.2 Support for and cooperation with hospital waiting-list validation exercises and the National Centralised Validation Unit

A National Centralised Validation Unit has been established in the National Treatment Purchase Fund (NTPF) to deliver a standardised approach to waiting list validation for out-patient, in-patient and day case elective procedures across all hospitals in line with best patient-centred practices.

This new function will support:

- The identification of patients on waiting lists who are ready and available to proceed with hospital care.
- The reduction in the Did Not Attend rate (DNA).
- An improvement in information for managing waiting lists.

As gatekeepers to Health Services and the primary referral agents for access to secondary care and specialist service, GPs will be required to participate in the waiting list validation process.

Expected Outcomes:

- More accurate and current waiting lists.
- Reduced waiting times.
- Improved access.
- Better patient outcomes.

GP Cooperation & Participation Required

- Following up in a timely fashion with the HSE/ National Centralised Validation Unit on those patients who have either been removed from a waiting list because of non-response to the validation letter or who have requested removal themselves as set out below:
    - When a patient receives a validation correspondence (while not advised to) some patients may contact their GP for advice. On completion of a hospital validation cycle; there are a number of potential patient outcomes:
        1. Patient responds and requests to remain on the waiting list – no action required by the GP.
        2. Patient responds and indicates that they no longer require hospital care – these patients are reviewed by the hospital and where appropriate removed in line with the National Inpatient, Day Case, Planned Procedure Protocol (the "IDPP Protocol 2017"). The patient and the source of referral must be notified of this in writing by the hospital.
        3. Patient fails to respond to the validation correspondence - these patients are reviewed by the hospital and where appropriate removed in line with the National Inpatient, Day Case, Planned Procedure Protocol (the "IDPP Protocol 2017").

The patient and the source of referral must be notified of this in writing by the hospital.

- In relation to outcomes 2 and 3 where a GP is notified by letter that the patient has been removed from the waiting list there is an option for reinstatement (at the original date) should the GP deem this appropriate.
- In order to establish whether or not reinstatement is required it may be necessary for the GP to communicate with both the patient and the hospital in a timely manner.

2.1.3 Making Every Contact Count (MECC)

Healthy Ireland, a Framework for Improved Health and Wellbeing 2013-2025, provides a framework of action to achieve a greater emphasis on prevention, early intervention and to support keeping individuals and communities well. The Service Modernisation and Reform process provides an opportunity to accelerate the process of re-orientating the focus of General Practice toward prevention and health promotion in addition to diagnosis and treatment. It is well known that the majority of chronic conditions are related to a small number of lifestyle issues, which if modified could avoid these conditions. General Practice is centrally positioned to lead this approach.

In the above context GP GMS Contractors will introduce brief intervention in defined areas, i.e. practicing Making Every Contact Count with their GMS/GPVC patients. This will provide opportunities for GPs to reinforce healthy lifestyle messages particularly but not exclusively when seeing patients with chronic diseases and supporting and encouraging patients to play an active part in their self-care.

Expected Outcomes:

- Better management of Chronic Illnesses.
- Greater patient awareness of importance of lifestyle factors.
- Enhanced compliance with treatment programmes.

GP Cooperation & Participation Required

- Ensure that MECC is applied to all patients who come to the GP surgery, as appropriate.

2.1.4 Children First National Guidance for the Protection and Welfare of Children

Children First is Ireland's National Guidance for the protection and welfare of Children. The aim of Children First is to promote the safety and well-being of children. Professionals have an important part to play in promoting the safety and well-being of children. In the above context, both parties are committed to ensuring that the Services adhere to the principles and objectives of Child Care Legislation and of the Children First National Guidance and that at all times the safety and welfare of children is paramount.

GPs will fully comply with the roll out of Children First National Guidance for the protection and welfare of Children including ensuring that they and their practice staff undertake relevant training courses (available on-line).

Expected Outcomes:

- Increased awareness of safety and well-being of children across all practice staff.
- Compliance with Child Care legislation and Children First National Guidance.

GP Cooperation & Participation Required

- Ensure that all practice staff undertake and complete the relevant training as set out and any updated modules as they become available. The free online Children First training support is e-learning module is available on http://childrenfirst.hseland.ie/

2.2 eHealth & Data Management

eHealth - Bringing improved population wellbeing, health service efficiencies and economic opportunity through the use of technology-enabled solutions

eHealth (Electronic Health) involves the integration of all information and knowledge sources involved in the delivery of healthcare via information technology-based systems. This includes patients and their records, caregivers and their systems, monitoring devices and sensors, management and administrative functions.

It is acknowledged that General Practice has made significant strides over recent decades in the area of computerisation. According to GPIT some 95% of GP practices have invested in and are utilising a GP Practice Management System *(http://www.ehealthireland.ie/Case%20Studies/GP-Systems/).* This investment by GPs has significantly modernised the day to day operation of their practices and has made General Practice one of the more eHealth advanced parts of the Irish Health Care System. Not only has this investment modernised the operation of General Practice itself, but it has also facilitated the deployment of electronic communication between General Practice and secondary care through, for example, the receipt of diagnostic test results and the introduction of electronic referrals.

Under this reform and modernisation process, the State will work with GPs to build on the advanced position that GPs have achieved through the implementation of the following eHealth measures during the term of this Agreement (2019 – 2023).

It is recognised that this is an ambitious programme of modernisation that will take a number of years to fully implement. Over the course of the next four years, GPs will, in line with this agreement, commit to active cooperation in the roll out of these eHealth initiatives and ensure that there is effective inter-operability between the GP Practice Management Systems and the HSE IT Systems. It will be necessary for GPs and the HSE to work collaboratively on this work programme and GPs have agreed to use a certified Practice Management System that meets GPIT Accreditation requirements.

The benefits of this agreement include a more integrated service delivery through the deployment of improved client identity *(IHI),* electronic communication within community services *(PCMS/EHR)* and also between primary care and secondary care. Safer clinical practice through ePrescribing and improved client identity *(IHI)* mentioned above. In addition, greater involvement of patients in their treatment plans through the Summary Care Record and the Shared Care Record.

2.2.1 IHI

The Health Identifiers Act 2014 required all healthcare providers to store the individual health identifier (IHI) for all their patients against each patient's record.

The purpose of the IHI is to provide patient safety by identifying patients correctly and identifying their associated health records. In addition, it enables the delivery of eHealth as it provides the ability to identify multiple health records that may be associated with a patient.

The ability to include the IHI in the GMS file which the PCRS send to GP practices every month is already established and the GP practice systems can 'import' the IHI when they process that file. No action is required by the GP practice.

For private patients the data required is quite limited and represents what is required to select the correct IHI off the national IHI database. The data items required to provide an IHI match are: First name, Surname, Gender, Date of Birth, Address, and PPSN. There is an algorithm used to score the data in order to get a match with the IHI. Not all data items are required to get an IHI, however the better the data, the higher chance of getting an IHI number.

No consent is required in respect of this matter as it is covered in primary legislation.

The data supplied is matched with the IHI register and returned to the GP, it is only held by the IHI team for a short period to allow the GP to process the IHI data supplied by the GP before it is destroyed.

The IHI number does not change. Details on the IHI record can change e.g. change of address etc., there is no ask of the GPs in this respect and the system updates as transactions happen in the background.

IHI numbers for GMS/GPVC patients will be provided as part of the PCRS file made available to each GP, every month. An interactive interface will pull data from the IHI register for GMS/GPVC patients not listed and for all other patients.

The IHI register is responsible for the master register and has an office to support the matching of data. The IHI is not responsible for individual client reconciliations at a GP surgery.

The IHI is a key enabler of future patient safety and eHealth measures.

The area of impact will be on practice staff who are registering new patients as there will be some additional information that they will have to request for the purpose of finding an IHI for the patient.

All of the accredited general practice systems have already been configured to store and display the IHI and an interface is in development which will automatically notify the IHI if a client's name or address has changed. This will be seamless to the GP.

The roll-out of the IHI to a GP will require a once-off seeding for existing patients whereby the GP will provide the IHI Business Service with the demographic details for all of their patients. The GP's client index will be run against the IHI database and find matches. It will be necessary for the system to be run in respect of all GMS/GPVC and non-GMS clients. An IHI number will be returned for all records for which a match can be found and this will then update the GP system with that IHI number. Once completed, an interface will automatically re-verify the IHI if a change has been made to the demographic details or find an IHI for a newly added patient.

The IHI is not the same as the Personal Public Service Number (PPSN). The IHI is a unique number for the healthcare system only. A PPSN cannot be used instead. The Health Identifiers Act allows for a PPSN to be part of the information collected and stored within the IHI record, but the PPSN number itself cannot be used as an individual health identifier. http://www.ehealthireland.ie/Strategic-Programmes/IHI/IHI-FAQs/. The planned IHI sign-up rates are outlined below:

GP Cooperation & Participation Required

- Comply with the national IHI programme and incorporate IHI numbers for all patients on practice systems on a phased basis over the next 4 years.

IHI Patient Sign-Up Rates (Phased Timeline):

- **2019** – 30%
- **2020** – 50%
- **2021** – 75%
- **2022** – 85/90%

The full implementation of the IHI is the key building block and enabler supporting the maximum utilisation and further roll out of the wider eHealth agenda.

2.2.2 eReferrals

GPs will utilise electronic referrals as more specialties are offered and the service is expanded into the community.

The current usage of the eReferral system is 31%, but once the IHI is implemented it is envisaged that the number of electronic referrals will increase significantly on a phased basis outlined below.

By 2021, it is forecast that the Integrated Referral Pathway System (IRPS) will be ready to roll out and further discussion will take place between the parties with regard to the IRPS system at that point. In the interim period GPs will utilise the eReferral system where available and a migration will take place from eReferrals which will provide an enhanced level of referral support and information for GPs.

GP Cooperation & Participation Required

- GPs to utilise eReferral system and agree to uptake usage over a phased basis.

eReferrals usage (Phased Timeline):

- **2019** – 40%
- **2020** – 50%
- **2021** – 75%
- **2022** – 85/90%

2.2.3 ePrescribing

The eHealth Strategy for Ireland, the Knowledge and Information (K&I) plan from eHealth Ireland and Sláintecare, all refer to the implementation of ePrescribing as one of the fundamental components of an eHealth programme and typically one of the first items tackled. The solution will facilitate the elimination of the need for GPs to stock and use (3 part) PCRS prescriptions and associated dot matrix printers. GPs will still have the ability to prescribe as before i.e. this does not imply any commitment by GPs in relation to medications management. This will be used for public and private patients. It should be quicker for a GP to prescribe using ePrescribing than using the current solution. To enable ePrescribing there is a requirement to clean up the existing drug file that GPs use today and that still uses items no longer available over the counter. There are several ways this can be addressed to minimise the impact to a busy practice. This is an essential enabler for ePrescribing and can be discussed further.

The drug file will be provided by the GP Practice System vendor. It will be provided for all accredited practice systems. It will contain all items that can be dispensed by the community pharmacist (reference is made to the work of the National Medicinal Product Catalogue and this file for the vendors may be a subset of this.)

In order to clean up the drug file a third party will be engaged by the HSE to map all items on repeat scripts that can be dispensed by the community pharmacist. This does not mean that a third party would see patient specific data – they would only see the full list of products being prescribed (not who they are for) for the purposes of mapping them to the latest equivalent product.

The development of the IT solution for ePrescribing will roughly take 18 to 24 months, but once integrated there will be a phased approach to adoption with ePrescribing to commence in 2021 with continued uptake from GPs through 2023.

GP Cooperation & Participation Required

- GP cooperation and participation in the design and development of the IT solution for ePrescribing over 18 to 24 months.
- Once fully integrated, there will be a phased approach to uptake by GPs, with ePrescribing to commence in 2021 with continued uptake from GPs through to 2023 in line with the phasing outlined below.

ePrescribing adoption (Phased Timeline):

- **2021** – 30%
- **2022** – 50%
- **2023** – 85/90%

2.2.4 NIMIS

GPs already receive reports from diagnostic imaging services such as NIMIS via Healthlink. In response to requests from GPs, the HSE will build, pay for, and offer GPs the option to order diagnostic imaging tests on line. This will provide closed loop management of tests and will streamline the ordering process for GPs. It will also enable the migration from paper to electronic orders.

Once fully available, it is proposed that an 85/90% GP uptake on usage of NIMIS will take place.

GP Cooperation & Participation Required

- GPs to fully uptake the usage of NIMIS once fully rolled out nationwide.

NIMIS usage (Phased Timeline):

- **2019** – 40%
- **2020** – 50%
- **2021** – 75%
- **2022** – 85/90%

2.2.5 Summary and Shared Care Records

eHealth Ireland will develop a Summary Care Record and a Shared Care Record solution for patients. Summary Care Records are normally generated based on data held in GP practice systems. The most common use case, for a Summary Care Record is to give GPs access to at least a basic dataset on a patient when they present at an out of hours GP service, but they can be useful to other healthcare professionals e.g. ED, community pharmacy, AHPs. Whilst Shared Care Records use a similar set of data from GP Practice Systems, they also incorporate data from hospitals to provide a more complete view of the patient, which makes it a significant asset to facilitate integrated care. Whilst the Summary Care Record is a 'snapshot in time' the Shared Care Record is longitudinal, i.e. it collects data over time.

Development of the Summary Care and Shared Care Record will start in parallel as the lead time required to develop the more complex shared care record is longer than that required to develop the Summary Care Record. It will not be possible to populate the Shared Care Record until the Summary Care Record data set has been provided.

Purpose of the Shared Care and Summary Care Records

The Summary and Shared Care Record is for information sharing. It does not alter existing clinical protocols or arrangements in relation to the discharge of care or transfer of care for patients.

Difference between the Summary Care and Shared Care Record

In addition to the Summary Care Record data which is provided by the GP, the Shared Care Record will also include data provided by other parts of the health system including scheduled care, unscheduled care (Emergency Departments/ Out of Hours), Community Care and diagnostics, etc. The Summary Care record and Shared Care record require the same data from GP systems with the only exception being the facility to record encounters with the GP. Encounters with other parts of the health services are also captured in the Shared Care Record. Using this, the GP will be able to see whether a patient has had attendances at ED, outpatient department or other parts of the health service.

Data Flow

Data from the GP system will auto-populate the Summary Care and Shared Care Records with data from the agreed dataset, utilising background processes, on a daily or twice daily basis.

Data Elements in the Summary Care and Shared Care records

The information requirements for the summary care record are as follows:

- Subject of care.
- Health condition.
- Medication prescribed.
- Allergies.
- Procedures.
- Vaccinations.

Detailed information requirements are listed in **Appendix D.**

Data Management

Data required from the GP for the Summary Care and Shared Care Records will be a by-product of data being collected by the GP during normal patient encounters and will be auto-populated from the GP Practice Systems.

Patient identifiable data provided for the Summary Care and Shared Care Records will be used for direct provision of care to the patient.

Pseudo-anonymised patient data in the Summary Care and Shared Care Records will be used for the purposes of the management of health and social care systems and services, for reasons of public interest in the area of public health, and ensuring high standards of quality and safety of healthcare e.g. to verify the effectiveness of a clinical programme or to manage patient risk stratification where the name of the patient is not required but the need to 'link the same patient' over a period of time is necessary. Data for these purposes will be circulated in aggregate form only to ensure that details relating to an identifiable person or undertaking are not divulged.

Anonymised patient data provided for the Summary Care and Shared Care Records will be used for the management of the health service, health research and statistical purposes. Data for these purposes will be circulated in aggregate form only to ensure that details relating to an identifiable person or undertaking are not divulged. This data will be pseudo-anonymised at a Community Healthcare Network level or equivalent population size. Identification of the GP will also be anonymised in the process.

Patient Consent - Considerations in relation to the Summary and Shared Care Records

Three models are under consideration for the implementation of the Summary and Shared Care Records. Further engagement with the DPC and work on regulations and/or legislation will inform the model to be applied:

1. Informed Consent

   This must be provided by the patient to facilitate the creation and access to the Summary and Shared Care Records. The HSE will gather this data in the first instance however GPs will also have the facility to do this using their own practice systems. The HSE will provide materials and streamline the process.

2. Primary Legislation

   With this in place no additional patient consent would be required although we are likely to still invite patients to provide 'permission to view' at point of care.

3. Hybrid model

   Utilising GDPR, the data required to create the Summary Care and Share Care Records is safely and legally provided. Permission is requested from the patient at point of care to view the record.

   Typical patient permission (tick boxes) options are:

   a. Permission to view the record this time only.
   b. Permission to view the record for this episode of care.
   c. Permission to view for 12 months.
   d. 'Break the glass' option (patient unconscious and cannot provide consent). Drop down provide to select reason for 'breaking the glass'.

