Irish College of General Practitioners

Coláiste Dhochtúirí Teaghlaigh Éireann

SHAPING THE FUTURE

A Discussion Paper on the Workforce & Workload Crisis in General Practice in Ireland

October 2022

Contents

Introduction

General Practitioners (GPs) and their Practice Teams are pivotal to societal wellbeing. GPs provide comprehensive whole person and continuity of care. The GP is most likely the first point of contact in matters of personal health; coordinates the care of patients and refers patients to other specialists; cares for patients of all ages and disease categories and cares for patients over a period of their lifetime. However, general practice is under serious strain.

GP practices are busier than ever, but less able to find replacements for retiring GPs, or new GPs to expand their practices and deal with growing workloads. Outlined in this paper in the appendix are six real time practice profiles. They reinforce the challenges we are facing but they also detail the great satisfaction of being a GP, whether that is in a large urban practice, rural practice or a smaller practice. Being a GP is the most wonderful professional career. However, we must resource, expand and be creative in our thinking to ensure we do not cease to be patient centred, and patient focused.

We are in the midst of a general practice workforce and workload crisis that is not going away. The COVID-19 pandemic has brought longstanding workforce and workload challenges to a head. This notwithstanding, the COVID-19 pandemic has demonstrated that general practitioners are flexible, adaptable, and able to embrace change.

In this discussion paper, based on the findings of research and an ICGP Working Group (see Appendix 1), we have identified some deep-seated problems which feed into the crisis. In this discussion paper we illustrate the context within which general practice now operates and the challenges it faces.

We have listed a number of proposed solutions to start the discussion with all key stakeholders and if implemented we feel can support and enhance continued timely patient access to high quality GP care. We also realise that some of the areas we address and indeed some of the

solutions we propose may sit uncomfortably with some of our members and my colleagues. However, we have to reach the point after discussion and analysis that we have solutions that are acceptable, and capable of being implemented.

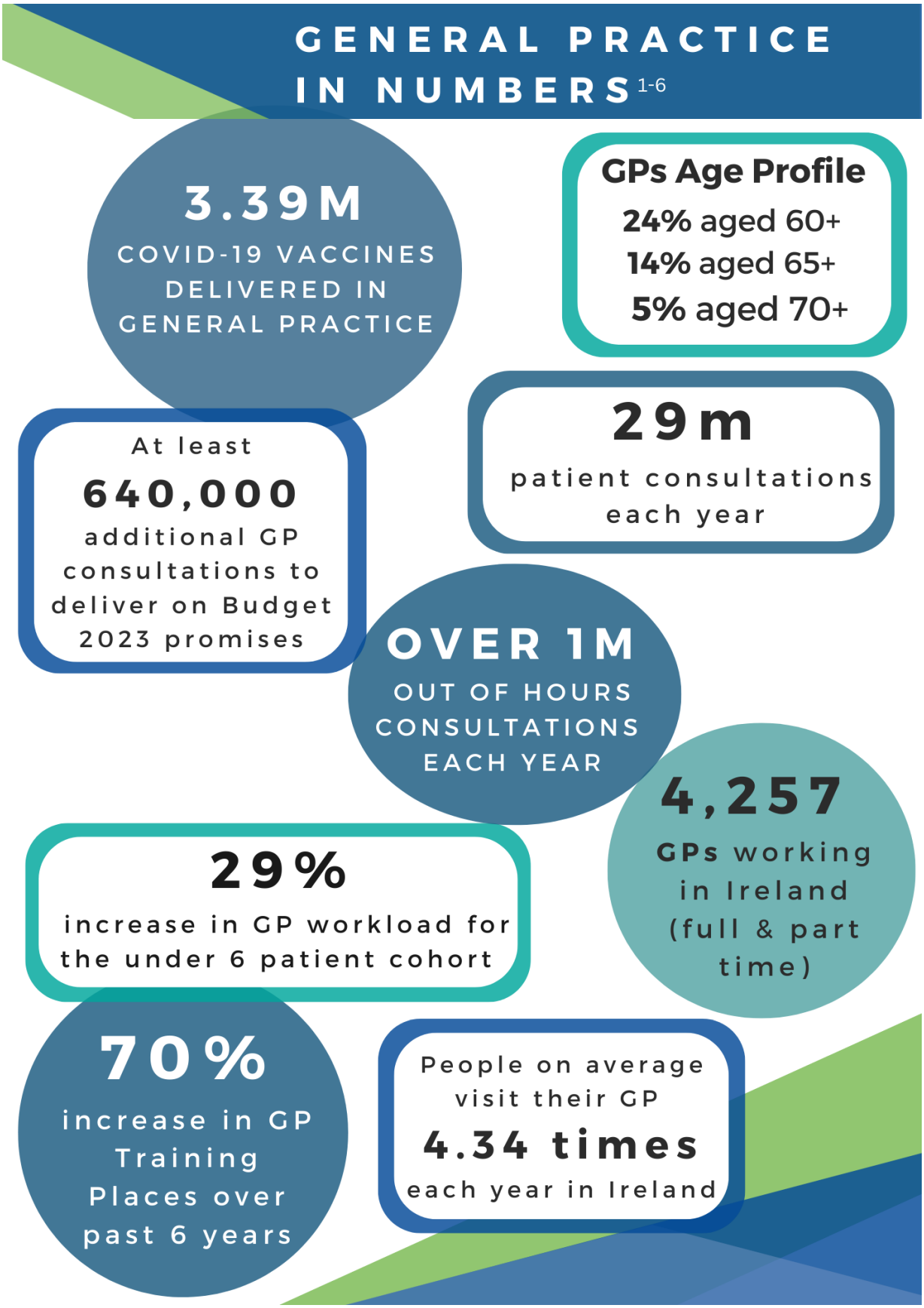
Addressing the general practice workforce and workload crisis will require meaningful engagement of all stakeholders with sufficient resources and 'real-time' data analytics. Working in partnership with the State agencies, we can deliver sustainable timely access to high quality GP care for all patients. We again call on the Minister for Health to establish a 'Working Group on the Future of General Practice'. This would ensure that the key stakeholders (Government, Health Services Executive (HSE), Department of Health (DoH), Irish College of General Practitioners (ICGP), Irish Medical Organisation (IMO), Irish Medical Council (IMC), Irish General Practice Nurses Educational Association (IGPNEA) and patient representatives) act now and collectively address the challenges facing general practice, to protect patient care. ICGP is committed to working collaboratively and collectively to resolve the crisis that is impacting on our ability to deliver timely patient care.

As a Postgraduate Training Body the ICGP is committed to producing highly trained GPs and increasing trainee numbers to meet healthcare demand.

GPs are committed to their patients and have a responsibility to them and to wider society to resolve the many challenges as a matter of urgency. The ICGP is ready to play its part. Critical to progress, however, is political commitment.

I would like to sincerely thank Professor Tom O'Dowd for chairing the Working Group and his colleagues for delivering this significant discussion paper.

Dr John Farrell
Chairperson
ICGP
October 2022


GENERAL PRACTICE IN NUMBERS 1-6
3.39M
COVID-19 VACCINES DELIVERED IN GENERAL PRACTICE
GPs Age Profile
24% aged 60+
14% aged 65+
5% aged 70+
29m
patient consultations each year
At least
640,000
additional GP consultations to deliver on Budget 2023 promises
OVER 1M
OUT OF HOURS CONSULTATIONS EACH YEAR
4,257
GPs working in Ireland (full & part time)
29%
increase in GP workload for the under 6 patient cohort
70%
increase in GP Training Places over past 6 years
People on average visit their GP
4.34 times
each year in Ireland

Executive Summary

"Leadership and learning are indispensable to each other." **John F. Kennedy**

As the Irish College of General Practitioners approaches its 40th year anniversary (1984-2024), it remains at the forefront of general practice education, training, advocacy and leadership. We have seen leaders within the general practice specialty impact not only general practice but the wider society. However, leadership is at its most important at a time of crisis and we are at that point.

This discussion paper attempts to point to a road forward; it is not negative as we have no time to be negative; it is solutions-focused and presents the reality of general practice as it exists in 2022 and where we, as a College, see its future. This discussion paper is based on our knowledge and understanding of our members and their patients within a healthcare system that is under significant continuing pressure. As a College with members totalling in excess of five thousand, who perform twenty-nine million consultations per year, we have a critical level of responsibility. This discussion paper also attempts to deal with the complicated issues of corporate general practice and private health insurance. We need to discuss where both sit within the provision of healthcare in relation to the delivery of general practice services.

We list ten potential solutions; and potential is all they can be because ICGP in its own right cannot implement them. However, we see this paper as opening the discussion and providing a framework for the 'Working Group on the Future of General Practice'; that we again ask the Minister to establish. One of the key elements within this discussion paper is the six current practice profiles which are a real time picture of general practice. They are full of optimism, but they clearly reflect the challenges. Yet the ambition remains. We cannot afford to lose that.
We can only reach a satisfactory end point with consultation and collaboration. We are ready to lead to design the future of general practice.

Summary of Proposed Solutions

1. **GP Led multidisciplinary teams.** We need to further develop the multidisciplinary Primary Care teams (nurses, pharmacists, phlebotomists, healthcare assistants, etc.) within general practice. The HSE are developing the "Enhanced Community Care" initiative and it is hoped that this will incrementally support GPs and our patients in timely access to clinical expertise, diagnostics and therapies. It is important that expansion in both areas is conducted simultaneously.

2. **The current number of approximately two thousand General Practice Nurses (GPNs)[7] needs to be doubled at a minimum.** We need substantially more general practice nurses, with resourcing and supports comparable to secondary care nurses. The ICGP and our colleagues in the Irish General Practice Nurses Educational Association (IGPNEA) have recently initiated engagement with our universities to deliver high-quality education to train general practice nurses.

3. **The relevant statutory bodies need to provide the resources to support the future career expectations of our doctors.** We need to take a realistic approach to the future career expectations of our young trainees and GPs and provide supports to ensure GPs have the option to undertake these careers.

4. **Suitable premises need to be provided for GPs and their teams.** As GP-led primary care becomes a reality, the demand for suitable premises will increase. Imaginative arrangements with leases and ownership need to be explored and delivered.

5. **The ICGP is proactively exploring a programme that will fast track suitably qualified GPs and enable them to qualify to take on a GMS list.** This initiative is titled the 'non-EU rural GP programme' and is an important component of the multi-faceted ICGP response to our severe GP workforce crisis.

6. **Increased use of remote consulting by the patients' own GPs should be explored.** However, we need to ensure that strict guidelines governing video and telemedicine, along with monitoring of outcomes to ensure its suitability to various patient groups are in place.

7. **GPs need to be incentivised to set up in rural Ireland and GP Training needs to incorporate specific time spent in rural Ireland as part of its training programme.** Rural general practice needs special supports to survive, and general practice must include a career pipeline with a specific rural focus.

8. **The role of the practice manager needs to be further developed to enable GPs to focus on clinical care and spend less time on the business aspects of general practice.** GPs need to spend less time on administrative work and more time on clinical work including *non-patient facing* clinical activity.

9. **To encourage more graduates to enter the specialty of general practice, medical schools need to increase the exposure time to general practice within the medical curriculum.** Not enough graduates of Irish medical schools select general practice as a career, leaving our long-term workforce planning in a highly vulnerable position. We need to adopt strategies similar to many other countries which have robustly engaged with the medical schools and successfully increased student selection of general practice careers.

10. **Sustained investment is required to harness and deploy GP data-informatics to ensure a responsive, effective and innovative service.** Data drives modern health services, informing, supporting and driving policy and practice. General practice is a data-rich environment.

Part One

What is General Practice and where does it belong in Irish Healthcare?

As of September 30th, 2022, there are 4,257 general practitioners (GPs) working in general practice.[1]

Excluding those who may not be working in mainstream general practice here, this reduces the number to 4,187 GPs which equates to 2,807 full time equivalents based on the number of clinical sessions recorded.[1] There are 932 GP trainees working in general practice on a supervised basis and who are undertaking the ICGP four-year National GP Training Programme.[6]

> "You just cannot whistle up a few GPs when you run short. It is not like that. You have to factor in 4-5 years of medical school, and intern hospital year followed by 4 years in a GP training scheme of selected hospital posts and general practices. That is nearly 10 years in all."
>
> Comment by a GP trainer, 2022.

General practice is the workhorse of the health services in Ireland. GPs and GPNs undertake in excess of 29 million consultations per year.[2] Additionally over 1 million consultations are delivered in GP Out-of-Hours (OOHs) clinics throughout the country.[3] These are evening, night-time and weekend clinics that are serviced by the same GPs that work during the day in a local area. GPs have played an agile and crucial frontline role at all stages of this COVID-19 pandemic. GPs and GPNs administered a total of 3.39 million COVID vaccines,[4] with 307,487 vaccines in the week commencing 20th December 2021.[4]

GP care has become complex in the face of medical progress, the transfer of hospital care, rising patient expectations and bureaucracy. General practice retains the highest levels of trust among all healthcare providers.[8,9]

General practice is fundamental to delivering timely, high-quality, accessible healthcare. International evidence shows that healthcare systems with strong primary care have better, more equitable population health outcomes and are cost effective.[10]

Ireland has one of the highest rural based populations in Europe – more than 1.6 million people, from a total population of 5.1 million.[11] Irish rural practices have a very high proportion of older people, with more health needs, and they face significant challenges in terms of geographical access and financial costs.[12]

What is General Practice care?