Note:

- A flag will be set on the GP system against each patient indicating consent status.
- Material will be provided by the HSE to simplify the consent process.
- Option 3 is the preferred model.
- If model 1 is required, then the HSE will engage with the IMO to agree details on how this model will be deployed. If implied consent is required it is intended there will be a single consent to cover the Summary and Shared Care Records.

GP Cooperation & Participation Required

- Summary and Shared Care Records will be populated for GMS/GPVC and private patients.
- The IMO agree to support the development and deployment of the Summary and Shared care records within the lifetime of the Agreement.
- GPs will maintain the patient data required to populate the Summary and Shared Care Records on their accredited GP Practice System.
- The data set required for the Summary Care Record is defined in Appendix D.
- If informed consent is required, the HSE will engage with the IMO on the details of how this will be implemented in practice.
- The HSE will promote the adoption of Summary and Shared Care Records.

Whilst the GP will have the facility to sign up patients for the Summary and Shared Care Records on their Practice System, the HSE will not be solely reliant on the GPs to sign up patients.

2.2.6 Integrated Immunisation Systems

As immunisations are administered by multiple clinicians (GPs, School Immunisations Nurses, Pharmacists), in multiple settings, there will be a requirement to link together the data from all these systems (specifically data related to immunisations administered). This creates the opportunity to streamline the current (mostly paper based) processes for GPs' data.

GP Cooperation & Participation Required

- GPs will cooperate with the development and deployment of an integrated solution for immunisations (to include a reimbursement module) to go live in 2021, in line with the phasing outlined below:

Integrated Immunisation Systems (Phased Timeline)

- 2021 – 30%
- 2022 – 60%
- 2023 – 90%

2.2.7 Healthlink

As the most secure method to transmit structured messages which automatically upload to the GP system. The National Healthlink Project provides a web-based messaging service which allows the secure transmission of clinical patient information between Hospitals, Health Care Agencies and General Practitioners and support and enables the use of **MedLIS** and **NIMIS.**

Patient information is generated on the source hospital system and transferred to and from servers using secure network connections. Users login to the Healthlink website with a unique username, password and PIN plus a digital client certificate to verify your identity. The application is also accessible via web service calls, meaning the accredited Practice Management Systems can integrate patient information automatically without opening the website. Web service calls are also used to generate referral messages from within the Practice Management System which are then sent on to the hospital via Healthlink. http://www.healthlink.ie/index.htm

GP Cooperation & Participation Required

- Continued adoption of Healthlink by GPs as the primary mechanism to facilitate other eHealth related services e.g. IHI, eReferrals, ePrescribing, NIMIS ordering and other relevant data returns, etc.

2.2.8 Healthmail

GPs will use Healthmail, which is the most secure method to transmit unstructured messages between health providers that do not have an enterprise email address that is securely connected. Healthmail reduces GP reliance on faxes and increases compliance with GDPR. https://www.healthmail.ie/index.cfm There is a recognised dependency on cooperation from hospital departments to make adoption of Healthmail more valuable to a GP practice. To make Healthmail easier to use, the Health Service is prepared to fund the cost of integrating Healthmail into accredited GP practice systems. (Healthmail integration has already been done for HEALTH one).

GP Cooperation & Participation Required

- Continued adoption of Healthmail as the primary mechanism for secure communication of unstructured health related messages.
- Adoption of Healthmail as a mechanism to reduce our reliance on unsecure and non GDPR compliant solutions such as fax machines.
- Protocol agreed and adopted in relation to the use of Healthmail between GPs and the wider health care service Q4 2019.

2.2.9 Use of PCRS Application Suite

Those GPs who are using the PCRS GP Application Suite to submit reimbursement claims will continue to do so. New GPs entering the GMS will submit reimbursement claims electronically. This will remove the need for paper and digitise at source. GPs will operate the online choice of doctor functionality to facilitate electronic registration of all approved medical card, GP visit card and Under-6 applications.

GP Cooperation & Participation Required

- GPs to continue to submit reimbursement claims electronically.
- GPs will operate the online choice of doctor functionality to facilitate electronic registration of all approved medical card, GP visit card and Under-6 applications.

2.2.10 MedLIS:

GPs already receive lab results electronically via Healthlink. The operational roll out of MedLIS will commence on in the following sites;

- Beaumont in Q2 2020
- Cavan in Q3 2020
- The Mater and St James hospitals in 2021

GPs will be required to use the MedLIS functionality (Powerchart) to order online for the sites listed above. Once an order is placed a message will be sent to their system confirming the order and they will continue to receive results via Healthlink.

As MedLIS functionality is rolled out in these initial locations, the HSE will engage with GPs in the further design and improvement of the solution for online ordering so as to minimise, to largest extent possible, the operational impact for GPs' surgeries.

During this initial phase, a review will be undertaken of the effectiveness of the solution for GP ordering to inform any improvement in the design solution and GPs will agree to work with the HSE in this review process.

Until the review is completed and further discussions are held with the IMO, no further roll out of GP ordering will proceed beyond the sites listed above.

GP Cooperation & Participation Required

- GPs located in the areas of hospital roll out mentioned above to use MedLIS functionality (Powerchart) to order online for the sites listed above as it is rolled out.
- A review will be undertaken as referenced above and until the review is completed and further discussions are held with the IMO, no further roll out of GP ordering will proceed beyond the sites listed above.

2.3 Medicines Optimisation

All sets of Guidance issued from time to time within the overall Medicines Optimisation Programme are designed to aid clinical decision making and are not intended to outweigh clinical judgement exercised in the interests of the patient. Clinicians retain discretion to prescribe the product which the clinician considers best meets the needs and interests of the patient.

The HSE/DOH overall approach to Medicines Optimisation has three main strands:

1. The first involves a pharmacist supported medicines usage review process in primary care.
2. The second strand involves the application of prior authorisation/pre-approval requirements for new medicinal products.
3. The third strand involves a number of systemic interventions on existing medicinal products which can be applied at both primary and secondary care level.

2.3.1 Medicines Usage Review

A pharmacy supported medicines usage review process to support GPs in safe prescribing and reduce where appropriate high risk prescribing, arising due to the age of the patient, and potential co-morbidities and co-prescription. This will be introduced and targeted at those GMS/GPVC patients over 75 years resident in the community. This programme will commence in 2019 and operate as follows:

- HSE employed pharmacists (initially starting with 15 – 20 HSE contracted pharmacists operating within PCRS and engaging with GPs as appropriate) will analyse prescribing practice data within the PCRS reimbursement systems for patients over 75 years and resident in the community and identify patients whose medication should be reviewed and may make recommendations on optimising therapies and/or dosing to the GP. The HSE will work with the IMO/profession to optimise the use of information technology as the medium for transmission of reviews. In the longer term this may include the use of secure messaging with the GP ICT systems.
- The pharmacist will agree a schedule for reviewing patients' prescriptions with the GP having regard to the GP's work schedule/panel size. However, as a principle, reviews will be handled and communicated to GPs on the basis of criticality as informed by the data and the algorithm used in the primary interest of patient safety.
- GP reviews the pharmacists' recommendations and discusses them with the pharmacist if necessary, thereafter the GP can either:

    (i) Following a discussion with the patient, make the recommended changes to the prescription.
    (ii) Discuss with the patient and make partial changes to the prescription (patient centred preferences and capabilities need to be taken into account).
    (iii) Based on the GP's own clinical judgement of the patient's needs, make no changes to the prescription and provide a reason(s) for same.

- HSE pharmacists will conduct follow up reviews of recommendations made and will engage with GPs on a structured basis to discuss cases that are outside the normal parameters and do so in a manner consistent with accommodating the GP's work schedule as far as possible.
- While the HSE pharmacists will identify patients who they consider appropriate for review individual GPs will also be able to nominate patients who may benefit from review, and the pharmacists will consider these patients in the same fashion as patients they have identified.

Furthermore, where the HSE pharmacist as part of the medication review process identifies individual patients from the over 75 cohort (not referenced above) for whom prescribing risk/safety issues may arise, the pharmacist will submit his/her recommendations to the GP for consideration. These arrangements refer to GPs and relevant HSE pharmacists only and not to any other parties.

A key design principle will be to ensure that it works for GPs and the HSE and that the administrative burden on GP practices and use of GP time is minimised through, inter alia, deployment of integrated IT based solutions, scheduling of reviews and working arrangements between GPs and HSE pharmacists. In this regard the HSE will engage with the IMO at structured intervals during the course of the programme design phase.

2.3.2 New Medicinal Products-prior authorisation/approval measures

The HSE, in the discharge of its statutory obligations under the Health (Pricing and Supply of Medicinal Goods) Act, 2013 may from time to time be required to introduce such measures for new drugs. The initiating prescribing clinician will be the clinician responsible for seeking prior authorisation/approval. In the vast majority of these instances the measures will apply at Acute Hospital level as this is where the prescription of such medicines is ordinarily initiated. Examples of this are High Tech Medicines, DOACS (when first introduced) and the arrangements pertaining to sacubitril/valsartan (entresto) which were introduced in December 2017. In this regard it should be noted that of the 30,000 applications seeking to initiate patients on DOACS received by the HSE since 2012 the vast majority of these were from hospital based consultants. While in the case of entresto the product licence does not preclude a GP from initiating treatment the majority of patients are initiated on entresto at hospital level.

In applying prior authorisation/approval measures for new medicinal products it is the HSE policy that the requirement to seek prior authorisation/approval (where such is required) will rest with the initiating prescriber. The HSE, through its Hospital Improvement Programme, will work to ensure effective compliance with this principle by hospital based prescribers. Prior authorisation/approval will apply at patient level and not at prescriber level. Therefore once prior authorisation/approval is given for a patient it will continue to apply for that patient, particular product, for that class of product, and will continue to apply where there is a change in the prescribed dosage.

2.3.3 Systemic Interventions on Existing Medicinal Products

The HSE, in the discharge of its statutory obligations, has in the past and will continue to be required to implement systemic interventions on existing products. These interventions can include one or a combination of the following:

(i) Issuing of prescribing guidelines to GPs.
(ii) Providing prescribing reports to GPs so that they can compare their prescribing practice with their peers. An example of this would be prescribing reports on benzodiazepines.

2.3.4 Oral Nutrition Supplements (ONS)

In relation to ONS, an administrative system will be implemented, whereby if the prescriber selects an ONS product from the preferred list then no prior approval requirements will arise for the prescriber, but where they prescribe an ONS product outside of this list there will be an approval process which the GP will follow.

In parallel with the foregoing the HSE will, through the Value Improvement Programme, engage with dieticians and public health practitioners and nurses regarding the guidelines and seek to ensure that these guidelines are observed by these groups in recommending appropriate ONS products. The HSE will also engage with Nursing Homes through established channels to promote awareness of the ONS prescribing guidelines and to obtain their active collaboration in the optimisation of the use of the preferred list ONS products for their residents.

The HSE does not envisage, save in exceptional circumstances, any measures, (in respect of 2.3.3 above), requiring prior authorisation being introduced, save for the arrangements pertaining to ONS products as outlined in this section pending the completion of the discussions referenced in 2.3.5 below.

2.3.5 Effective Medicine Management

The parties will commence discussions in 2019 on the various options for effective medicines management, including (a) on-going development of medicine safety initiatives and (b) the effective management of preferred drug initiatives. These discussions will consider, the needs of the eligible population, will examine the resource and workload implications arising from such initiatives for GPs and the HSE's statutory obligations in relation to the appropriate use of finite health care resources.

GP Cooperation & Participation Required

Medication Reviews
GP reviews the pharmacist's recommendations and can either:

- Discuss with the patient as necessary and make the recommended changes to the prescription.
- Discuss with the patient and make partial changes to the prescription (patient centred preferences and capabilities need to be taken into account).
- Decide that recommendations are not appropriate in certain cases and provide reason for same.
- Cooperate with follow up reviews undertaken by the HSE pharmacist's recommendations.

Cooperation with Clinical Guidelines for ONS
GPs will cooperate with the HSE's administrative system for ONS, including adherence to preferred list of products and prior authorisation by exception requirements where alternative products are being prescribed.

2.4 Streamlining & Coordination

(See Appendix E, Figure 2)

It is recognised by the parties that a strategic review of the contractual terms for the GMS and other publicly-funded GP services is required to meet the challenges facing the health system. The Government intends, in the context of Sláintecare, to undertake a fundamental review of the contractual framework for GP services so as to develop and put in place arrangements which will ensure a sustainable GP service as a core element of primary care, focused on facilitating integrated provision of care in the most appropriate settings.

Future arrangements must also support achievement of the best health outcomes for the population in a person-centred and cost-effective way. The objective will be to provide for more flexible and modernised features in the interests of both service users and general practice, in support of service responsiveness, sustainability and accountability in particular. This project will commence later in 2019 and when proposals for contractual change have been developed, the Department and the HSE will engage with the IMO.

Pending the completion of the fundamental review of the GMS and all publicly funded health sector contracts and the introduction of a new contractual framework, the Parties have agreed to the introduction of the following measures aimed at streamlining and co-ordinating a number of pressing contractual issues under the GMS contracts (i.e. Medical card and GP Visit Card Contracts).

2.4.1 Contract Suspension, Sanction and Termination and Dispute Resolution Procedures

The Parties have agreed that the versions of these two procedures, as originally set out in the Under 6 contract to reflect new HSE organisational arrangements, will be incorporated in to the GMS contracts (i.e. Medical Card and GP Visit Card Contracts) in replacement of the existing procedures in the aforementioned contracts. This will require repeal of the 1972 Health Services Regulations (Section 8) procedure.

2.4.2 Complaints Policy and Procedure

The Parties are in agreement that GMS contract holders will operate a patient centred complaints policy and procedure in their practice, in line with agreed guidance. The existence and availability of the policy and procedure will be communicated to patients via visible notices in the practice and via the practice's website, where such exists. Each GP will be required to confirm the existence of their practice's policy and procedure as part of the annual compliance assurance process as outlined at 2.4.4.

2.4.3 Practice Profile

A once off and agreed baseline practice profile will initially be completed by each GMS contractor and will be updated as changes arise. An annual stocktake exercise will be carried out in which the HSE will provide each contractor with the details on file and ask them to advise of any changes as a opposed to completing full survey de-novo. The Parties will commence work on defining data fields for the Practice Profile with a view to agreeing final version by end of quarter 2 of 2019 for commencement in Quarter 4 of 2019.

GPs will display their routine surgery hours in their practices and will make available information on the practice, on the practice website, where such exists, including opening hours, details of services provided by the practice and the practice's out of hours arrangements.

2.4.4 Assurance Arrangements

The specific items for inclusion in this annual assurance arrangement are tax clearance status, annual Medical Council Registration Certificate which confirms satisfactory fulfilment of CPD and clinical audit requirements, confirmation of existence of complaints policy and procedure and confirmation of clinical indemnity status. The parties will agree composition of annual compliance process by end of Quarter 3 of 2019 for implementation in respect of 2019 and each year thereafter. The contents of the compliance assurance process will be subject to annual reviews and any changes required thereto will be implemented by the HSE following agreement with the IMO.

2.4.5 Premises Standards

The practice premises standards shall be those as set out below;

1. The Medical Practitioner shall ensure that the Practice Premises and facilities are fit for purpose, suitable for the delivery of the services and sufficient to meet the needs of patients.

2. The Medical Practitioner undertakes to work towards meeting and maintaining generally accepted standards in relation to Practice Premises.

3. Without prejudice to the generality of the foregoing, the Medical Practitioner shall ensure, as a minimum that the Practice Premises meet the following requirements:

    i.) The Practice Premises shall have a waiting room with a reasonable standard of comfort and hygiene, sufficient in size to accommodate the normal demands of his/her practice with adequate seating accommodation.
    ii.) The Practice Premises shall have a surgery sufficient in size for the requirements of normal general practice, with facilities including adequate lighting, hot and cold running water, adequate hand washing facilities, an examination couch and other essential needs of a practice, including adequate toilet facilities for patients.
    iii.) A high standard of cleanliness shall at all times be maintained throughout the Practice Premises.

4. The Medical Practitioner shall not change the location of his/her Practice Premises or open additional centres of practice (whether under this Agreement or otherwise) without the prior approval of the HSE.

2.4.6 Patients with Violent or Abusive Behaviour

It is accepted by the Parties that the optimal arrangement for eligible patients is to have their medical needs met through their GP of choice. However for a very small number of patients exceptional circumstances can arise due to persistent and serious violent or abusive behaviour on their part causing serious health and safety risks to GPs and their practice staff requiring different service arrangements from time to time**.** The Parties are in agreement that a high level working group will be established to:

- Assess the prevalence and impact of this issue in General Practice.
- Develop an appropriate model of service to respond to the service needs of this client group.