General practice is now seen as:[13]

- The patient's first point of contact with the health services. All else in the health service flows from that encounter.
- Person-centred.
- Comprehensive care from the beginning to the end of life.
- Coordinating care between the many agencies involved in the care of complex chronic illnesses.

In this context, general practice is key to:

- Timely equitable access to high quality care.
- Urgent and Acute care.
- Continuity of care.
- Local availability.
- Access to clinical knowledge and expertise.
- Generalist care.

General practice in Ireland provides professional quality care, at the heart of the local community. It is the cornerstone of the Irish health service. GPs are the first port of call for most patients.

On a normal day, a GP must deal with multiple issues presented by patients, from a depressed young adult to a new-born baby, to an elderly woman with several complex needs. General practices are not a generic group - they vary hugely between larger urban group practices in suburbs, to smaller rural practices, and practices in deprived areas, all with a high level of complexity. During the pandemic, GPs pivoted to telemedicine to ensure continuity of patient care.

General practices are under significant pressure. The population continues to increase with our population now at 5.1 million, an increase of 7.6% since 2016,[14] and people are living longer. However, there has not been a similar increase in the General Practice workforce to deal with the many increasing challenges. GPs are dealing with highly complex illnesses from a wider range of patients, under very challenging circumstances. GPs work on average almost 10 hours per day in practice.[15]

Looking at those working in general practice, 56% are female.[1] The proportion of females among all clinically active doctors on the medical register is 46%.[1] The average age of GPs in practice is 50.0 years.[1] This is higher than the average age of all clinically active doctors on the Medical Council register which is 44.2 years.[16] The average age of female GPs in practice is significantly lower than male GPs in practice, 46.9 years compared to 53.9 years respectively.[1] When we compare the GP number and FTEs, we see the greatest disparity is in the younger age groups indicating that more GPs in these age groups are working less than full time in clinical practice (many have other key roles e.g., teaching, research).[1]

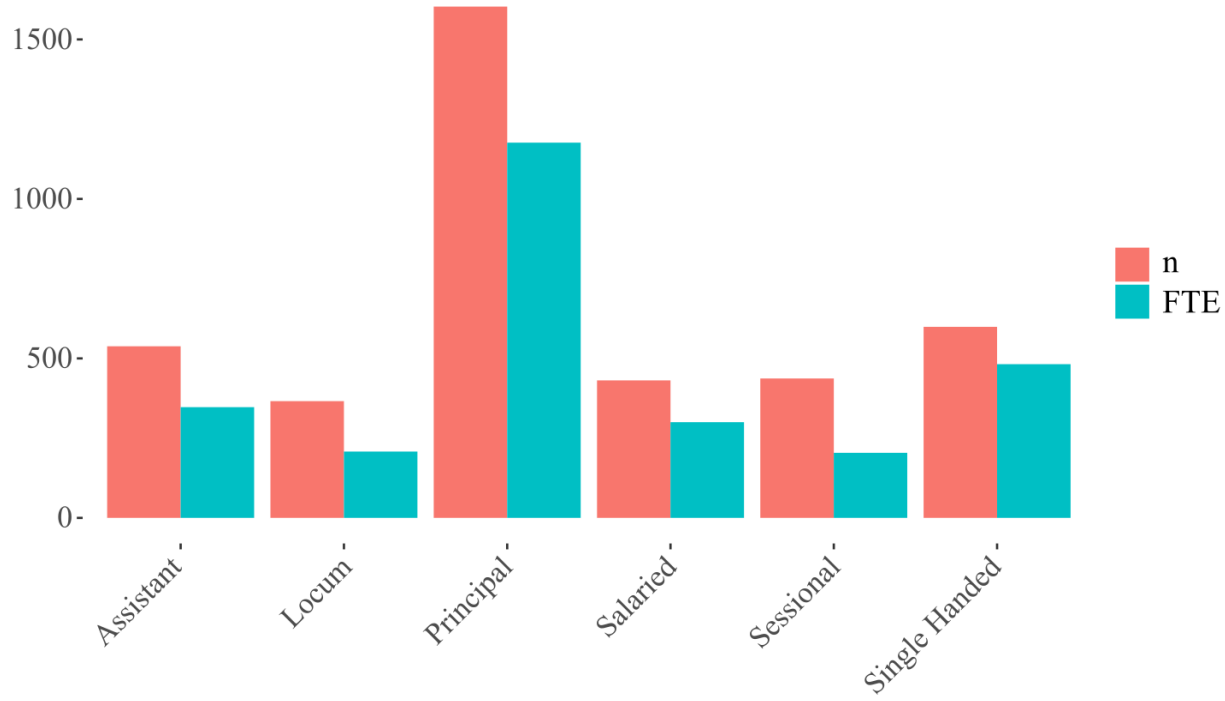
Looking at those who are working (4,187 GPs) in general practice, 24% (989) are aged 60+ years and therefore due to retire within ten years, 14% (589) are aged 65+ years and are therefore due

to retire within five years. However, it is notable that almost 5% (221) of those working in clinical practice currently are aged over 70 years.[1]

GP number and FTEs by age group

Among those working in clinical general practice, almost 14% report being single handed; and these GPs are least likely to be working part-time.[1]

GP number and FTEs by position



Overall, 45% of GPs are working <8 sessions per week in clinical general practice.[1] The normal GP working day is 10 hours on average.[2] A GP working week of eight clinical sessions is working 40 hours, excluding additional GP OOHs, and continuing professional development.[15] Two hours of clinical work generates one hour of administrative work. [2, 15]

Reducing one's clinical sessions may be a means of addressing quality of life issues [17] and may point to GPs engaging in careers which are not totally focused on clinical practice. However, the trend of decreased clinical sessions has consequences for a profession which has had a consistent short supply and will impact on replacement ratios. It has been forecast that a 37% rise in the primary care workforce is needed to meet demand.[18]

Recent work published by the ICGP calculated a total of 29 million consultations (GP and GPN) take place in general practice annually with GPs spending an average of 13.7 minutes per consultation.[2] The same study estimated that Irish people visit their GP 4.34 times a year,[2] similar to data reported elsewhere. This increases to 5.91 general practice visits per person per year when both GP and GPN visits are included. [2]

Part Two

Why do we have a General Practice workforce and workload crisis?

We are experiencing a workforce and workload crisis in general practice in Ireland with a deficit of general practitioners. Our population is growing and getting older.

A recent ICGP survey shows that only one in five (21%) GP practices can take new GMS patients, and one in four (26%) can take new private patients.[19]

The factors contributing to our GP workforce deficit are:

- we have a growing population.
- people are living longer with incrementally complex care needs.
- our GP workforce is ageing.

The factors contributing to general practice workload issues are:

- Sláintecare policy is to expand free GP care to all.
- Transfer of secondary care work into general practice.
- COVID-19 related workload.

Our population is growing and recently exceeded five million people.[14] Demand for healthcare is expected to grow significantly in the next 15 years as a result of demographic and other changes in Ireland and is projected to result in up to a 46% rise in demand for primary care.[18] The Department of Health forecasts a 59% growth in people aged over 65 years and 95% growth in the over 85-year-old population by 2025. Older people are "*higher users of health services*".[18] We do not have enough GPs to meet the current or future needs of our expanding and ageing population with highly complex care needs.

Already, Ireland has a lower than EU average number of GPs per head of population[20] and 29% fewer GPs per head of population than the UK[21] requiring efforts to increase the number of GPs trained here but also the need to recognise and accredit GPs from elsewhere. Workforce planning also needs to take into account the losses from the system, such as emigration and retirement.

The HSE predicts a GP shortage of between 493 - 1,380 by 2025[22] and the most recent analysis of medical workforce requirements estimates that an additional 1,260 – 1,660 GPs are needed by 2028.[23] The "*HSE 2018 Capacity Review*" identified a need for a '*sharp rise in capacity'* of the primary care workforce by between 37- 48% by 2025.[18] The 2021 Medical Council of Ireland reports a need for 42% more GPs.[24] We see this as the development of a multidisciplinary GP team within general practice.

This well-documented workforce crisis in general practice should be viewed against the continued significant expansion of the hospital consultant doctor workforce for the past two decades. The total consultant workforce doubled from 1,947 in 2004, to 3,847 in 2021.[25] This does not include the expansion in both the number of private hospitals and private consultants. In stark contrast, the number of full-time equivalent GPs has remained relatively static.

> "We are really desperate for a GP. Just cannot find anyone interested. We were five now only 3 GPs for over 10,000 patients. Would you know anyone at all? Will pay whatever and whatever terms. We spent five million building a clinic we cannot staff. This surely is the biggest challenge in general practice right now."
>
> Email to ICGP from a GP, February 2022.

We have substantially increased the number of GP training places by 70% in the past six years and continued expansion is underway (see Appendix 2). However, there are restrictions due to limited capacity in hospitals to expand training places. Nevertheless, in line with the Programme for Government, the ICGP is increasing the number of training places, and plans to have 350

training places by 2026.[26] It is notable that half of the current applicants for GP training are from non-EU doctors (Appendix 2).

Single-handed GP practices, particularly in rural and remote parts of Ireland, are finding it increasingly difficult to find a successor or locum cover. GPs are unable to find locums (replacements) for sick leave or annual leave. The 2021 ICGP membership survey showed that one-third of GPs in 2021 were unable to take annual leave due to a lack of GP cover in their practice.[19]

GPs are working longer days, placing further workload pressures on their staff and themselves. These factors fuel GP burnout and impair GP recruitment, exacerbating our workforce deficit. Most newly qualified GPs wish to work in group practices, closer to cities and in practices that combine clinical care, teaching, research and specialist opportunities (women's health, musculoskeletal, dermatology etc). At present, approximately 15% of the GP workforce are working in rural general practice.[1]

The pandemic has accelerated the retirement plans of older GPs, further exacerbating the GP workforce crisis.[12]

We have a longstanding dependence on hospitals to meet the demands of urgent and acute healthcare in Ireland. We must now adequately resource general practice to meet the healthcare needs of the next decade. A general practice workforce with a manageable workload can deliver timely, high quality and safe patient care while avoiding unnecessary emergency department (ED) attendance and hospital admissions especially for older patients with chronic diseases.[27]

What does the shortage of GPs mean for patients?

Patients identify with a regular GP who provides good continuity of care which is associated with better patient satisfaction and better health outcomes for those with ongoing chronic conditions, and also notably associated with fewer ED attendances and hospital admissions.[28]

The shortage of GPs across Ireland means that thousands of people are denied timely access to a GP. This inevitably causes continued difficulties for themselves with unscheduled care pressures across the entire healthcare ecosystem.

General practices have closed, compromising patient care. GPs are unable to find replacements for retiring partners and have closed practices to new patients. When a GP retires with no successor, the fabric of that rural community is destabilised. Practices limit access and do not take on new patients. This places further pressures on patients, local hospitals, emergency departments and GP Out-of-Hours services. Medical card holders are allocated to a temporary locum (replacement) GP by the HSE or allocated to other GPs. This impacts considerably on continuity of care.

Patients' ability to access their GP in a timely fashion is now seriously compromised.
Ireland has had a long tradition of the patient being able to see their doctor promptly – on the same day, if necessary, in most cases.

Part Three

General Practice is changing

General practices range from solo practitioners at the heart of a small community, to large primary care centres, with teams of over twenty staff with a practice manager, administrative staff, GPNs and GPs.

General practice is flexible and adaptive, as witnessed during the COVID-19 pandemic, when GPs and their practice teams adapted to the new restrictions, pivoted to telephone and video consultations and verifiably continued to deliver care to their patients. COVID-19 has imposed an additional layer of work right across our health service, including general practice.

The ICGP's 2021 Membership Survey showed that 89% of respondents reported their practice being busier now compared to before COVID-19.[19]

But there are obstacles to a flexible general practice future.

The capital costs of acquiring 'bricks and mortar' are substantial and a barrier to young GPs establishing practice.

In an unpredictable economic environment, and high interest rates, this situation is getting even worse. The challenge of becoming an employer of many practice staff is a further barrier to young GPs establishing a new practice in a new community.

The next generation of GPs will do things differently

Newly qualified GPs seek a more flexible career, which combines general practice with teaching, research or specialist medicine. This means we need substantially more GPs as the trend towards a broader career grows. Data further shows a reluctance among recent graduates to be in single-handed practice.[29]

In the ICGP 2021 Recent Graduate survey only 1.7% of recent graduates (those qualified in the last five years) were working as a single-handed practitioner and less than 4% want to do so in the future. Having a broad career is attractive with 85% wanting to be involved with education/training and half in research. Almost 62% of recent graduates do not find the traditional role of being a practice principal/partner attractive.[29] In the ICGP 2019 survey, 63% of recent graduates were working 8+ sessions per week[30] compared to 45% in the 2021 survey.[29] Furthermore, only 22% of the 2021 recent graduates expressed a desire to work 8+ clinical sessions five years from now.[29]

Research demonstrates that 81% of Irish recent GP graduates would choose to specialise in general practice compared to 78% of other European GPs. However, more Irish recent graduates, 35.5%, were dissatisfied with the amount of time spent at work, compared to 16% their European counterparts. Satisfaction was related to number of hours worked per day – those who reported working more hours being more likely to be dissatisfied.[29, 31]

Part Four

The Irish Healthcare Context

The Corporate Model in General Practice

The dominant model of general practice in Ireland is an independently run practice, owned and run by general practitioners.

However, this is changing, as more newly qualified GPs prefer to be salaried doctors, working for primary care centres owned by corporates.