This working group shall commence in quarter 3 of 2019 with the recommendations to be completed in quarter 4 of 2019. The model of service will then be piloted in quarter 2 of 2020 and its evaluation will inform future service arrangements.

2.4.7 Reduction of Succession Timeframe for GMS Lists

The Parties have had discussions relating to arrangements for succession to GMS lists. Under the GMS Contract there are a number of provisions in relation to succession. There are differing rules in place, dependent on the type of practice configuration involved.

The Parties are in agreement that it would be beneficial to review and consolidate the circulars pertaining to succession arrangements and filling of vacant GMS panels to increase clarity for GPs and HSE Managers. In this regard, the parties have agreed that a joint Working Group be established in quarter 2 of 2019 to review current arrangements and circulars with a view to updating and consolidating current circulars and to identify a range of measures aimed at enhancing workforce planning in General Practice and succession arrangements in the GMS. In its deliberations the Working Group will prioritise the review of succession arrangements under the GMS where vacancies arise in registered partnerships. The Working Group will aim to complete its deliberations by end of quarter 3 of 2019 so that its findings and recommendations can inform sustainability and reform measures for 2020 and subsequent years.

2.4.8 Setting of Fee Rates

The Minister for Health may, with the consent of the Minister for Public Expenditure and Reform, by Regulation, set or vary the amount or the rate of payment to be made to GPs in respect of the provision of the services under the GMS and other publicly funded contracts, as provided for in Section 42 of the Public Sector Pay and Pensions Act 2017.

2.4.9 Framework Agreement

The parties agree that the process set out in the Framework Agreement shall apply to this Agreement and future negotiations between the Department of Health/HSE and the IMO for the GMS/GP contract and all other publicly-funded contracts for service. The Framework Agreement is subject to periodic review as per paragraph 2.12 of the Agreement and any changes to its terms will be subject to agreement between the parties.

2.4.10 Paternity & Maternity Leave

GMS contractors receive locum contribution for maternity leave and male GPs currently receive 3 days locum contribution for paternity leave. The State has agreed to increase the locum contribution available for paternity leave from 3 days to 2 weeks and to double the locum expenses contribution rate. Similarly, in respect of maternity leave, the State has agreed to double the existing locum expenses contribution rate.

2.4.11 Allocation of Funding to Support General Practice in Areas of Deprivation

On-going revenue of €2m will be allocated to allow the project to commence in 2019 in a targeted manner to support and maintain GP services for communities with a high degree of social deprivation. A recognised social deprivation index will be used to assist in the identification of the socially disadvantaged communities that will be eligible for additional practice supports.

2.4.12 Average Weighted Panel Calculations

The current formula for calculating subsidy payments to GPs is based on a weighted average panel size for the previous twelve months (based on a rolling twelve months). This has resulted in unforeseen anomalies where a GP, at the HSE's request, takes over another panel and combines it with his/her own. Under the current formula the GP must wait for twelve months to elapse before he/she receives the full weighted average relevant to the now combined panel size. In such circumstances the formula should not apply in the strict fashion that it currently does. Instead the calculation of practice support subsidies for a GP in such circumstances should be based on the

combined weighted average of both panels as it applied on the date that they were amalgamated. This change in the rule set will address what is an unforeseen anomaly and will contribute to better succession planning in those exceptional circumstances as typified by the example alluded to above where the HSE is experiencing significant challenges in maintaining GP services when vacancies arise. The Parties have agreed to extend this new rule set where, subject to HSE prior approval, a GP takes over the panel of a retiring/resigning partner. Such partnership arrangements are ones which have been registered with the HSE.

2.4.13 HSE & IMO On-going Process of Engagement

The HSE and the IMO have agreed to establish a process whereby the Parties will meet quarterly to discuss current issues in relation to strategic health service developments and operational matters as they pertain to GP services. A formal protocol will be developed jointly to set out how this process will operate. This process is to commence in June 2019. Priority issues for discussion by the Parties under this process shall include systems and processes for maintaining accuracy and currency of GPs GMS Panels and the framing of a protocol for communications from the HSE to individual GPs.

2.4.14 Engagement on Agreement

The Parties agree to meet three times a year, on dates to be agreed between the Parties to review and discuss any issues arising from the operation of the agreement.

2.4.15 Dispensing Doctors Arrangement

In the context of phased increases to the Dispensing Doctors Arrangement (Capitation Agreement) in relation to the Opt –in GP (dispensing doctor) fee and the Pilot GP (dispensing doctor) fee over the period 2020-2022 each dispensing doctor who is in receipt of either of the above fee rates shall provide a written undertaking to the HSE that he/she:

- Shall use the Drugs Dispensing Module, once integrated into the GP practice management system, and forward monthly updates to records of dispensed medicines (through the integrated system) at a patient level to the PCRS in the format prescribed by the HSE. While this is populated currently with the GMS Reimbursable List the HSE will work with the cohort of Dispensing Doctors to tailor it to a personal formulary that the Dispensing Doctor can update as required in his/her own practice.

- Shall actively participate in quality improvement in relation to Health Product Regulatory Authority (HPRA) recalls and patient alerts.

Receipt of the written undertaking from each Dispensing doctor will trigger the 2020 fee increase at an individual Dispensing Doctor level and fee increases planned for the years 2020-2022 at this individual level will be conditional on satisfactory implementation of the above measures by the Dispensing Doctor.

2.4.16 Review of Under 6s Contract

The Parties agree that a review of the Form of Agreement for Provision of Services to Children Under 6 Years Old will be undertaken in accordance with the principles set out in Section 41.2 of that Contract.

This review will take place in parallel with discussions with the IMO in relation to extension of access to GP care without fees, on a phased basis, to all children of primary school age.

2.4.17 Assessment & Confirmation Process

The State Side has set out the indicative fee rates that will be applied in return for the implementation of the reform and modernisation measures agreed by the parties. The increase in fees will be applied to the following capitation categories and allowances.

Capitation

Male Patients

- Male patient aged 6 years or more and less than 16 years
- Male patient aged 16 years or more and less than 45 years
- Male patient aged 45 years or more and less than 65 years
- Male patient aged 65 years or more and less than 70 years

Female Patients

- Female patient aged 6 years or more and less than 16 years
- Female patient aged 16 years or more and less than 45 years
- Female patient aged 45 years or more and less than 65 years
- Female patient aged 65 years or more and less than 70 years

Patients

- Patient aged 70 years or more residing in the community
- Patient aged 70 years or more residing in a private nursing home (approved by the HSE) for continuous periods in excess of 5 weeks

From 1 July 2019, GPs who sign up to the Agreement will receive service modernisation & reform fees for each patient on their panel. These will be in addition to the current capitation fees set under SI 233 of 2016.

The service modernisation & reform fees will be set by the Minister under Section 42 of the Public Service Pay and Pensions Act 2017 each year from 2019 - 2022.

The indicative service modernisation & reform fee rates for 2019 – 2022 are set out in Appendix E. The indicative total capitation fees payable per patient (current capitation rates + indicative service modernisation & reform fees) for 2019 – 2022 are also set out in Appendix E.

GPs who do not sign up to the Agreement will continue to receive the current capitation rates set out in S.I. 233 of 2016.

Allowances

- GP Support for areas of Deprivation
- Rural Practice Support Framework Allowances
- Dispensing Fees
- Maternity & Paternity Leave Locum Rates

The fee revisions will be effected by statutory instruments made under section 42 of the Public Service Pay and Pensions Act, 2017. The Act empowers the Minister for Health to set and vary fees with the consent of the Minister of Public Expenditure and Reform and specifies a number of factors which the Minister may take into account in setting the rates. General Practitioners will receive the

enhanced capitation fees following confirmation that they will participate in the Service Modernisation and Reform Measures outlined in this agreement.

It has been agreed that as part of decision-making process on fee rates, the HSE will submit an annual report to the Minister setting out its assessment of GP cooperation with implementation of the reform and modernisation measures contained in this agreement. The IMO will also have the opportunity to make a submission to the Minister. In the event that the progressing of any measure is delayed owing to factors on the HSE side, this will not have an adverse bearing on the assessment of GP cooperation.

Areas that the HSE will report on include:

Service Models

- Implementing Community Healthcare Networks (CHNs) and associated operating model for Community Services (Community Healthcare Organisations/CHOs)
- Support for and cooperation with hospital waiting-list validation exercises and the National Centralised Validation Unit

Implementation of eHealth Initiatives

- Individual Health Identifier
- eReferrals
- ePrescribing
- Development & Implementation of Summary and Shared Care Records
- Integrated Immunisation System
- Healthlink
- Healthmail
- Use of PCRS Application Suite
- NIMIS
- MedLIS

Medicines Optimisation

- Medicines Reviews
- Pre-Authorisation Approval Measures/ONS

Streamlining & Coordination

- Patient-centred Complaints Policy
- Practice Profile
- Assurance Arrangements

GP Cooperation & Participation Required

- Replace the Disciplinary and Dispute Resolution Procedures with relevant procedures from the Under 6 Contract.
- GPs to implement patient centred Complaints Policy and Procedure.
- GPs to assist in compilation of profile of GMS Practices and with the on-going updating of same.
- GPs to implement Annual Compliance Assurance Process.
- Premises standards updated.
- Joint HSE/IMO working group to assess the prevalence of violent or abusive behaviour in General Practice and following same to pilot and evaluate a model of service.
- Joint HSE/DOH/IMO working group to review current circulars pertaining to succession arrangements to GMS panels and arrangements for filling vacant lists, including succession arrangements in the case of registered partnerships. Group to make recommendations aimed at updating and consolidating current circulars.
- Acknowledgement by Parties of statutory basis for setting fee rates under the Public Service Pay and Pensions Act 2017.
- Paternity Leave provisions to be increased from 3 days to 2 weeks.
- Changes to Average Weighted Panel calculations to be introduced in defined circumstances such as where a GP, at HSE's request, amalgamates a vacant panel with his/her own panel. To include situations where, subject to HSE prior approval, a vacant GMS panel is taken over by surviving partner(s) in a registered partnership.
- IMO/HSE Process of engagement to commence in June 2019.
- Dispensing Doctors in receipt of the fee rates alluded to at 2.4.15 shall implement HSE's enhanced quality assurance and accountability requirements.

3. Eligibility

The Minister for Health intends to develop proposals for Government to extend access to GP care without fees, on a phased basis, to all children of primary school age (i.e. those who have not reached their 13th birthday). The Minister envisages that eligibility will be conferred on these additional cohorts by way of a phased approach over four years, beginning in Q3 of 2020. The scope of the service to be provided will be informed by appropriate clinical evidence. It is agreed that, in the event of the Government deciding that this measure is to be advanced, the Department and the HSE will engage with the IMO in relation to the contractual aspects in advance of implementation.

During the period of this Agreement and pending the outcome of detailed policy work on future eligibility issues, the Government's approach to any further extension of coverage will be on the basis of adjustment of the GPVC thresholds.

The Government has no plans to extend eligibility to GP care without fees to specific cohorts of patients on the basis of condition or circumstances other than means, other than as may arise in very discrete cases involving relatively small groups where overall health service supports may need to be put in place for very specific considerations. In the event that Government considers it necessary to introduce further measures in this area, the IMO will be consulted to seek its views on any resourcing and/or capacity implications for general practice.

Appendices

Appendix A (Chronic Disease Management)

Appendix A1: Minimum Dataset to be recorded and submitted to HSE

(GP Clinical Systems will be enhanced to auto populate to the maximum extent possible)

	Answer Options	Treatment Data Set	High Risk Preventive Data Set	Opportunistic Screening Data
Identification and Demographic Details				
Date of Review	dd/mm/yyyy	**Record and Submit**	**Record and Submit**	**Record and Submit**
GP GMS No.		**Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Patient ID		**Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Patient GMS Number		**Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Date of Birth	dd/mm/yyyy	**Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Sex	Male/Female	**Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Occupation	As per Census 2011	**Record and Submit**	**Record and Submit**	
Ethnicity	As per Census 2011	**Record and Submit**	**Record and Submit**	
Clinical Details				
Primary diagnosis	Dx and date of diagnosis dd/mm/yyyy	**Record and submit as part of GP contract dataset**	**Record and Submit**	
Comorbidities	Y/N: drop down menu: Cardiovascular disease including Heart Failure; Diabetes; Respiratory Disease; Mental Health (e.g. depression/anxiety)	**Record and submit as part of GP contract dataset**		
Care type	1 = primary care only /2 = care by hospital only /3 = care between hospital and primary care	**Record and submit as part of GP contract dataset**		
Medication Review				
Risk Factors				
Smoking (2 questions)	• Smoking status (drop down menu) • Brief intervention (drop down menu)	**Record and submit as part of GP contract dataset**	**Record and Submit**	**Current Smoker Y/N**
Alcohol (4 questions)	Use agreed classification of alcohol status, Audit C Tool drop down menu • 3 questions on frequency and amount of alcohol will automatically generate a risk score. • Risk relevant drop down menu for brief intervention given	**Record and submit as part of GP contract dataset**	**Record and Submit**	
Weight	KG's	**Record and Submit**	**Record and Submit**	**Record and Submit**
Height	M	**Record and Submit**	**Record and Submit**	**Record and Submit**
Waist Circumference	CM's	**Record and submit as part of GP Contract**	**Record and Submit**	**Record and Submit**

Weight Brief Intervention	Drop down menu relevant to BMI category	**Record and Submit**	**Record and Submit**	
Physical activity (3 questions)	• Drop down menu for 2 questions on amount of physical activity • Brief Intervention given (drop down menu)	**Record and submit as part of GP contract dataset**	**Record and Submit**	
Influenza vaccine	Y/N - date of vaccination	**Record and submit as part of GP contract dataset**		
Pneumococcal vaccine	Y/N - date of vaccination	**Record and submit as part of GP contract dataset**		
CVD Risk Score	QRISK Score	**Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Physical Examination				
Pulse Rate	Beats per minute	**Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Pulse Rhythm	Regular/Irregular	**Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Systolic Blood Pressure	mmHg	**Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Diastolic Blood Pressure	mmHg	**Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Foot and lower limb review	Pulses present / Absent date of dd/mm/yyyy; pitting oedema present / absent date of diagnosis dd/mm/yyyy; Foot ulcer date of diagnosis dd/mm/yyyy; Peripheral neuropathy date of diagnosis dd/mm/yyyy	**Record and submit as part of GP contract dataset**		
Amputation – (above knee/below knee/midtarsal/digit or metatarsal)	date of dd/mm/yyyy	**Record and submit as part of GP contract dataset**		
Retinal Screening	Referred to retinal screening Yes/No/Under treatment	**Record and submit as part of GP Contract dataset**		
Symptoms Review				
Investigations				
ECG performed	Yes/No; Result – (drop down menu normal/abnormal requiring action)	**If clinically indicated Record and submit as part of GP Contract dataset**	**Record and Submit if clinically indicated**	**Record and Submit if clinically indicated**
Echocardiography	Yes/No; Result - free text	**If clinically indicated **Report should include ejection fraction. Record and submit as part of GP contract dataset**	**Record and Submit if clinically indicated**	
Spirometry	Yes/No; Result -	**Record and submit above if clinically indicated**		
Bloods	Populated via Healthlink if available			
Full Blood Count	Yes/No: Result -	**Record and submit above if clinically indicated**	**Record and Submit**	**Record and Submit**
Urea & Electrolytes	Yes/No: Result -	**Record and submit above if clinically indicated**		
Fasting Lipid Profile	Yes/No: Result-	**If clinically indicated ; To include total cholesterol, LDL, HDL and Triglycerides; Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**

HB1Ac	Yes/No: Result -	**If clinically indicated; Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
FPG (Fasting Plasma Glucose)	Yes/No: Result -	**If clinically indicated; Record and submit**	**If clinically indicated; Record and submit**	**If clinically indicated; Record and submit**
Creatinine	Yes/No: Result -	**If clinically indicated ; Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
eGFR	Yes/No: Result -	**If clinically indicated; Record and submit as part of GP contract dataset**	**Record and submit if clinically relevant**	**Record and submit**
Albumin/Creatinine Ratio (ACR)	Yes/No: Result -	**If clinically indicated; Record and submit as part of GP contract dataset**	**Record and submit if clinically relevant**	**Record and Submit**
Proteinuria			**Record and Submit**	**Record and Submit**
Haematuria			**Record and Submit**	**Record and Submit**
B-type Natriuretic Test (BNP) (NT Pro BNP)	Yes/No: Result -	**If clinically indicated; Record and submit as part of GP contract dataset**	**Record and Submit**	**Record and Submit**
Disease Assessment Scores				
COPD dyspnoea score	MRC dyspnoea score (1 – 5)	**If clinically indicated ; Record and submit as part of GP contract dataset**		
Afib anticoagulation score	CHADS 2 score	**If clinically indicated ; Record and submit as part of GP contract dataset**		
Patient Education				
Referral to appropriate structured education programme	Yes/No	**Record and submit as part of GP contract dataset**	**Record and Submit**	
Education provided by GP / Practice team.	Yes/No	**Record and submit as part of GP contract dataset**	**Record and Submit**	
Agreed written Care Plan	Y/N. Includes action plan/self-management plans	**Including self - management and action plans. Record and submit as part of GP contract dataset**	**Record and Submit**	
Specialist Referral:*	Y/N Referral and Attended: drop down menu	***depending on clinical judgement: Record and submit as part of GP contract dataset**	**Referral to preventive services only**	
Enrolment on Chronic Disease Register	Yes / No	**Record and submit as part of GP contract dataset**	**Record on high risk register**	
Questions for Opportunistic Screening				
History of gestational diabetes				**Y/N**
Dyslipidaemia (HDL less than 0.9 or triglycerides greater than 2.82) (previously recorded):				**Y/N**
Moderate or severe chronic kidney disease (eGFR less than 60 mL/min/1.73 m2)(previously recorded):				**Y/N**
History of severe Mental Illness				**Y/N**
Member of the Irish Traveller/Roma/African/Asian Ethnicities				**Y/N**

Appendix A2: Personalised Care Plan

(GP Clinical Systems will be enhanced to auto populate to the maximum extent possible)

Your personalised care plan

We have created this form so you can put down on paper how you plan to take care of your health. It is for people who have chronic (long-term) conditions or who are at high risk of developing a chronic (long-term) condition.
This care plan can help you to manage your condition and to get help when you need extra support. It will also help you plan what to do if your condition gets worse.
You should jointly agree this plan with your healthcare professional, for example:

- GP,
- practice nurse, or
- other healthcare professional.