Doctors in hospital are employees who are resourced with a place to work and the infrastructure that goes with it. General practice breaks with this model in that the GP is a contractor who must provide their own premises, hire staff and in general run a small business that becomes a medium sized enterprise over time. It is evident from our research with GP registrars and recent graduates that many are reluctant to take on this aspect of medicine.[29-30]

It is difficult to know if registrars are disinterested in practice management until it becomes a reality or if equipping them with management tools as part of their training would make a difference. If the latter, then a significant overhaul of practice management teaching geared towards meaningful innovation in general practice as part of the curriculum is worthwhile.

Trainees need to be able to 'get under the bonnet' of practice workings, including discussing practice finances. Immersion in the finances will help inform both the earning prospects and the concerns about the costs of running a practice. This needs to include discussion and career advice on the so called 'corporate' sector of general practice.

A GMS list is not seen by many registrars as a sufficiently challenging career end point and is leading them to seek out other parallel challenges such as teaching, research and advisory work. It is noticeable that many of the challenges experienced by GPs are non-patient facing which reflects the strain of clinical medicine in the current climate. A broader career with multiple components often comprises challenges early on but can become less challenging when new skills are learned, and the post holder is unable to effect change at that time in their career.

The corporate approach to medicine addresses some of these issues, particularly the one of practice management and infrastructure.

> "This is the type of medicine I want to practice - I get to look after my patients in a super facility that I could not aspire to myself, focus on what I do best and leave the drudgery of day-to-day operations and administration to my much more efficient and lovely colleagues. I can take the time to specialise in the areas that interest me most and I have clarity as to how my employer will progress my career, financially and professionally. This would be so much harder and slower on my own."
>
> GP Associate Doctor working in 'corporate' general practice

Financial risk may underlie young GPs' who wish to become salaried. Getting a GMS list is filled with uncertainties about income especially in the early years. Getting a mortgage based on income can be particularly fraught early on as a consequence. This uncertainty is removed in joining a corporate practice.

A 2022 commentary on one corporate's performance, Healthcare Business International (HBI) which analyses the global for-profit health care market notes that one of the corporates has 300,000 patients on their books who are looked after by 120 GPs in fifty-seven clinics.[32]

In a comment HBI says “It is worth noting that traditional (as opposed to digital) primary care isn’t the most profitable area of healthcare; profit margins are typically low as there are limits to how much patients are willing to pay for GP consultations …” It goes on to say that general practice does not lend itself to huge economies of scale from being part of a larger group. In their 2022 analysis of the corporate’s performance, HBI concludes “Its future success may depend on its ability to harness the power of new digital tools and integrate other aspects of care (outside of primary care’s traditional remit) into its business model.”[32] To ensure continued profitability there will have to be some provider-induced demand, according to this analysis.

The HBI analysis thinks that traditional consultations are not where the profit is – it is in digital primary care. It also sees the corporate as having to innovate in the digital space and in the hospital sector, in for example, the management of heart failure. This brief case study on a corporate is based on an economic analysis and is valuable, while limited to what is available in the report. The HBI insights recognize that even in private general practice, the face-to-face fee is a rate limiting step in profitability as patients may be unwilling to pay more for it. The commentary points the way towards digital innovations and the absorption of current hospital outpatient activities.

Young GPs joining a corporate GP provider will gain valuable experience. They may learn about business culture, the funding model and the need to adapt to profit driven innovations. They will also provide good clinical care. However, they will not have the same level of control as they would in a more traditional structure. Some will thrive in such an environment. Like the more traditional general practice, it means selecting the right doctor who will thrive in such an environment.

As a society we have shown disregard for social capital - be it Garda stations, post offices or banks. The ‘No doctor no village’ campaign brought this issue to the political table.[33]

If the State wants general practice to survive especially in rural and deprived urban areas, it must attract GPs by making sure they have suitable premises to practice from and address the financial uncertainty in the early years of the practice.

The Government must respect the nature of the Doctor-Patient relationship - which is not commercial - and must always view patients as persons undergoing medical treatment as opposed to persons purchasing goods or services. The role of the GP as gatekeeper/guardian of the health system must be recognised as in the best interest of the patient and the State.[34]

Sláintecare[35]

Healthcare funding in Ireland has increased substantially over the years. The OECD 2019 data shows that Ireland spends 6.7% of its GDP on health while Denmark spends 10% and the UK and the Netherlands spend 10.2%. All these figures include both government and private expenditure.[36] In the 2014 OECD Report, the proportion of the health budget spent on general practice was 4.5% of which 1.9% was private spending.[37]

Sláintecare is the direction of travel for healthcare. Research from the UK that each additional GP per 1,000 population was associated with fewer emergency hospital admissions in deprived areas is compelling.[38]

Whatever happens at policy level will impact hugely on our work. GPs and community services are extensively referenced in the Sláintecare guidance document.[35] Its core aims, namely free primary care services and transfer of work from hospitals to primary care, will guarantee increased workload and demands on GPs. The extension of State funded care to children under six years has increased GP workload by 29%, in GP daytime and OOHs services.[5]

There is an obvious link between the demand for GP consultation and the cost to the patient.[39] The ICGP predicts that, if implemented, the Budget 2023 pronouncements will lead to an increase

of between 640,000 and 740,000 daytime GP consultations.[1] Free care will increase demand on our GP services, with inevitable and predictable consequences across the wider health ecosystem.

Private Health Insurance & General Practice

Private Health Insurance (PHI) was originally developed as 'catastrophe insurance' for those who could afford peace of mind in the face of serious or catastrophic illness. It has always been focused on secondary care and has not made the link between good general practice and moderation of the annual cost of their premiums which regularly outstrip the annual consumer price index.

General practice has had no role in private health insurance. Sixty per cent of patients are not covered by the GMS and most of these must pay to see the doctor. On the other hand, 45% of patients have PHI to pay for private hospital care only. This is anomalous in international terms and is seen as a deterrent to seeing the doctor.[40] If GPs have shown little interest in PHI, it seems to view general practice as a marketing add-on.

We now have a situation where PHI is investing in acute care centres that are located alongside their diagnostic modalities in localities with a large private practice. Follow up is often devolved to the patient's GP. Similarly, PHI has become involved in screening well people and finding abnormalities such as overweight and raised lipids whose further management is again devolved to the patient's GP. The practice of "health checks" also raises issues around appropriate ethical follow up. What responsibility does the initiating doctor have? Should insurance and other provider companies be able to literally 'dump' the results on the GP's desk? Medical Council guidelines only deal with this issue in an indirect way by requiring the organiser of the test or investigation to refer to an appropriate specialist.[41]

The current strategy of PHI is bringing it into conflict with local GPs on a regular basis. It is seen as passing up opportunities to get involved in the management of, for example, chronic disease where good clinical care reduces the need for expensive secondary care. The recently introduced chronic care packages (or Chronic Disease Management programmes), [42] run by general practice, are excellent in design and execution but are solely limited to GMS patients. It would be a good population health approach if PHI joined with the HSE in funding a similar model of care for their subscribers. However, we recognise that this would lead to a further rise in GP consultations.