Please feel free to ask them any questions. This is a very important document. Please keep it safe and share it with your carer as appropriate.

Today's date

Day	Month	Year

These and other details which are shaded blue will be filled automatically from electronic patient record, in the computerised system

Your details

Name

Address

Your date of birth:

Day	**Month**	**Year**

Your GMS number (medical card number)

Contact details of your GP and carers

Your GP contact details.

Is there any carer or person that you would like involved in your care plan?

Include family members involved in your care planning process.

Can the GP or practice nurse disclose contents of this care plan to your carer?

Yes ☐ No ☐

Medical conditions you have

Medical conditions will be pre-populated with coded medical conditions. The nurse should add any other relevant conditions. Relevant conditions which are not coded will need to be entered manually.

Your health and wellbeing

When you think about your long-term condition, you are most concerned about:

Invite the patient to share their concerns:

- Use open ended questions
- Asking closed ended questions can seem judgemental and cause resistance
- E.g. What concerns do you have in relation to your health and wellbeing?

Consider physical, psychological, emotional, social issues, activities of daily living.

Encourage the patient to identify the following

'These are the areas of my health and well-being which are good or have improved'

'These are the concerns I have about my health

Medications

Medications you are prescribed	

Engage the patient in a conversation about their medications

-include medication concordance

-inhaler technique

Examples of questions to start the conversation:

-Tell me how and why you take your medications

- *What side effects have you experienced?*
- *What problems have you had taking your medication. Some patients have problems such as that they cost too much or they forget to take them.*

This will include medicine management review and discussion with nurse

Issues discussed with your doctor or nurse about your medications

Your health and wellbeing

What you do to manage your condition For example: • monitoring your blood sugar; • eating an appropriate diet; • monitoring your weight if you need to; • monitoring symptoms such as breathlessness; and • attending appointments.

Enquire regarding appointment attendance and potential barriers,

- blood sugar monitoring

-appropriate diet

-monitoring weight if applicable

-monitoring symptoms

Behaviour you need to change Based on your conversation with your doctor or nurse, you have both identified the following factors and behaviours that you need to work on.
Smoking
Alcohol
Body weight
Physical activity

Behaviour change can be pre populated from MECC to prompt a discussion regarding goals.

Use caution: asking closed ended questions can seem judgemental and cause resistance from the patient.

Start by asking the patient to tell you what they are already doing to keep themselves healthy?

After congratulating them and providing affirmation for positive behaviours, ask them what things they are doing to make their health worse.

Or start the discussion with a normalising statement such as that all of us sometimes do things that aren't good for us. What behaviours have you been doing that might put you at risk?

Your plan if your condition gets worse

This is what you should do if you become unwell with your condition, for example, 'COPD self-management plan'. (We call this an 'Exacerbation plan'.)

Please fill in the name of your plan here.

This exacerbation plan can be completed for the relevant long term condition e.g. COPD, cardiovascular disease, heart failure

Signs and symptoms	What you should do	Who you should contact

Summary of relevant test results and what they mean

Test result	What it means:

Nurse will select relevant test results which will be autofilled.

A link to the minimum dataset for relevant conditions should be available which should provide information on recent test results

A brief explanation of the test result should be provided for the patient. This might include what a normal result is, what the patients result is, why this is important and how to improve this where relevant.

Vaccination and discussion

Have you had these vaccines?

Name of vaccine	Yes	No
Pneumococcal	☐	☐
Yearly influenza vaccine	☐	☐

Influenza vaccination status can be pre-populated from clinical record. Influenza vaccination status should be recorded for the current season.

Refer to vaccination guidelines: http://www.hse.ie/eng/health/immunisation/hcpinfo/

Your plan of action

Review previous goals

	How did you get on with this goal?
1 What was your goal?	
2 What was your goal?	
3 What was your goal?	

Previous goals can be pre-populated from previous plans.

Goals about your condition for the future that you have agreed with your health professional

Goal	Plan

These should be jointly agreed goals

Encourage the patient to choose which issue to work on first. This will strengthen their commitment to take action.

Consider asking the patient:

To improve their health what would they like to achieve?

What will they do to achieve their goal?

What support will they need?

Consider barriers and enablers

Health services you have been referred to today

Any relevant referrals will be listed here.
Other services and places where you can get information which may be helpful for you in managing your long term condition.
Name of person or organisation you are dealing with now

Name of person or organisation that we suggest you contact after this review	**Contact details**

Referrals may include: specialist, dietician, physiotherapy, cardiac/pulmonary rehab etc. Referrals made will be included as a list on the patient version of the plan.

Patients with cardiovascular disease should be considered for cardiac rehab where appropriate.

Patients with COPD should be considered for referral to pulmonary rehab.

Patients with Type 2 Diabetes should be considered for diabetes structured education.

Other Services:

This might include inhaler technique training, podiatry, community organisations e.g weight watchers, walking groups; community cooking; green gym etc.

Link to local directory of self-management supports

e.g. learning to live with their long term condition, day to day practical support, self help and support groups, medication, financial information, legal information, research in relation to their condition.

Information needs

Consider the persons health literacy and needs associated their level of literacy

People with chronic conditions, and their carers, need a variety of information at different times, depending on their personal situation and the stage of their conditions. Link to HSE resources and voluntary organisations resources. Practices may wish to stock information leaflets from these organisations:

https://www.diabetes.ie/, https://irishheart.ie/, http://copd.ie/, https://www.healthpromotion.ie/, https://www.mabs.ie/en/, http://www.citizensinformation.ie/en/

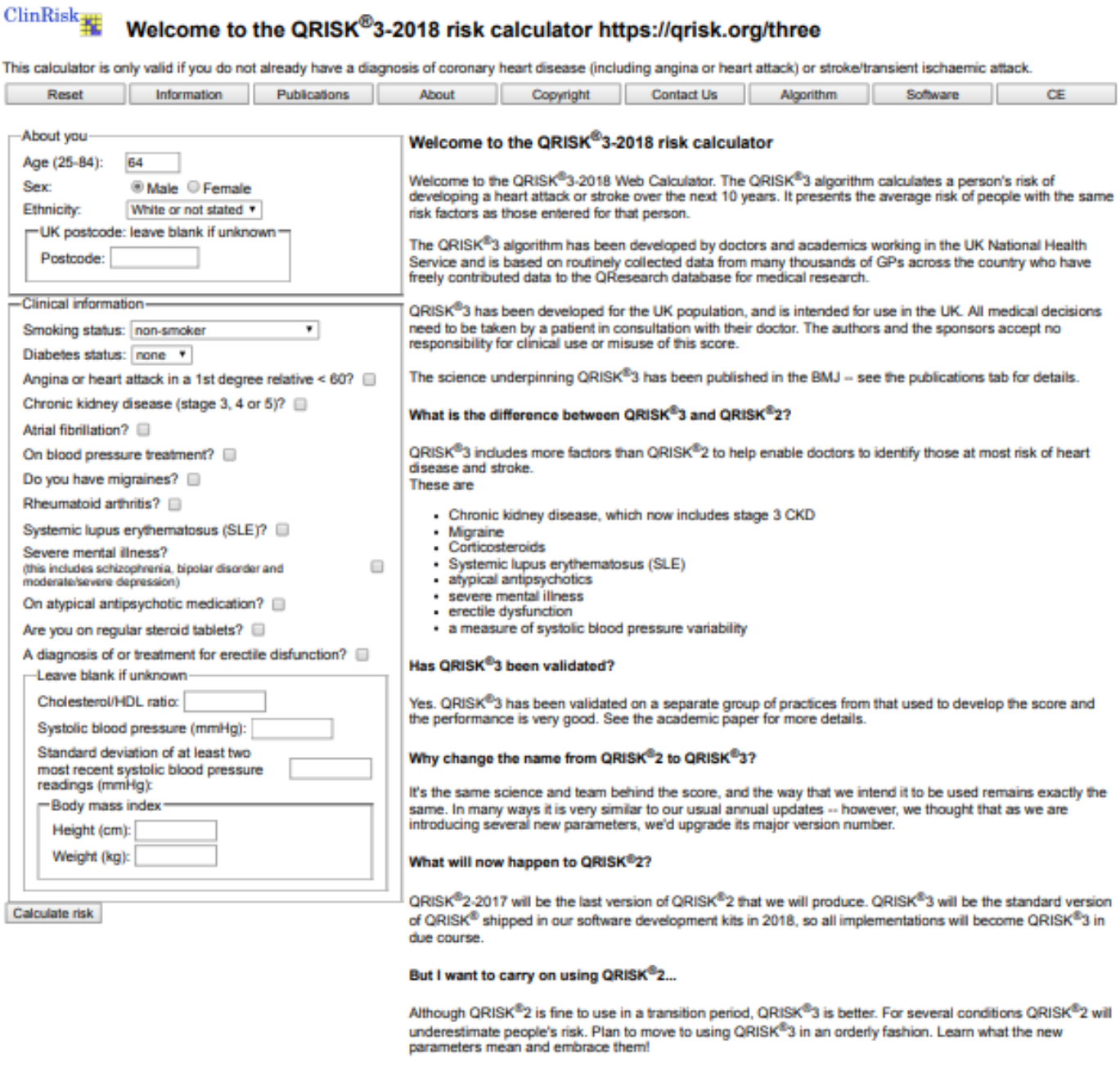
Signatures for this form

Please confirm that you (the patient) and the healthcare provider have discussed this care plan and have received a written copy of the plan.		
	Patient	**Healthcare professional (HCP)**
Name in print		
Signature		
Date		

When should this care plan be reviewed?

Day	Month	Year

Appendix A3: QRISK



ClinRisk

Welcome to the QRISK®3-2018 risk calculator https://qrisk.org/three

This calculator is only valid if you do not already have a diagnosis of coronary heart disease (including angina or heart attack) or stroke/transient ischaemic attack.

Reset | Information | Publications | About | Copyright | Contact Us | Algorithm | Software | CE

About you

Age (25-84): 64

Sex: Male Female

Ethnicity: White or not stated

UK postcode: leave blank if unknown

Postcode:

Clinical information

Smoking status: non-smoker

Diabetes status: none

Angina or heart attack in a 1st degree relative < 60?

Chronic kidney disease (stage 3, 4 or 5)?

Atrial fibrillation?

On blood pressure treatment?

Do you have migraines?

Rheumatoid arthritis?

Systemic lupus erythematosus (SLE)?

Severe mental illness?
(this includes schizophrenia, bipolar disorder and moderate/severe depression)

On atypical antipsychotic medication?

Are you on regular steroid tablets?

A diagnosis of or treatment for erectile disfunction?

Leave blank if unknown

Cholesterol/HDL ratio:

Systolic blood pressure (mmHg):

Standard deviation of at least two most recent systolic blood pressure readings (mmHg):

Body mass index

Height (cm):

Weight (kg):

Calculate risk

Welcome to the QRISK®3-2018 risk calculator

Welcome to the QRISK®3-2018 Web Calculator. The QRISK®3 algorithm calculates a person's risk of developing a heart attack or stroke over the next 10 years. It presents the average risk of people with the same risk factors as those entered for that person.

The QRISK®3 algorithm has been developed by doctors and academics working in the UK National Health Service and is based on routinely collected data from many thousands of GPs across the country who have freely contributed data to the QResearch database for medical research.

QRISK®3 has been developed for the UK population, and is intended for use in the UK. All medical decisions need to be taken by a patient in consultation with their doctor. The authors and the sponsors accept no responsibility for clinical use or misuse of this score.

The science underpinning QRISK®3 has been published in the BMJ – see the publications tab for details.

What is the difference between QRISK®3 and QRISK®2?

QRISK®3 includes more factors than QRISK®2 to help enable doctors to identify those at most risk of heart disease and stroke.
These are

- Chronic kidney disease, which now includes stage 3 CKD
- Migraine
- Corticosteroids
- Systemic lupus erythematosus (SLE)
- atypical antipsychotics
- severe mental illness
- erectile dysfunction
- a measure of systolic blood pressure variability

Has QRISK®3 been validated?

Yes. QRISK®3 has been validated on a separate group of practices from that used to develop the score and the performance is very good. See the academic paper for more details.

Why change the name from QRISK®2 to QRISK®3?

It's the same science and team behind the score, and the way that we intend it to be used remains exactly the same. In many ways it is very similar to our usual annual updates -- however, we thought that as we are introducing several new parameters, we'd upgrade its major version number.

What will now happen to QRISK®2?

QRISK®2-2017 will be the last version of QRISK®2 that we will produce. QRISK®3 will be the standard version of QRISK® shipped in our software development kits in 2018, so all implementations will become QRISK®3 in due course.

But I want to carry on using QRISK®2...

Although QRISK®2 is fine to use in a transition period, QRISK®3 is better. For several conditions QRISK®2 will underestimate people's risk. Plan to move to using QRISK®3 in an orderly fashion. Learn what the new parameters mean and embrace them!

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https://qrisk.org/three/

Appendix A4: Chronic Disease Definitions

The following definitions etc. for chronic diseases have been agreed with the National Clinical Programmes.

Diabetes Type 2

Definition

Type 2 is a metabolic illness. It is the commonest type of diabetes and is characterised by disorders of insulin action and secretion, either of which may be the predominant feature. Both are usually present at the time that type 2 diabetes is clinically manifest. The specific reasons for the development of these abnormalities are not yet known.

Case Finding General Practice

Type 2 diabetes has a long pre-clinical phase and may be asymptomatic until well after long-term micro vascular and macro vascular complications have occurred. Early identification of patients and initiation of treatment can reduce the development of complications of diabetes and therefore testing for diabetes in asymptomatic patients with risk factors associated with the development of diabetes is recommended.

National Clinical Programme agreed criteria for case finding in asymptomatic assessment of adult individuals

Testing for diabetes should be considered in all adults who;

- Have BMI ≥ 30kg/m2 and who have one or more additional risk factors
- First-degree relative with diabetes
- High-risk ethnicity (e.g. African, Asian, Hispanic etc.)
- Have a history of gestational diabetes
- On previous testing had Impaired Fasting Glucose (IFG) or HbA1c

Criteria for diagnosis

1. Symptoms of diabetes plus random plasma glucose concentration > 11.1 mmol/L*. The classic symptoms of diabetes include polyuria, polydipsia, and unexplained weight loss.

or

2. Fasting plasma glucose ≥ 7.0 mmol/L.**
   Fasting is defined as no caloric intake for at least 8 hours.

or

3. 2-hr plasma glucose > 11.1 mmol/L during a 75g Oral Glucose Tolerance Test (OGTT). The test should be performed as described by W.H.O., using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.

or

4.A HbA1c ≥ 48mmol/mol (≥ 6.5%)**^
   The test should be performed using a standardised assay.

*Random is defined as any time of day without regard to time since last meal.

**In the absence of symptoms, the result should be confirmed by repeat testing on a different day. ^A value less than 48mmol/mol (6.5%) does not exclude diabetes diagnosed using glucose tests.