As it stands, in business terms, general practice has become dependent on a single purchaser for its public patients. It makes good strategic sense to involve another purchaser which makes negotiation more complex but ensures that the business of general practice is not overly dependent on the State as happens currently. When the State suffers economic hardship, its contractors also suffer. Having another purchaser such as PHI would reduce the hardship and reduce the business risk to the practice.

Part Five

Potential solutions to the General Practice workforce & workload crisis

1. Build GP-led Practice teams

We need to build GP-led practice teams. We need to further develop the multidisciplinary GP team (nurses, pharmacists, phlebotomists, healthcare assistants etc) within general practice. We need substantially more general practice nurses, with resourcing and supports comparable to secondary care nurses. The ICGP and our colleagues in the IGPNEA have recently initiated engagement with our universities to deliver high-quality education to train GPNs. This will require resources.

The ICGP welcomes the HSE "Enhanced Community Care"[43] initiative. This will incrementally support GPs and our patients in timely access to diagnostic, clinical expertise, and the therapies such as dietetics, physiotherapy, podiatry, etc. This is part of the solution to supporting vulnerable patients and ICGP looks forward to continued engagement with the HSE.

GPs reported working between six and 13.5 hours (including non-clinical work), with an average of 9.7 daily work hours; undertaking an average of 29 consultations per day.[2] Ireland has almost 30% fewer GPs per head of population than the UK, and fewer again than Canada and Australia.[21] The Netherlands has double the number of practice nurses, administrative staff and has wider access to allied health professionals such as physiotherapists and occupational therapists. Building the team will include more GP nurses and allied healthcare staff ideally located in the practice premises.

2. An enhanced role for Nurses in General Practice (GPNs)

General practice nurses are skilled autonomous clinicians with a broad clinical expertise. The ICGP has long advocated for a substantial increase in the number of GPNs.[44,45] As it stands there are approximately 2000 GPNs in Ireland[7] making up about 45% of clinicians in general practice. Both their practices and the GPNs themselves have embraced enhanced roles but have legitimate concerns about the training, funding and indemnity for such development.[46]

A recent Canadian systematic review of the impact of nurses in primary care concluded that they have a role in medication management, patient triage, chronic disease management, sexual health, routine preventative care, health promotion/education, and self-management interventions (e.g., smoking cessation support).[47]

GPNs are central to the vision GPs have for the development of general practice. There is the potential for career development for GPNs as some will want to become advanced nurse practitioners, nurse prescribers, or clinical nurse specialists to support chronic disease management and triage minor illness. To achieve this requires investment, training and support.[47] To allow GPNs to practice to their highest levels, it is important that tasks that they currently do are devolved to another member of the team. Taking bloods, ECGs, spirometry, fitting 24-hour blood pressure monitors can all be done by a practice technician/phlebotomist. This presents an opportunity for a 'quick win' at relatively modest cost. Like for GPNs, there are insufficient courses available to train suitable candidates.

3. Provide supports to ensure GPs have the option to participate in the broad church of general practice (General Practice Family)

We need to take a realistic approach to what are the career expectations of our trainees and future GPs. They will not work 5/6 days in practice and nor should they. Like all highly skilled clinicians, whether that is a consultant in a hospital or a GP in a primary care setting, they want

career options, which includes the option for research, teaching at undergraduate and postgraduate level, etc. We need to build our workforce models around this reality. The ICGP wants to see our highly skilled members involved in transformational research, being leaders in clinical care. This is the future, and this is the reality.

4. Help provide suitable primary care premises

The built infrastructure is increasingly perceived as an unwanted, unnecessary, and unwarranted liability by potential GPs. Society does not require other healthcare workers to provide the work premises. The 'bricks and mortar' is now a barrier to recruitment, retention, mobility and retirement. This is especially the case in affluent urban areas where property and rents are unaffordable for young GPs. The Scottish government and NHS Scotland have addressed this challenge, to incrementally reduce the built infrastructure risk burden on GPs.[48] Ireland urgently needs multiple innovative approaches to GP built infrastructure.

The HSE can support younger GPs establish practice by providing purpose-built GP premises, thereby avoiding substantial capital expenditure on 'bricks and mortar'. This 'built infrastructure' approach will support young establishing GPs, support relocation of overseas GPs to Ireland, and the amalgamation of smaller GP practices. This may include a variety of options, including interest free loans, HSE provided and HSE leased premises.

Expansion of the GP healthcare team, especially nurses, will require substantially more clinical space. Incentives to support an expanded GP team must address the built infrastructure requirements.

5. The Non-EU rural GP initiative is an important component of the multi-faceted ICGP response to our severe general practice workforce crisis. We need to deliver that urgently

Irish general practice is experiencing a severe workforce crisis. The current, ongoing shortage of GPs in Ireland has serious implications for the health of our community. An inability to access high quality GP care, in a timely manner, adversely affects both the individual patient and overall patient safety, while having profound ramifications across the entire healthcare system.

The HSE, ICGP and IMC recognise the need to expand the GP workforce by 40% to meet the healthcare needs of our population. To increase the GP workforce to this level, we will need approximately 1,660 more GPs,[18] to support the 4,187 GPs[1] already working beyond capacity in our communities, countrywide. The number of HSE consultants has doubled since 2006. [25] This 40% increase in GP numbers is long overdue.

We are rapidly expanding our GP training numbers, currently 258, expanding to 285 in 2023, and 350 in 2026,[26] in an attempt to resolve this crisis. However, approximately 14% of GPs are >/= 65 years old, with retirement plans accelerated by the pandemic. GPs are also seeking a work-life balance, which is changing GP work patterns away from full time clinical commitments, towards a career, incorporating clinical work, teaching, and research. Our GP workforce crisis is likely to further deteriorate in the coming five years.

The 350 doctor 2026 training cohort will qualify as GPs in 2030. If every newly qualified GP works full time, without any emigration, any GP retirement, or deaths, we might bridge the GP workforce deficit by 2030. This will not happen. We simply cannot 'train our way' out of the GP workforce deficit. We urgently need more GPs.

The Non-EU Rural GP Programme is an important component of the multifaceted ICGP response to the severe GP workforce crisis in Ireland, especially in rural Ireland. This initiative is supported

by ICGP, HSE and all the GP indemnity organisations. This workforce shortage has workload implications for our ICGP members, with profound implications for patient care and patient safety.

This initiative will enable non-EU GPs to work in routine, daytime rural GP practice for two years, with some GP OOH work. The ICGP and the 'host' GP practice will provide substantial ongoing educational supports and clinical supervision. Some Non-EU GPs are currently working in Irish general practice, without educational supports or supervision. This raises patient safety issues.
We are supporting non-EU doctors who already have appropriate general practice experience. To enrol in this 2-year programme, these non-EU GPs must already have at least three years general practice experience. The Non-EU GP must also have experience in other clinical fields, such as paediatrics and general medicine. We require that they have passed the applicable English test required by the IMC. The Non-EU GP will have a named GP supervisor in their rural host general practice.