Diagnosis of Pre Diabetes

Pre diabetes can be diagnosed when HbA1c lies between 42 – 47 mmol/mol (6.0 – 6.4%) and when FPG lies between 6.1 – 6.9 mmol/litre. In the absence of symptoms the result should be confirmed by repeat testing on a different day.

Chronic Obstructive Pulmonary Disease (COPD)

COPD Definition

Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible.

COPD Diagnosis

The National Clinical programme for COPD recommends that the diagnosis is suspected on the basis of risk factors, symptoms and signs. Spirometry is required to confirm the diagnosis. For the purpose of the contract, patients can be enrolled on the chronic disease register based on clinical symptoms and signs. The diagnosis should then be confirmed with spirometry within 12 months of enrolment.

A diagnosis of COPD should be considered in patients who have a risk factor for COPD.e.g.

- Smoking (current or ex-smoker)
- Genetic illnesses e.g. Alpha-1-anti-trypsin deficiency
- Second-hand smoke exposure
- Outdoor air pollution
- Indoor air pollution e.g. biomass fuel stoves
- Occupational exposure – e.g. dust, gases, fumes
- Chronic asthma
- Co-morbid illness e.g. inflammatory conditions

And / or who present with one or more of the following symptoms

- exertional breathlessness
- chronic cough
- regular sputum production
- frequent winter 'bronchitis'
- wheeze

In addition, a diagnosis of COPD should be considered in any smoker presenting with shortness of breath.

The following spirometry results, post-broncodilator should be used as a definition of COPD

- Airflow obstruction is defined as a reduced FEV_1/FVC ratio (where FEV_1 is forced expired volume in 1 second and FVC is forced vital capacity), such that FEV_1/FVC is less than 0.7.
- If FEV_1 is ≥ 80% predicted normal a diagnosis of COPD should only be made in the presence of respiratory symptoms, for example breathlessness or cough.

Assessment of severity

Assessment of COPD severity is based on the

- Degree of airflow limitation i.e. severity of the spirometric abnormality* (mild, moderate, severe, very severe)
- Patient's level of dyspnoea which can be assessed by the modified Medical Research Council (mMRC) Dyspnoea Scale^
- Patient's quality of life as measured by COPD Assessment Test (CAT) score or other measures.
- Occurrence of exacerbations
- Presence of comorbidities and complications

***Spirometry results:**

- Stage I: Mild -FEV1/FVC <0.7; FEV1 ≥ 80% predicted
- Stage II: Moderate - FEV1/FVC <0.7; 50% ≤ FEV1 <80% predicted
- Stage III: Severe - FEV1/FVC <0.7; 30% ≤ FEV1 <50% predicted
- Stage IV: Very severe - FEV1/FVC <0.7; FEV1< 30% or FEV1 < 50% predicted plus chronic respiratory failure

^modified Medical Research Council (mMRC) Dyspnoea Scale

- Grade 0: Not troubled by breathlessness except on strenuous exercise
- Grade 1: Short of breath when hurrying or walking up a slight hill
- Grade 2: Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
- Grade 3: Stops for breath after walking about 100m or after a few minutes on level ground
- Grade 4: Too breathless to leave the house or breathless when dressing or undressing

Heart Failure

Definition

Heart failure is a medical condition where heart efficiency is compromised, resulting in various symptoms such as dyspnoea, fatigue and loss of energy. Heart failure often develops because of another medical condition, such as coronary artery disease or high blood pressure, which has damaged or put extra workload on the heart.

Heart Failure is a clinical syndrome in which patients have the following features

- Symptoms typical of heart failure

  (breathlessness at rest or on exercise*, fatigue, tiredness, ankle swelling)

- Signs typical of heart failure

  (tachycardia, tachypnoea, pulmonary rates, pulmonary effusion, raised jugular venous pressure, peripheral oedema, hepatomegaly)

- Objective evidence of a structural or functional abnormality of the heart at rest

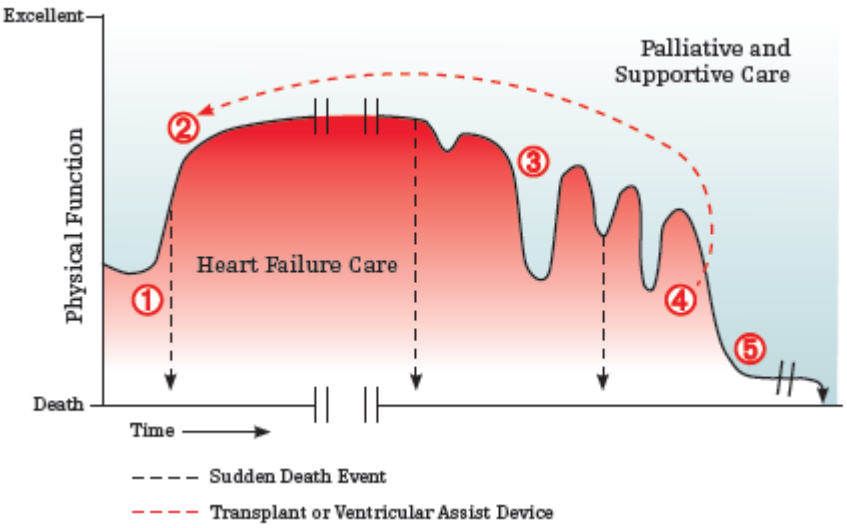
  (cardiomegaly, third heart sound, cardiac murmurs, abnormality on the echocardiogram, raised natriuretic peptide concentration)

Natural History of Heart Failure–

Heart failure (HF) is a complex and progressive disease where the heart cannot pump sufficient blood to meet the body's demands, resulting in poor exercise tolerance, fatigue, and reductions in quality of life and survival. Patients with HF typically pass through a number of advancing stages before reaching the end stage condition. This means that the eventual deterioration of heart function due to HF can be predicted early in the course of the disease and ideally, clinical strategies can be deployed early on to stabilize symptoms and prevent or slow disease progression and improve the quality of life.

The patient with HF experiences periods of relative stability, interspersed with unpredictable acute episodes that result in declining health, repeated hospitalizations and ultimately death. The typical HF patient is elderly and may have multiple comorbidities in addition to coronary artery disease (CAD) including hypertension, atrial fibrillation, diabetes mellitus or chronic obstructive pulmonary disease (COPD).

Canadian studies show that the median survival for heart failure patients is 1.75 years, demonstrating that 50% of those diagnosed have died within 2 years and that the 10 year mortality rate is 99%. It is estimated that in Ireland approximately 20% of heart failure patients will move from low risk i.e. stable clinical status to high risk i.e. unstable and will require hospital admission in any one year.



Phase ① - Initial symptoms of HF develop and HF treatment is initiated

Phase ② - Plateau of variable length reached with initial medical management, or following mechanical support or heart transplant

Phase ③ - Functional status declines with variable slope; intermittent exacerbations of HF that respond to rescue efforts

Phase ④ - Stage D HF, with refractory symptoms and limited function

Phase ⑤ - End of life

Dotted lines represent sudden cardiac death that can occur anytime during the trajectory.

Source: Goodlin, 2009

Stable Heart Failure

The Heart Failure Model of Care recognises that the natural history of heart failure is that patients tend to deteriorate gradually over time. At the start of the disease trajectory, patients are often reasonably stable in a low risk category. As symptoms of heart failure develop the patient often has periods of clinical stability (criteria for clinical stability include; no change in diuretic dosage, HF symptoms and NYHA class constant, no signs of overload on clinical exam). This can generally be managed successfully in the community by General Practitioners, following specialist diagnosis and establishment of a treatment plan. As time progresses patients may deteriorate acutely. These periods of clinical instability, lasting from days to weeks will require referral to specialist services, either urgent out patient attendance or hospitalisation. Patients may then recover functional capacity, to the point where after a transition period following hospital discharge they again reach clinical stability. Following a deterioration and admissions patients should remain under the management of the specialist OPD service until they have been clinically stabilised for at least 3 months. This in effect means that they have not required intravenous diuretic for management in this 3 month period. The patient can then be referred back for General Practice management as before, with an updated management plan. Some patients following deterioration and hospitalisation will not recover so well, and if they survive to discharge, will require ongoing care by the specialist OPD service. A cycle of deterioration may occur with repeated rehospitalisation. Phase 1 and 2 can be managed in General Practice and the stable periods of phase 3.

The National Clinical Programme for Heart Failure defines adults with stable heart failure as “adults diagnosed with chronic heart failure whose clinical condition has not deteriorated to require hospital admission within the last year”. This cohort of adults with stable heart failure should be the cohort registered by General Practitioners for management in Primary Care. Patients who subsequently deteriorate should be referred to specialist services either on an inpatient or an outpatient basis as appropriate and remain on the GP register. They should stay under the care and clinical responsibility of the specialist services, as outlined above until they have been re-stabilised clinically for at least 3 months. They can be discharged back for GP management in the community while they remain stable.

Diagnosis

Figure 1 below outlines appropriate algorithm for diagnosis of heart failure.

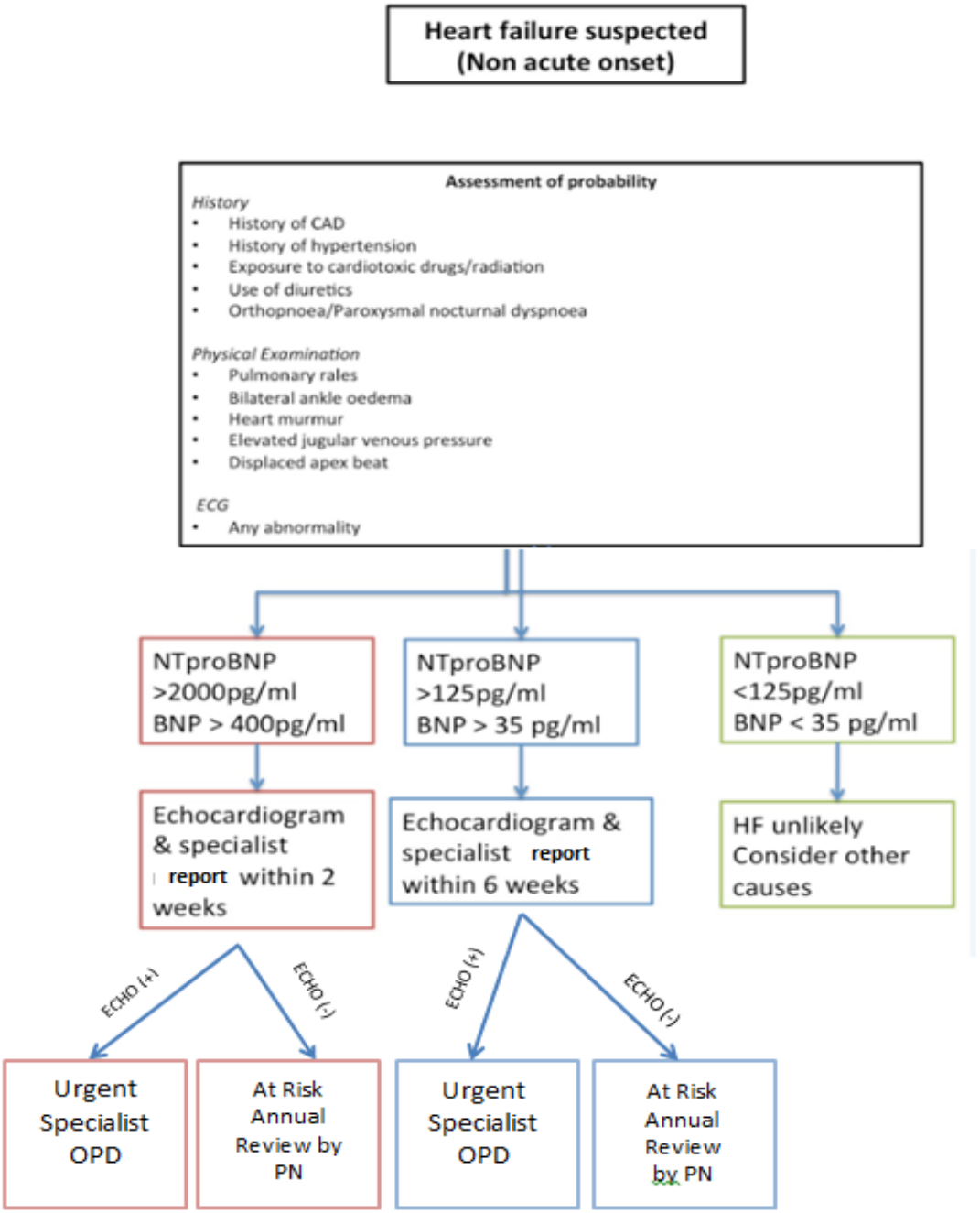


Figure 1 Algorithm for suspected heart failure in general practice, Irish Cardiac Society 2017

New York Heart Association (NYHA) Classification

NYHA Class	Functional Capacity
I	Patients with cardiac disease but resulting in no limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, or shortness of breath.
II	Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitations, or shortness of breath.
III	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitations, or shortness of breath.
IV	Patients with cardiac disease resulting in the inability to carry on any physical activity without discomfort. Symptoms of HF may be present even at rest. If any physical activity is undertaken, discomfort increases.

Source: The Criteria Committee of the New York Heart Association. (1994)

Ischaemic heart disease

Stable Angina

Stable coronary artery disease is generally characterized by episodes of reversible myocardial demand/supply mismatch, related to ischaemia or hypoxia, which are usually inducible by exercise, emotion or other stress and reproducible—but, which may also be occurring spontaneously. Such episodes of ischaemia/hypoxia are commonly associated with transient chest discomfort (angina pectoris).

Definition

Angina is usually caused by coronary artery disease (CAD). Making a diagnosis of stable angina caused by CAD in people with chest pain is not always straightforward. Clinical assessment alone may be sufficient to confirm or exclude a diagnosis of stable angina, but when there is uncertainty, additional diagnostic testing (functional or anatomical testing) is required.

Classical angina pain is constricting discomfort in the front of the chest, or in the neck, shoulders, jaw, or arms, precipitated by physical exertion and relieved by rest or GTN within about 5 minutes.

Diagnosis

Stable angina is diagnosed based on clinical history, physical examination, relevant investigations which may include 12 lead ECG, blood tests and cardiac investigations such as exercise testing, coronary angiography and cardiac CT imaging.

Cerebrovascular Accident/Stroke

Definition

A cerebrovascular accident is caused by the interruption of the blood supply to the brain, usually because a blood vessel bursts (haemorrhagic stroke) or is blocked by a clot (ischaemic stroke). This cuts off the supply of oxygen and nutrients, causing damage to the brain tissue[12].

Transient Ischaemic Attack

Definition

Transient ischemic attack (TIA) is a defined as a transient episode of neurologic dysfunction caused by focal brain, spinal cord, or retinal ischemia, **without** acute infarction[13].

Diagnosis

In people with sudden onset of neurological symptoms a validated tool, such as FAST (Face Arm Speech Test), should be used outside hospital to screen for a diagnosis of stroke or TIA[14].

People who have had a suspected TIA should be assessed as soon as possible for their risk of subsequent stroke.

Atrial Fibrillation

Definition

Atrial fibrillation is a cardiac arrhythmia characterised by an irregularly irregular heart rate.

Diagnosis

Diagnosis is based on manual pulse palpation revealing an irregular pulse. The diagnosis is confirmed on electrocardiograph (ECG). The sensitivity of pulse palpation with confirmatory ECG is estimated to be 80%.

AF is defined as a cardiac arrhythmia with the following characteristics on ECG.

(1) The surface ECG shows ‘absolutely’ irregular RR intervals, i.e. RR intervals that do not follow a repetitive pattern.

(2) There are no distinct P waves on the surface ECG. Some apparently regular atrial electrical activity may be seen in some ECG leads, most often in lead V1.

(3) The atrial cycle length (when visible), i.e. the interval between two atrial activations, is usually variable.

Opportunistic case finding for Atrial Fibrillation

A 2015 health technology assessment (HTA) undertaken by HIQA supports annual opportunistic case finding of men and women aged 65 years and older by pulse palpation followed by ECG confirmation of an irregular pulse in the Irish primary care setting[17].

Definition of High Risk of Cardiovascular Disease

High risk primary prevention of cardiovascular disease

In addition to the group of patients with clear cut risk of cardiovascular disease due to atrial fibrillation, another group of patients are at risk of cardiovascular disease due to a suite of risk factors, including smoking and hypertension. Risk in this group is assessed using one of the validated risk assessment tools, in conjunction with history taking and clinical exam.

The risk assessment tool used in this paper is the UK QRISK Score. **Appendix A3** gives the details of the latest version. It is intended that patients with a QRISK Score of ≥= 20% will be considered high risk for the purpose of the annual preventive visit. These patients will be included in an annual High Risk Preventive Programme.

Hypertension

Definition

Hypertension is defined as a systolic blood pressure > 140mmHg and/or diastolic blood pressure of >90mmHg. This target may not be suitable for all patients and a more individualised approach may be preferred (e.g. in frail elderly patients).

Diagnosis

The diagnosis of hypertension should be based on at least two BP measurements in the sitting position at an office visit. If the second measurement is substantially different from the first, take a third measurement. Record the lower of the last two measurements as the clinic blood pressure. If the clinic blood pressure is 140/90 mmHg or higher, ideally offer ambulatory blood pressure monitoring (ABPM) to confirm the diagnosis of hypertension.

Ambulatory Blood Pressure Monitoring (ABPM)

When using ABPM to confirm a diagnosis of hypertension, ensure that;

- at least two measurements per hour are taken during the person's usual waking hours (for example, between 08:00 and 22:00).
- use the average value of at least 14 measurements taken during the person's usual waking hours to confirm a diagnosis of hypertension.

When ABPM is not available or is not acceptable to the patient, home blood pressure monitoring can be used.

Home Blood Pressure Monitoring (HBPM)

When using HBPM to confirm a diagnosis of hypertension, ensure that:

- for each blood pressure recording, two consecutive measurements are taken, at least 1 minute apart and with the person seated and
- blood pressure is recorded twice daily, ideally in the morning and evening and
- blood pressure recording continues for at least 4 days, ideally for 7 days.
- discard the measurements taken on the first day and use the average value of all the remaining measurements to confirm a diagnosis of hypertension.

Hypertension is diagnosed when office BP is 140/90 (stage 1) or higher and subsequent ABPM daytime average OR HBPM average blood pressure (measured as outlined above) is 135/85 mmHg or higher.

In the absence of ABPM and HBPM, office blood pressure measurement can be used to diagnose hypertension. When using office blood pressure measurement, at least two BP measurements per visit in the sitting position should be taken on two separate visits.

Stage 2 hypertension is diagnosed at ≥ 160/100 mmg or higher on office measurement and subsequent ABPM daytime average or HBPM average blood pressure of 150/95 mmhg or higher.

Patients with stage 1 hypertension and a QRISK 3 of ≥ 20% are identified as having high cardiovascular risk. Patients with stage 1 hypertension and target organ damage and patients with stage 2 hypertension are also identified as high cardiovascular risk. These patients will be included in the annual preventive programme.

Patients with stage 1 hypertension low risk, will not be included in the programme currently and will remain under the usual care of their GP.

Appendix A5: Categorisation Following Opportunistic Case Finding - Data Return

Action (Tick either a, b or c)

☐ (a) Normal - Review in 5 years if risk criteria persist

☐ (b) Preventive Programme – Register on Preventive Programme (drop down menu)

Tick the appropriate reason for high risk classification

☐ 1. QRISK Greater or equal to 20%
☐ 2. Hypertension stage 1 with target organ damage
☐ 3. Hypertension stage 2
4. Pre-diabetes
5. BNP greater or equal to 34 pg/ml or NTPRO BNP greater or equal to 105 pg/ml

☐ (c) Diagnosed chronic disease – Register on Treatment Programme

Tick the appropriate diagnoses (drop down menu)

☐ 1. Type 2 diabetes
☐ 2. Ischaemic heart disease
☐ 3. Cerebral vascular disease
☐ 4. Atrial Fibrillation
☐ 5. Asthma
☐ 6. COPD
☐ 7. Heart Failure

Appendix A6: ICGP-IMO agreed statement

ICGP-IMO agreed statement

High CV-Risk Intervention as part of the GP contract talks

21st November 2018

1. QRISK Vs. other cardiovascular risk calculators

It is recommended that a risk assessment tool is used to estimate the patient's 10-year risk of developing cardiovascular disease (CVD), to identify high-risk people for primary prevention (1). There are several CVD risk calculators in widespread use and these are constantly evolving and new ones emerging. All of the risk models have advantages and disadvantages and it is recognised no single risk model will be appropriate for all patients (2). For the purposes of a national programme, however, a single risk calculator recommendation is desirable.

The QRISK calculator is used by many Irish GPs and has been updated recently as QRISK3 (**Appendix 3**). There are many other cardiovascular risk calculators, including SCORE, ASSIGN, Reynolds Risk Score and the UKPDS Risk Engine for patients with type 2 diabetes, but we would recommend the use of QRISK3. Many Irish GPs use the QRISK calculator currently, as it was calculated on a UK population and has been promoted by NICE and through education events, which Irish GPs attend.

All the risk calculators utilise similar variables, such as the patient's gender, age, systolic blood pressure, smoking status and cholesterol (Total and HDL) to estimate the patient's total risk of developing (or dying from) CVD over the following 10 years. A high CVD risk is defined "10-year cardiovascular risk equivalent to 20% or greater" calculated using QRISK3 (or a "10-year risk of fatal cardiovascular disease of 5% or greater" calculated using HEART Score).

Definition:
High CV risk = Greater than 20% risk of a cardiovascular (CV) event over 10 years using QRISK3 [or, greater than 5% risk of fatal cardiovascular disease over 10 years].

2. A Preventive Programme for Patients with a High-CV Risk

The Chronic Disease Prevention & Management Programme consists of 3 components;

1. Opportunistic Case Finding
2. An Annual Preventive Programme
3. Chronic Disease Treatment Programme

1. The Opportunistic Case Finding Programme aims to identify those at high risk for the Preventive Programme and those with undiagnosed listed Chronic Disease for the Treatment Programme.

2. The Annual Preventive Programme focuses on patients at high risk of:

- Cardiovascular Disease
- Diabetes

3. The Chronic Disease Treatment Programme comprises of four structured visits per annum, for patients with the following diseases:

- Asthma
- COPD
- Type 2 diabetes mellitus
- Cardiovascular disease:
    - IHD/ Stroke
    - AFib (excluding warfarin monitoring)
    - Heart failure

Preventive Programme

The Preventive Programme should encompass the following patients: QRISK ≥20% or hypertension stage 1 with target organ damage or hypertension stage 2, as well as patients with high risk of heart failure and diabetes.

This intervention programme does not need to be as intense as the CDM programme above, and could include one annual visit to the GP practice (nurse visit for 30 minutes with a phlebotomy to assess on-going CV risk assessment and a further GP visit)

Thresholds for commencing medication (such as lipid lowering agents or hypertensive medications) are a separate issue to the intervention programme and decisions should be made by GPs, in accordance with international and national guidance and in conjunction with medicines management programme advice from the HSE.

References

1. https://patient.info/doctor/cardiovascular-risk-assessment
   https://www.ahajournals.org/doi/10.1161/CIR.0000000000000625
   http://eurheartj.oxfordjournals.org/lookup/doi/10.1093/eurheartj/ehw106
   https://pathways.nice.org.uk/pathways/cardiovascular-disease-prevention
   https://www.nice.org.uk/guidance/cg127
2. DeFilippis AP et al An analysis of calibration and discrimination among multiple cardiovascular risk scores in a modern multiethnic cohort. Ann Intern Med. 2015;162(4):266-75
3. http://www.qrisk.org
4. https://www.bmj.com/content/357/bmj.j2099

Appendix A7: Making Every Contact Count Drop Down Menu's

Making Every Contact Count Drop Down Menu's

SMOKING STATUS AND INTERVENTION

1. Do you SMOKE any tobacco products?

- Current (daily or occasional) ☐
- Ex-smoker (gave up 6 months +) ☐
- Never ☐
- Unknown / not asked ☐

2. ACTION if patient is a current smoker (Tick ALL actions taken)

- **GIVEN** brief advice / brief intervention ☐
- **DIRECTED** or **REFERRED** to HSE cessation services /QUIT service ☐
- **PRESCRIBED (or REFERRED FOR)** PHARMACOTHERAPY ☐
- **Patient declined/not interested** ☐
- **No action documented** ☐

ALCOHOL STATUS AND INTERVENTION (System Generates the Score Automatically)

*AUDIT-C Tool

1. How OFTEN do you have a drink containing ALCOHOL?

Never	☐	SCORE 0
Monthly or less	☐	SCORE 1
2-4 times a month	☐	SCORE 2
2-3 times a week	☐	SCORE 3
4 or more times a week	☐	SCORE 4

Total score 0-4 = low risk
Total score 5 – 7 = increased risk
Total score 8 – 12 = high risk

2. How MANY standard drinks (10 grams) of alcohol do you have on a typical day when drinking?*

1-2	☐	SCORE 0
3-4	☐	SCORE 1
5-6	☐	SCORE 2
7-9	☐	SCORE 3
10 or more	☐	SCORE 4

3. How OFTEN do you have 6 or more drinks (10 grams each) on one occasion?*

Never	☐	SCORE 0
Less than monthly	☐	SCORE 1
Monthly	☐	SCORE 2
Weekly	☐	SCORE 3
Daily or almost daily	☐	SCORE 4

Total ALCOHOL SCORE = ☐
System generated total alcohol score

4(a) ACTION INCREASED RISK (Tick ALL actions taken)

- **GIVEN** brief advice / brief intervention ☐
- **RECOMMENDED** that patient discuss with GP & complete full AUDIT assessment ☐
- **Patient declined/not interested** ☐
- **No action documented** ☐

4(b) ACTION HIGH RISK (Tick ALL actions taken)

- **Offered REFERRAL** to health professional ☐
- **Patient declined/not interested** ☐
- **No action documented** ☐

Standard drink contains 10g of pure alcohol, equivalent to:

- half pint lager *or* pub measure spirit *or* small glass wine

Recommended Max Standard drinks per week is

- **11 for women** **17 for men**

BODY WEIGHT (BMI) STATUS AND NUTRITION INTERVENTION

1. BMI status

Height _____ Weight _____

BMI _____

System Generated BMI and Categories

Underweight	BMI < 18.5
Normal weight	BMI 18.5 - 24.9
Overweight	BMI 25 - 29.9
Obese	BMI >30 –
BMI not done	

2(a) ACTION: BMI 18.5 – 24.9 Normal weight
(Tick ALL actions taken)

- **GIVEN** brief advice / brief intervention (key nutrition messages) ☐
- **DIRECTED** to national guidelines on healthy eating ☐
- Patient declined/not interested ☐
- No action documented ☐

2 (b) ACTION: BMI 25 - 30 INCREASED RISK
(Tick ALL actions taken)

- **GIVEN** brief advice / brief intervention on benefits of weight reduction ☐
- **DIRECTED** to resources to help ☐
- Patient declined/not interested ☐
- No action documented ☐

2 (c) ACTION: BMI < 18.5 HIGH RISK
BMI > 30 HIGH RISK
(Tick ALL actions taken)

- **REFERRED** to Dietitian ☐
- Patient declined/not interested ☐
- No action documented ☐

PHYSICAL ACTIVITY STATUS AND INTERVENTION

1. In a typical week, how many days have you been physically active (PA) for total of 30 minutes or more?

- 0 days (Inadequate) ☐
- 1-4 days (Inadequate) ☐
- 5-7 days (Adequate) ☐
- Unable to be physically active ☐
- No information available ☐

2. If FOUR days or less, in a typical week have you been PA for either 150 minutes moderate or 75 minutes vigorous activity?

- Yes (Adequate) ☐
- No (Inadequate) ☐
- No information ☐

3. ACTION: System indicates if physical activity is inadequate
(Tick ALL actions taken)

- **GIVEN** brief advice / brief intervention on benefits of physical activity ☐
- **DIRECTED** to national website ☐
- Patient declined/not interested ☐
- No action documented ☐

Physical activity may include: walking or cycling for recreation or to get to and from places; gardening; and exercise or sport which lasts for at least 10 minutes

Recommended Physical Activity is at least 30 minutes of moderate intensity physical activity 5 days per week

Appendix B: Draft GP Lead Role Job Description & CHN presentation

Appendix B1: Job Description

To be agreed between both parties– this is contingent on arrangements for GP unit doctors being agreed at the same time.

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

GP Contract

GP involvement in Community Services

15th April 2019

V0.10

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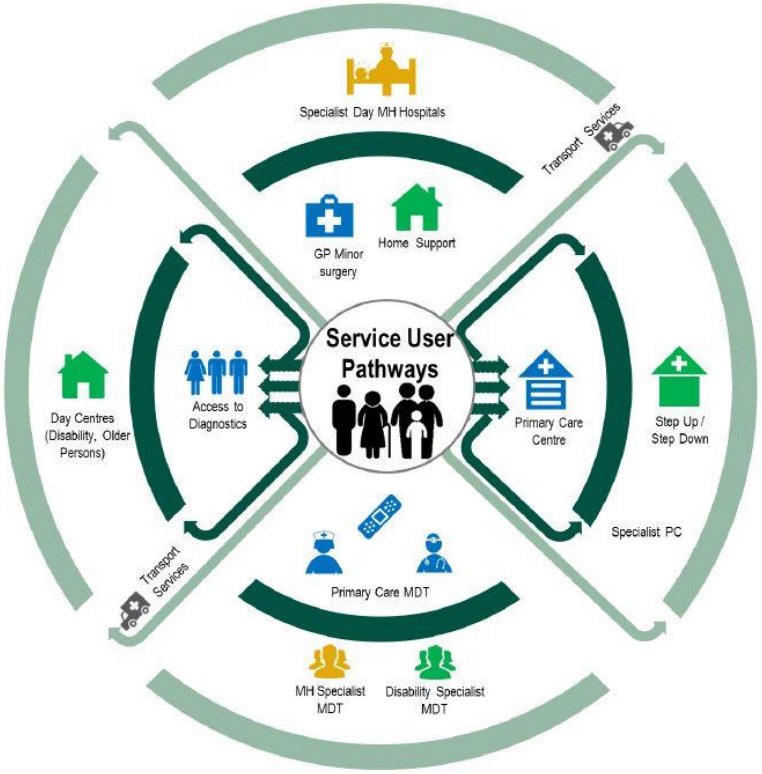
1. Model of Care for Community Healthcare

All services delivered through all Community Health Networks (CHN) in CHOs

- All service management is configured to CHNs or a cluster of CHNs
(frequency and volume dependent)



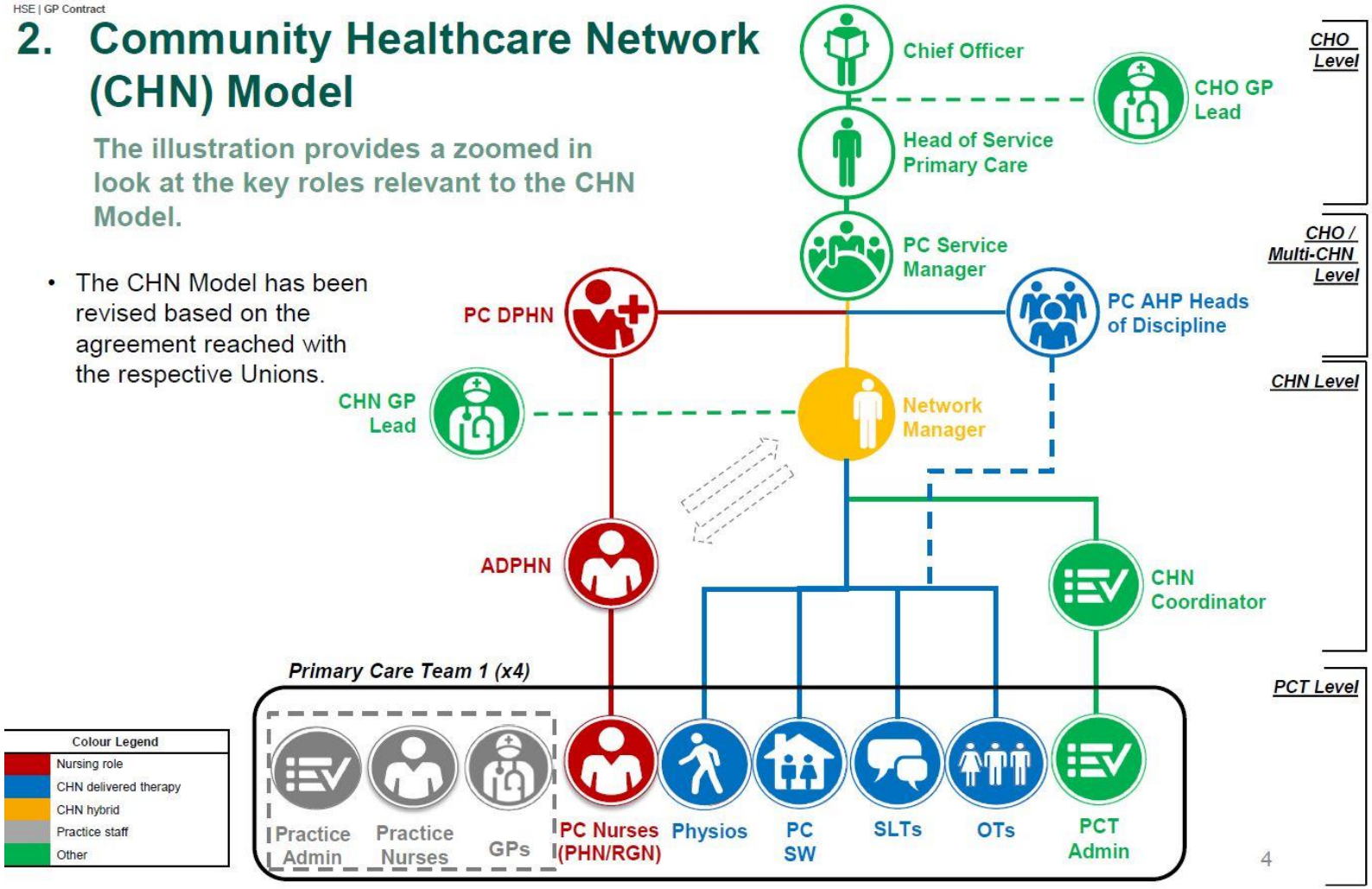
Primary Pathway / Service
Secondary Pathway / Service
Primary Care Services
Social Care Services
Mental Health Services