Patient safety is our top priority. The patient safety risks arising from our GP workforce crisis are stark. The programme will provide a robust education programme including generous protected study time. This, combined with ongoing clinical supervision, will help ensure that participants practice safely and learn effectively. The programme will enable successful participants to undertake the MICGP exam, a benchmark of professional competence. The programme will have ongoing evaluation of both process and outcomes.

The Non-EU Rural GP Programme is an important component of the multi-faceted ICGP response to our severe GP workforce crisis. We need substantially more GPs now, especially in rural Ireland. This initiative is supported by HSE and all medical indemnity organisations, who recognise the nature and scale of the GP workforce crisis. The consequences of this crisis on patients, patient safety and the wider healthcare ecosystem are profound.

6. Remote consulting: A pandemic legacy

Telemedicine is "*the delivery of health care services through ICT to promote the health of individuals and their communities*."[49] Pre-COVID-19, almost 2/3 of GP practices had telemedicine facilities and approximately 10% of GP consultations were telemedicine consultations.[50] This engagement pivoted with the pandemic, with GPs 'embracing' video consultation.[50,51] Remote consultation or at least the telephone, is now an important component of healthcare, with an appetite for continued telemedicine consultations among doctors and patients.[50] A recent systematic review struck a note of caution, concluding that the impact of telemedicine "*on quality and clinical outcomes remains uncertain*", especially among disadvantaged people.[53]

The IMC recognises the utility and clinical value of telemedicine consultation for patients, doctors and the wider healthcare system.[54] Telemedicine facilitates acute and chronic disease management, patient connectivity especially for vulnerable/disadvantaged/ geographically remote patients, including OOHs patient care. Telemedicine ethical concerns are similar to face-2-face, include confidentiality, consent and quality of care. Limitations of telemedicine include inability to undertake physical examination, diagnosis, prescribing, telemedicine education, addressing sensitive issues and technological limitations.[53-56] It is recommended that "face-to-face consultations should remain the gold standard".[55] While telemedicine may benefit patient time management, there is no evidence that clinician time is reduced.[55] Crucially, the impact of telemedicine "*on quality and clinical outcomes remains unknown*".[53]

The key ethical concerns around telemedicine are confidentiality and data privacy. Telemedicine was not extensively used 'pre-pandemic': resources and training are required to safely embed telemedicine. Telemedicine is potentially more convenient for some patients but is not superior to face-to-face consultation.[56] While supporting many patients, telemedicine is less appropriate for people needing urgent care, physical examination and people with complex care needs.[53-56] These situations are common for sick children, many adult acute illness, mental illness and for frail elderly patients requiring GP care.

7. Rural General Practice needs special supports to survive

A third of our population is rural[11] and cared for mainly by rural general practices. Many of these are single-handed practices. The ICGP considers rural populations and rural GP as a vital aspect of workforce planning. The ICGP endorses the recently published Limerick Declaration on Rural Healthcare (https://www.woncarhc2022.com/limerickdeclarationonruralhealthcare).[57]

The continuity of care created by rural general practice is associated with reduced need for OOHs services, acute hospital admission, ED attendance and with decreased mortality. Our rural general practice infrastructure is especially fragile.

The general practice career pipeline must include a specific rural focus. The current focus on large urban based healthcare infrastructure development should be widened to include investment in rural healthcare. This practice infrastructure needs to attract and retain young GPs.

This investment in rural healthcare infrastructure should be co-created with our rural communities protecting and enhancing local environments while addressing the social determinants of health. Amalgamating rural practices is not necessarily a desirable or viable solution given the distances involved. However, resources can be shared such as nursing, admin, GP locum, sessional GPs and practice management staff.

GPs in rural Scotland and Australia have locums provided by the health authority, thus guaranteeing their annual and maternity leave. This approach has proven essential and highly successful to attract GPs and their families to permanently live and work in rural areas. The big issue for single handed doctors is GP Locum cover for sick, holiday or maternity leave. We must develop and deliver meaningful and comprehensive incentives to enhance the attractiveness of rural practice. This Rural Practice Support Framework will guarantee locum provision to cover holiday, sick and maternity leave, additional GMS annual leave, suitable practice premises.

An ICGP Clinical lead, and an Academic Professor for Rural General Practice should be appointed to provide advocacy and leadership to this group to inform, support and guide government rural policy and practice.

8. Develop the role of Practice Manager

If we have learned anything from the corporate approach to general practice, it is that young GPs especially value practice management and even more having someone to do it competently for them. General practices require professional management.

9. Building a GP Workforce "Pipeline": from medical student to qualified GP

We must build a diverse and inclusive workforce that is representative of the communities we wish to serve, underpinned by the principles of social accountability while being committed to gender equality and social inclusion and social justice.

Building on established international examples, and rigorous research evidence, we recommend focusing existing undergraduate medical programmes to producing graduates who select a career in general practice. The Scottish government "SCOTGem"[58] model is one exemplar.

The length and quality of general practice experience at medical school is accepted as a key positive factor in promoting general practice as a career.[59] Exposure to general practice as part of the formal, informal, and hidden curriculum, positive experiences and role models in general practice have all been identified as contribution factors in young doctors choosing to undertake higher education in general practice. [60,61]

The international literature is very clear that resourcing longitudinal placements in general practice is a key and essential first step in the GP workforce 'Pipeline'.[62] This should include a

curriculum consisting of a minimum of 25% of GP placements. The recently opened Ulster University provides 30% of all teaching in general practice, commencing in the first week of medical school.

Ireland with the notable exception of the University of Limerick at 25%, has very limited exposure to clinical general practice. To increase the general practice curricular footprint to international norms, will require increased funding to support both general practice placements and general practice university academic staff. An anomaly currently exists where the terms and conditions of clinical academic general practice staff are not the same as those of other equivalent clinical staff in other university disciplines. This is a key deterrent to both attracting and retaining senior academic general practice staff who will be essential to lead and support such radical curricular change.

A specific rural curriculum and pathway should exist within undergraduate medical education and GP training. Rural students and GP trainers /mentors should be recruited and retained with exposure to rural practice maximised. This will also support the development of hospital physicians who wish to practice in rural regions.