HSE | GP Contract

2. Community Healthcare Network (CHN) Model

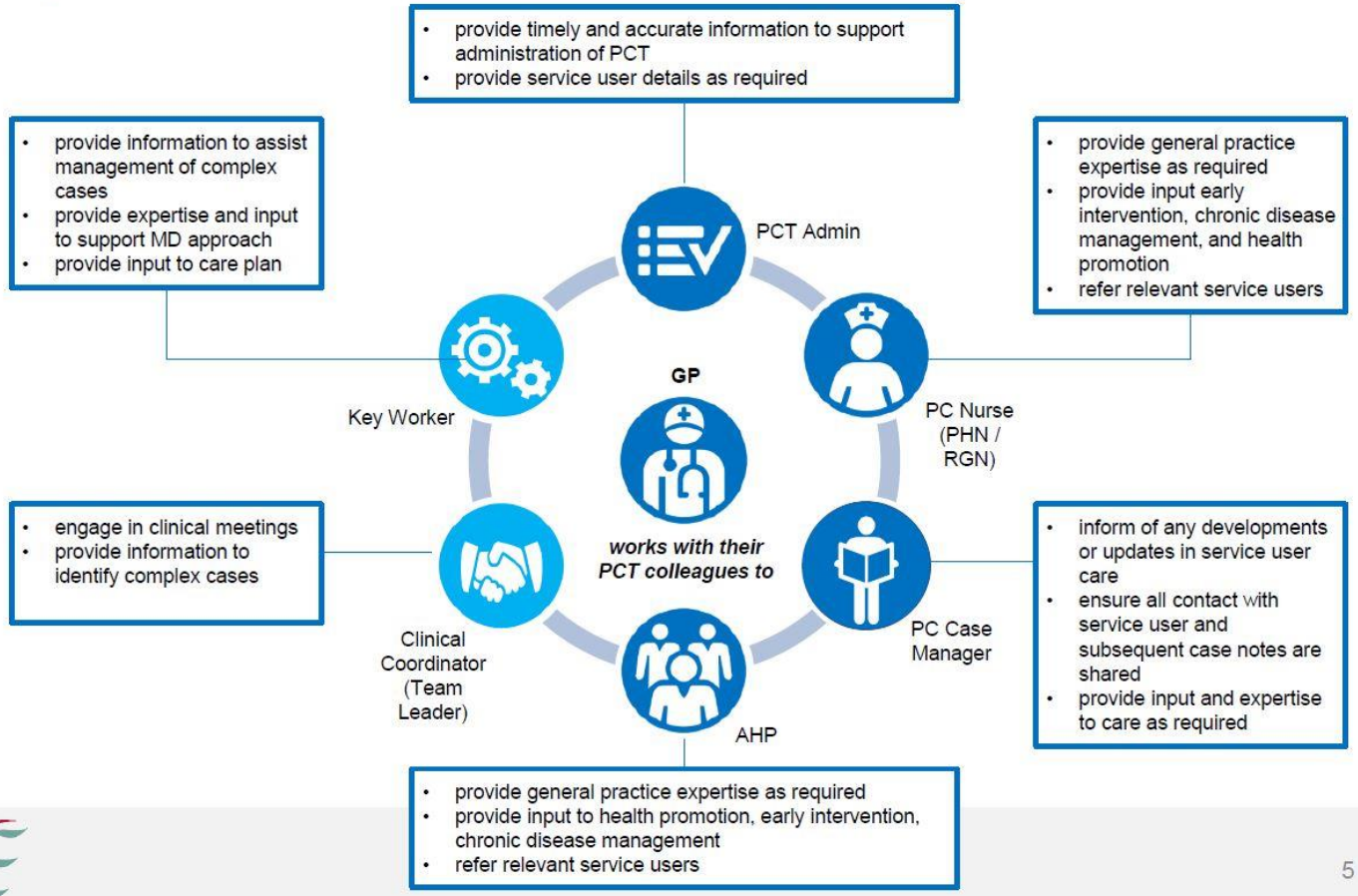
The illustration provides a zoomed in look at the key roles relevant to the CHN Model.

- The CHN Model has been revised based on the agreement reached with the respective Unions.



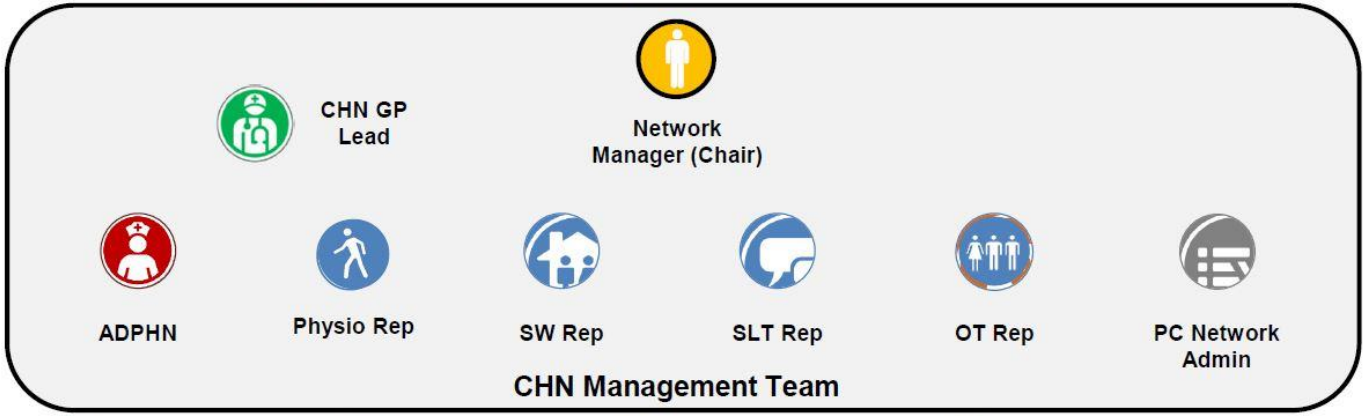
3. PC Team Interaction

Proposed interaction of GPs with the PC Team



4. CHN Management Team

CHN GP Lead integral to the CHN Management Team



CHN GP Lead

1. Provides GP leadership at a CHN level linking with all GPs in the CHN

ADPHN (CHN level)

1. Provide resource management to PHN / RGN
2. Provide clinical supervision to PHN / RGN

AHP Rep

1. Represent all Allied Health professionals

Network Manager

1. Ensure delivery of high quality, safe and integrated care within CHN
2. Provide day-to-day operational management of PC staff
3. Work with other services in provision of provide integrated care

PC Network Admin

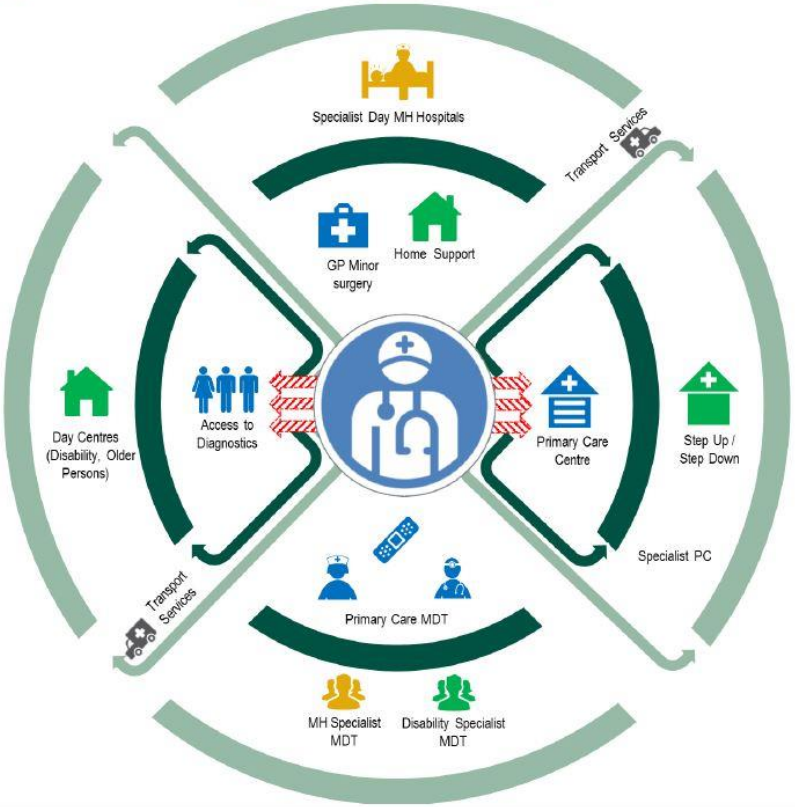
1. Provide administrative support to Network Manager
2. Ensure coordination across CHN
3. Manage liaison with PCTs

Purpose of the CHN GP Lead:
The Community Healthcare Network (CHN) GP Lead will support the development and maintenance of relationships between GP practices and Primary Care Teams in order to ensure delivery of high quality patient centred service to the local population. The CHN GP Lead will support the Network Manager and CHN Management Team to roll-out clinical programmes; develop innovative solutions and multidisciplinary approaches to challenges within the CHN; and to implement CHN structures and service delivery within CHNs.

5. Input towards Referral Pathways

A parallel design process is ongoing to define care pathways including GP referrals

- A process in ongoing to design the care pathways within the CHN Model
- The GP referral pathways will be an integral part of the future integrated care
- Input is sought from the GP community to help detail the care pathways
- GP's should be in a position to avail of both Primary and Secondary pathways / services



6. Phased Expansion post-Learning Sites

Upon completing 9 Learning Sites, a phased expansion will ensue for 87 remaining CHN's.

Expansion will happen on a proportional basis depending on the number of CHN's in each CHO

Learning Sites	Initial Expansion	Latter Expansion
9 CHN's (~10%)	40 CHN's (~41%)	47 CHN's (~49%)
1 in CHO 1	4 in CHO 1	3 in CHO 1
1 in CHO 2	4 in CHO 2	4 in CHO 2
1 in CHO 3	4 in CHO 3	3 in CHO 3
1 in CHO 4	7 in CHO 4	6 in CHO 4
1 in CHO 5	5 in CHO 5	5 in CHO 5
1 in CHO 6	4 in CHO 6	3 in CHO 6
1 in CHO 7	7 in CHO 7	6 in CHO 7
1 in CHO 8	6 in CHO 8	5 in CHO 8
1 in CHO 9	6 in CHO 9	5 in CHO 9
2019	2020	2021

Appendix C: GP Involvement in Community Healthcare Services

Appendix C1: GP Involvement in Community Healthcare services – Network Level Service Planning & Management

GP Involvement in Community Healthcare services – Network Level Service Planning & Management

Introduction

There is a strategic re-positioning of health services necessary in Ireland, supported by international practice, which sets out the need for the shift in provision of care from acute to community settings, supporting the prevention and management of chronic disease at a community level. Community Healthcare Networks are the building blocks of community care and will see a coordinated multi-disciplinary approach to care provision, providing better outcomes for people requiring services and supports both within and across networks. GPs are a crucial factor in the success of networks and the GP Lead role will play a major part in the management and delivery of services within the CHN. For GPs, optimising integrated service planning at a CHN level will support more coordinated care and reduce the burden of care from the GP by ensuring that primary care and other specialised services are available to whom and when they're needed.

Network Service Planning

In order to facilitate local planning for network services based on population need, bi-annual planning workshops will be held, jointly chaired by the Network Manager, the GP Lead and the Network Assistant Director of Public Health Nursing. The GP Lead will play a crucial role in these workshops and will act as the representative for all GPs in their CHN.

Frequency & Duration

The workshop will be held bi-annually. In line with publication of the National Service Plan, a workshop will allow network representatives to assess the most efficient and effective way to allocate available funding to network services. In May-June, a second workshop will allow adequate preparation and decision making for the requirements for the following year's NSP based on delivery of services and population needs. Each workshop will be two hours long.

Attendees

As well as the CHN team (comprising of the Network Manager, the ADPHN, the GP Lead, the Clinical Coordinators and a Patient Representative if appropriate) a GP representative from each practice will attend and participate in both workshops. The Clinical Coordinators from the CHN would attend to represent the views of their fellow primary care professionals. Depending on agreement with the appropriate representative bodies, nursing staff would be represented by Clinical Coordinators or a nursing specific representative.

Case Study - Illustration

At a CHN planning meeting in Ballyfermot, Dr. Quinn brings data from her fellow colleagues showing an increasing trend of re-admission to hospital with COPD exacerbation. This is backed up by data held by the Network Manager and anecdotally by the other primary care representatives who report an increased follow up for COPD patients required by GPs, PHNs, physios, OTs and dieticians. The team decide to prioritise additional pulmonary rehabilitation programmes in the network to combat this trend. This action results in self-empowerment and improved respiratory status and functional levels for the patients, gives carers more support and reduces the dependency on them and results in less admissions and shorter lengths of stay in acute care. It also results in reduced input needed from GPs and the other primary care professionals.

GP Cooperation & Participation Required

For the GP Lead, this will involve:

- Planning and prioritising CHN services in line with the population needs by attending biannual workshops with other key members of the CHN (see Network Service Planning).
- Representing GPs on the CHN network team and attending monthly management meetings (approximately four hours per month).
- Contributing to the development of Primary Care services within and outside the CHN
- Contributing to the integration of non-Primary Care and specialised services within the CHN.
- Being in direct and regular contact with HSE management.
- Encouraging GPs in their network to engage and communicate with other primary care professionals.
- Acting as a conduit between GPs and HSE management.

CHN Management Structure & Team Meetings

Purpose

The CHN team's purpose is to work with and provide management support to the Network Manager in decision making and provide leadership on the efficient, effective, safe management and delivery of a team based model of service, which is accessible, integrated and in line with national policy, legislative and service delivery frameworks.

Frequency/Duration

The CHN team is expected to meet monthly for approximately four hours. The timing of this meeting should be set in collaboration with all attendees and be cognisant of other commitments.

Membership

The CHN team will be chaired by the Network Manager, membership includes:

- GP Lead
- ADPHN
- Clinical Coordinators
- Patient/Community Representative (if appropriate)

HSE-provided Support

Administrative support will be provided to the CHN team by the **CHN Administration Coordinator** (Secretary) who will be responsible for scheduling meetings at appropriate times and locations (being cognisant of attendees work commitments and working locations. The CHN Administration Coordinator will also be responsible for preparation of all documentation required for the team

meetings, will take minutes at the meetings and will follow up with action owners to ensure progression of agreed actions.

Appendix C2.1: GP Involvement in Community Healthcare services – Multi-disciplinary Team Work and Clinical Team Meeting

GP Involvement in Community Healthcare Services – Multi-disciplinary Team Work and Clinical Team Meetings

Role of the GP in multi-disciplinary working within a CHN

Introduction

In order to deliver integrated, comprehensive care to individuals, primary care services including GP services, should be delivered as locally as possible. Local clinical team meetings within each Community Healthcare Network (CHN) provide the forum for multi-disciplinary care and to allow team members to develop a care plan to meet the complex needs of patients who require the diverse skills of different professionals working together to maximise the benefit of the care being provided.

The purpose of the clinical team meeting is to identify, plan and coordinate care in an effective and efficient manner. This is achieved by bringing the team together in order to:

- Respond to the needs of individuals and families with acute or on-going health needs in a timely fashion.
- Share information for the effective management of patient needs.
- Review and coordinate on-going care for individuals and families, including pathways into and out of services.
- Develop, plan, implement and evaluate a multidisciplinary care plan.

This enables the provision of a wide range of seamless services to patients which enhances continuity of care.

GPs and primary care professionals will continue to liaise and communicate with other primary team members on a one-to-one basis in person or by phone as necessary as part of appropriate communication on an on-going basis.

GP Cooperation & Participation Required

This will involve:

1. Referring any patients designated as a complex case and requiring discussion at a clinical team meeting (see Criteria for Referral to Clinical Meeting) to the appropriate Clinical Coordinator.
2. Attending clinical team meetings and discussing their relevant cases, approximately one hour a month per GP or GP Practice. In exceptional cases where the GP is unable to attend for any reason the GP should discuss with the case manager.
3. Giving clinical input where required.
4. Ensuring that their own clinical notes are updated in accordance with the care plan
5. Where the GP sees it as necessary given his/her relationship/knowledge of the patient the GP may agree to act as a Key Worker (details below).
6. Ensuring that the Clinical Coordinator is aware of any relevant updates in the patient's case note discussed at a clinical team meeting.

Clinical Team Meeting Membership

Depending on the need of the patient being discussed, a clinical team meeting may have attendance from physiotherapists, occupational therapists, speech and language therapists, social workers, nursing staff, dieticians, podiatrists and GPs. On occasion, other specialised service representatives may be invited to attend e.g. mental health nurses, community pharmacists, home support managers.

HSE-provided Support

Every meeting will be chaired by a **Clinical Coordinator** who will be appointed from the existing pool of therapy and nursing staff in each primary care team and will rotate yearly. They will:

- Chair Clinical Meetings
- Ensure all attending members, practice staff and GPs, receive a copy of the meeting agenda
- Provide a single point of contact for GPs
- Based on a "best practice" approach circulate to GPs the list of patients to be discussed at least seven days in advance of the meeting to facilitate the required preparation, having regard to the fact that meetings should take no more than an hour.
- Schedule meetings to suit GPs commitments
- Encourage discussion, input, and facilitate consensus in relation to clinical discussion
- Ensure a care plan is completed for patients, as required
- Send a copy of the care plan to all relevant GPs
- Ensure a Key Worker is identified where required.

In addition, each clinical team meeting will be attended by an **administrative resource** who will:

- Ensure the venue is in, or close to, the attending GP practice in accordance with GP requirements
- Circulate and follow up on documentation as required
- Be responsible for minute taking, record keeping and circulation of meeting documentation to all team members including the GPs.

Note on Clinical Accountability

Each clinician will retain accountability for his/her work in accordance with his/her professional standards and will have responsibility for his/her contribution to the care of the patient.

Criteria for Referral to Clinical Meeting

The guideline relates to those patients from within the population of the CHN to be discussed at clinical team meetings, as determined by primary care professionals and GPs. Not all patients require discussion at the Clinical meeting and patients should not be designated as complex cases unless there is a clear need. Similarly not all complex patients need discussion at clinical team meetings as they may be stable or their care needs are changing but can be managed by the professionals involved through regular communication and coordination. If a patient's pathway is clear and non-complex, e.g. they require a referral from their GP for a point in time physiotherapy session, there will be no need for their care to be discussed at a multi-disciplinary team (MDT) meeting.

The case study below provides an illustration of the type of profile of the patients envisaged who would be appropriate for inclusion in such clinical meetings. It is fully acknowledged that decisions are based on "best judgement" which should be used when designating a patient as a complex case. A care plan will be developed for each patient discussed at a clinical team meeting and will be held by the person acting as their Key Worker. A list of complex cases will be held by each administrator which will feed into a Network-level complex case list held by the CHN Coordinator.

Case Study

Tom is a 65 year old male. He has a history of reasonably well-controlled psychosis but has developed Parkinson's as a result of his medication. Cared for solely by his wife Marie, Tom is increasingly disabled with mobility issues and urinal incontinence. Input from Mental Health Services to reduce the effects of his medication have not been successful. Both Tom and Marie are regular visitors to Dr. Larkin, their local GP. Marie in particular is getting increasingly stressed at the situation and is unsure how long more she will be able to care for Tom. Dr. Larkin brings Tom's case to a clinical team meeting where he leads a discussion with the PHN, the OT, the physio and the community pharmacist. The team decide on a joint visit to Tom from the PHN, the OT and the physio so they can assess the situation and identify potential risk of trips and falls and assess that Tom's incontinence is caused by his reduced mobility. The physio arranges for Tom to visit her outpatient clinic to work on his mobility issues while the OT supplies a commode and other equipment for Tom to help him with his incontinence. The Community Nurse has included Tom on the respite list. Separately, Dr. Larkin discusses Tom's medication with the pharmacist and they make some small changes to optimise his medication. Although small interventions by each professional, coordinating Tom's care in this way has a considerable positive impact. Tom's mobility is improved and his incontinence ceases. His quality of life is improved and he avoids moving to long-stay care. Marie feels more supports and her stress levels reduce.

Appendix C2.2: Clinical Meeting Guidelines

The frequency of clinical team meetings should be based on need and determined by each team. However, the approximate time commitment each GP should expect to attend is an hour long meeting on a monthly basis.

Structure of Clinical Team Meetings

- The Clinical Coordinator chairs the meeting
- At the initial meeting the operational guidelines should be agreed by team members
- An agenda should be prepared and circulated in advance of each meeting. Standard agenda items must include:
    - Welcome matters arising.
    - New referrals for discussion.
    - Cases for discussion.
    - Cases scheduled for review.
    - A.O.B. and next meeting.

Cases for Review

- During clinical team meetings the primary care professionals will agree a review date for each case that has a care plan in place
- The Administrator will maintain a register of cases for review / reviewed at clinical team meetings and add these cases to the clinical team meeting agenda as necessary
- If a case is more complex and requires longer discussion time, and/or additional network services/outside agency involvement, a specific case discussion/family meeting will be arranged where exception circumstances require

Conclusion of Cases

- Cases will be concluded from the clinical team meeting review process when interventions on the care plan have been agreed and the required follow up has been completed. A single discipline may remain involved but the case is closed to clinical team meeting discussion, for example in cases such as :
    - Long term care.
    - RIP.
    - Moved to another area.

  On conclusion of a case, a Closing Summary Sheet must be completed by the Key Worker working with the individual/family. The Administrator will maintain a record of and circulate copies of the Closing Summary Sheets to each of the relevant clinical team members.

Clinical Team Meeting documentation

- A care plan should be completed for each case referred for discussion at the clinical team meeting and signed by the Chairperson (Clinical Coordinator)
- It is the responsibility of each professional to ensure that his/her clinical notes are updated in accordance with the care plan agreed at the clinical team meeting
- A record of attendance and all patients discussed (new and review) should be maintained by the administrator.

Feedback to Patients from Clinical Team Meetings

- In cases where a Key Worker has been nominated, he/she will take provide feedback to the patient.

Description of Key Worker Role

The Key Worker is the person nominated to:

- Link the person into the required services.
- Coordinate service delivery in accordance with the care plan.
- Communicate with the patient on behalf of the primary care professionals.
- Act as the lead contact for the patient and other staff and professionals.
- Link with relevant workers in other services as required e.g. disabilities/mental health.

Where the GP sees it as necessary given his/her relationship/knowledge of the patient the GP may agree to act as a Key Worker.

Appendix D: eHealth Summary/Shared Care Record Data

1.0 Subject of Care

The patient's demographic details for the purpose of an electronic patient summary.

No.	Data Item	Usage
1.1	**Title**	A patient's preferred title, for example, Mr, Doctor, Mrs.
1.2	**Forename**	A patient's first name or given name(s) as stated on the birth certificate.
1.3	**Surname**	The second part of a patient's name denotes their family or marital name.
1.4	**Address**	The particulars of the place where the patient lives.
1.5	**Date of birth**	The patient's date of birth should be provided.
1.6	**Sex**	Gender identity is a person's sense of identification with either the male or female sex, as manifested in appearance, behavior and other aspects of a person's life.
1.7	**Health identifier**	Both the code and the code type that the code relates to should be provided, for example, 0987654321 Individual Health Identifier. Other identifiers which may be carried in this field include the General Medical Scheme, Drug Payment Scheme, Long Term Illness Scheme and Hardship Scheme identifier.
1.8	**Next of Kin (optional)**	A patient's nominated next of kin, including their name and contact details such as telephone number.

2.0 Health Condition

GPs will choose the health conditions they deem to be appropriate for inclusion in the summary care record by selecting from the dictionary of standard terms from within the practice system using ICD10, ICPC, or free text. (ICPC will be phased out over a 2 year period).

Data will be extracted from a time going forward i.e. the system will not arbitrarily take historic data from the patient record in relation to conditions. An appropriate lead in time will be put in place prior to the introduction of the summary care record.

No.	Data Item	Usage
2.1	**Current health condition**	The name of the condition.
2.2	**No Health Condition Identified**	An indication that the patient has no known health conditions (using ICD10)

3.0 Medication Prescribed

A list of the current medications prescribed for the patient.

No.	Data Item	Usage
3.1	**Medicinal product**	The medicinal product that is prescribed. This field covers where package-level dispensing occurs or where a formulation takes place in the pharmacy in order to produce the substance dispensed to the patient.
3.2	**Dose form strength**	This field consists of a size value and unit, a combination of both to define the strength, for example, 250mg or 1g.
3.3	**Dose form type**	This field describes the dose type, such as tablet or vial.
3.4	**Number of units per intake**	This field is used to describe the number of units(s) to be taken at a given time.
3.5	**Frequency of intake**	This field is used to describe the frequency of the dose that should be taken by the patient.
3.6	**Duration of treatment**	This field is used to describe the duration of the dose described should be taken by the patient.
3.7	**Route of administration**	The route of administration is used to describe how the medication should be administered to the patient, for example orally, IV injections, rectally or topical administration
3.8	**Date medication prescribed**	Date field which indicates when the treatment was prescribed.

4.0 Allergies

This section describes the agent that is responsible for the adverse reaction. It includes allergies, intolerances and adverse reactions to all substances, not only those arising from medications or medicines. It also describes other clinical information that is imperative to know so that the life or health of the patient does not come under threat. For example, intolerance to aspirin due to gastrointestinal bleeding.

No.	Data Item	Usage
4.1	**Substance**	The substance that caused the allergy to occur. Example of a substance could include peanut, penicillin and so on.
4.2	**Reaction (if known)**	A subjective assessment of the type of reaction event as evaluated by the healthcare practitioner. Examples include rash, diarrhea and anaphylaxis.
4.3	**Severity of reaction (if**	An assessment of the severity of the reaction event as evaluated by the healthcare practitioner.

	known)	Examples include severe, serious, moderate or minor.
4.4	**Reaction onset date (if known)**	This field is used to capture the date and or time (or both) of the onset of the allergic reaction.

5.0 Procedures

GPs will choose the medical or surgical procedures they deem to be appropriate for inclusion in the summary care record by selecting from a dictionary of standard terms from within the practice system or free text.

Data will be extracted from a time going forward i.e. the system will not arbitrarily take historic data from the patient record in relation to procedures.

No.	Data Item	Usage
5.1	**Procedure**	The name of the procedure.

6.0 Vaccinations

Details of immunisations or vaccinations that have been administered to the patient.

No.	Data Item	Usage
6.1	**Names of vaccinations**	The name of the vaccination given to the patient.
6.2	**Vaccination date**	This field indicates the date and or time when the vaccination was administered to the subject of care

Appendix E: Service Modernisation & Reform, Fees & Allowances, Chronic Disease Management Programme & Special Items of Service

Figure 1: Capitation Payments

Type of Patient	6-15 (Male)	6-15 (Female)	16-44 (Male)	16-44 (Female)	45-64 (Male)	45-64 (Female)	65-69 (Male)	65-69 (Female)	70+	70+ in a Private NH
01 July 2019										
Current Capitation	€43.29	€43.79	€55.26	€90.37	€110.38	€121.29	€116.28	€129.72	€271.62	€434.15
Indicative Service Modernisation & Reform Fee 2019	€8.67	€8.77	€11.07	€18.10	€22.11	€24.29	€23.29	€25.98	€54.40	€86.95
2019 Total*	**€51.96**	**€52.56**	**€66.33**	**€108.47**	**€132.49**	**€145.58**	**€139.57**	**€155.70**	**€326.02**	**€521.10**
% Increase on Current Rate	20.03%	20.03%	20.03%	20.03%	20.03%	20.03%	20.03%	20.03%	20.03%	20.03%
01 January 2020										
Current Capitation	€43.29	€43.79	€55.26	€90.37	€110.38	€121.29	€116.28	€129.72	€271.62	434.15
Indicative Service Modernisation & Reform Fee 2019	€10.09	€10.21	€12.89	€21.07	€25.74	€28.28	€27.11	€30.25	€63.33	€101.23
2020 Total*	**€53.38**	**€54.00**	**€68.15**	**€111.44**	**€136.12**	**€149.57**	**€143.39**	**€159.97**	**€334.95**	**€535.38**
% Increase on 2019 total	2.74%	2.74%	2.74%	2.74%	2.74%	2.74%	2.74%	2.74%	2.74%	2.74%
01 January 2021										
Current Capitation	€43.29	€43.79	€55.26	€90.37	€110.38	€121.29	€116.28	€129.72	€271.62	434.15
Indicative Service Modernisation & Reform Fee 2019	€15.55	€15.73	€19.85	€32.46	€39.64	€43.56	€41.76	€46.59	€97.56	€155.93
2021 Total*	**€58.84**	**€59.52**	**€75.11**	**€122.83**	**€150.02**	**€164.85**	**€158.04**	**€176.31**	**€369.18**	**€590.08**
% Increase on 2020 total	10.22%	10.22%	10.22%	10.22%	10.22%	10.22%	10.22%	10.22%	10.22%	10.22%
01 January 2022										
Current Capitation	€43.29	€43.79	€55.26	€90.37	€110.38	€121.29	€116.28	€129.72	€271.62	434.15
Indicative Service Modernisation & Reform Fee 2019	€20.99	€21.23	€26.79	€43.81	€53.51	€58.80	€56.37	€62.89	€131.69	€210.48
2022 Total*	**€64.28**	**€65.02**	**€82.05**	**€134.18**	**€163.89**	**€180.09**	**€172.65**	**€192.61**	**€403.31**	**€644.63**
% Increase on 2021 total	9.24%	9.24%	9.24%	9.24%	9.24%	9.24%	9.24%	9.24%	9.24%	9.24%
*Total = Current Capitation + Indicative Service Modernisation & Reform Fee										

Figure 2: Indicative Expenditure Increases in Respect of Certain Fees and Allowances

Fees & Allowances	Base 2017	July 2019 - Dec 2019	2020	2021	2022	Total
Fees						
Dispensing Fees*	€ 900,000	€0	€ 73,062	€ 12,474	€ 92,665	€ 178,200
Allowances						
GP Support for areas of Deprivation	€0	€1,000,000	€1,000,000	€0	€0	€2,000,000
Rural Practice Allowances	€4,645,500	€0	€376,000	€0	€0	€376,000
Paternity Leave Increase	€0	€97,632	€0	€0	€0	€97,632
Maternity & Paternity Locum Increase	€1,875,795	€0	€1,955,032	€0	€0	€1,955,032
Total Allowances	€6,521,295	€1,097,632	€3,331,032	€0	€0	€4,428,664
Total Fees & Allowances	**€7,421,295**	**€1,097,632**	**€3,404,094**	**€12,474**	**€92,665**	**€4,606,864**

* Dispensing Fee Rate		Base	2020	2021	2022
Opt In GP		€38.03	€42.39	€43.12	€48.58
Pilot GP		€43.88	€48.90	€49.74	€56.05

Figure 3: Chronic Disease Management Fees

	Opportunistic Case Finding	Preventive Programme	Chronic Disease Management Programme
Indicative Fees	€60 per assessment	€82 p.a. + superannuation	Dependent on number of covered conditions as follows: 1 condition - €210 + superannuation 2 conditions - €250 + superannuation 3 conditions - €300 + superannuation

Figure 4: Special Items of Service

Special Items of Service	Activity Level	Fee per Item	Full Year €
Summary			
A1. Therapeutic Haemochromatosis	24,000	€ 100	€ 2,400,000
A2. Involuntary Admissions			
Involuntary Admissions in hours	800	€ 150	€ 120,000
Involuntary Admissions out of hours	1,200	€ 150	€ 180,000
A3. Virtual Clinics	17,500	€ 100	€ 1,750,000
Total Special Items of Service			**€ 4,450,000**

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