GP Intern places need to be sufficiently expanded and resourced to continue the 'Pipeline' into postgraduate GP training. To meet the expansion of training across all specialities and to meet the chronic shortage of doctors both in every area of healthcare delivery, we need a radical overhaul of numbers entering undergraduate and graduate medicine. In addition, on completion of GP training, an average number of postgraduate general practice academic fellowships, with some dedicated to rural practice, needs to be established. These fellowships, funded by the National Doctors Training and Planning (NDTP) and the Health Service Executive (HSE) should form another step in this general practice career 'pipeline'. [61,62]

10. Mainstreaming research in general practice (Informing and shaping the future with data)

Data produced in GP-led primary care has to be jointly used with the HSE to make a case to the political system for enough resources to succeed. The Health Research Board (HRB) sees health data as a valuable national asset.[63] Ireland has many data resources that may enhance health service delivery, inform policy and aid planning. The use of such data in a safe, secure manner, protecting privacy and confidentiality, is very important. The HRB observes that many questions that could inform policy and practice are not attempted, are abandoned, or are delayed because data cannot be accessed in a timely manner.[63]

An example of this is 'real-time' data on the workload and activity levels in Irish general practice. This requires sustained investment in GP data analytics.

The HSE-ICGP-Sláintecare research hub is addressing some of this strategic deficit. Irish general practice is almost entirely computerised, enabling 'real-time' data harvesting with the appropriate measures and data protection safeguards. Irish GP electronic medical records offer a potential single comprehensive data repository, containing all medications, laboratory results, diagnostic imaging and discharge summaries from across the healthcare system (e.g., out-of-hours services, hospital admissions and some emergency departments). The resource deployed to primary care research and analytics data needs a substantial, immediate and sustained uplift to better harness this data to inform national healthcare policy.

It is anticipated the ICGP can work with GP electronic medical records, other existing datasets and HSE partners (e.g., PCRS, Health Intelligence Unit, Clinical Design and Innovation Team) to gain insights that can improve care delivery in our communities. We must enable dynamic co-production of evidence on Irish general practice between communities, health workers, academic researchers, policymakers (in health, rural development, and other sectors) and civil society organizations by mainstreaming our research activities. The HSE-ICGP-Sláintecare Hub is

an excellent foundation from which this can happen. We recommend this is continued and potentially expanded to maximise this benefit.

The ICGP sees data and its analysis as essential for our health system to modernise and meet the needs of our patients and the population. There are many players to be involved and some data protection issues to be resolved. Accurate contemporaneous identification of healthcare needs can only be established with trusted expert analysis of real-time data. The management of COVID is a good example of the timely data being presented that modified behaviour and reduced deaths.

Conclusion

Irish general practice is changing rapidly and has changed beyond recognition in the last two years. General practice has also shown how flexible and adaptable it is to meet urgent needs. There are, however, huge pressures on existing GP practices, and general practice must be supported and resourced to retain existing doctors and recruit new GPs into practice. At present general practice is working efficiently, flexibly in a patient-centered way, based in the heart of the community, but is at breaking point.

The next decade will bring enormous change and all parties must come together and act now to protect and grow general practice in the interest of patient care. For the sake of our patients and to retain high quality clinical care within the community, the need for Government and those in authority to respond is now critical.

Appendices

Appendix 1
Purpose, Authority and Membership of the Working Group

Purpose of the Working Group

The Working Group was established to provide a discussion paper on the following:

- Guidance to the Board of the ICGP on the issue of workforce planning.
- To identify appropriate workable solutions for further analysis and discussion to the GP Workforce Crisis.
- To utilise the reports provided to date and the solutions contained within and identify short-, medium- and long-term solutions: These unpublished internal reports/submissions include:
    - Workforce & Workload Crisis in General Practice - Dr Diarmuid Quinlan
    - Health Insurance & Corporates – Dr Paul Armstrong
    - Review of Workforce and Workload in General Practice – Dr Lucia Gannon & Dr Pat Durcan
    - Oireachtas Submission – Dr John Farrell, Dr Diarmuid Quinlan and Mr Fintan Foy.
- To identify the terms of reference for the ICGP recommendation of a short-term Working Group on Workforce Challenges to be established by the Minister for Health (See *2022 Pre Budget-Submission*[45] *and Submission to the Oireachtas Health Committee, January 2022*).[26]
- All recommendations should be data driven (where possible) and grounded in general practice.

Authority of the Working Group

The Working Group reported to the Chair of ICGP, Dr John Farrell and to the CEO, Mr Fintan Foy.

The Final Report was presented to the ICGP Board, prior to release.

Membership of the Working Group

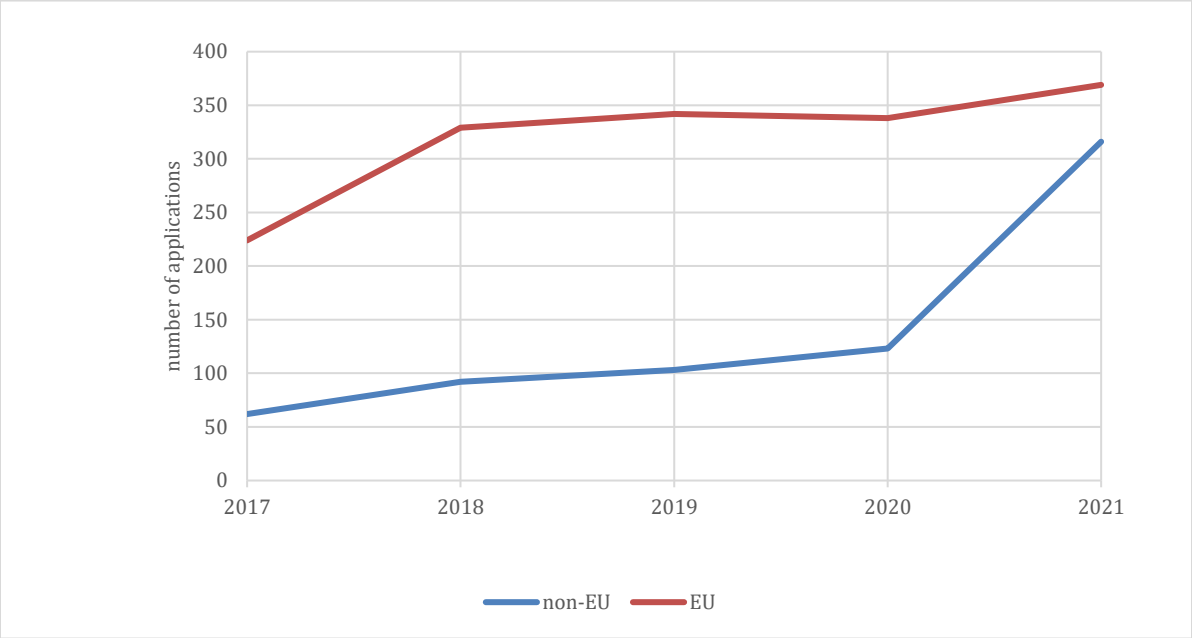
- Prof Tom O'Dowd, Chair
- Dr Lucia Gannon, Member of ICGP Board
- Dr Amy Morgan, GP Bryanstown Medical Practice, Drogheda
- Dr Paul Armstrong, Vice President
- Dr Pat Durcan, Member of ICGP Board
- Dr Diarmuid Quinlan, Medical Director
- Dr Knut Moe, NEGS Director
- Dr Noirin O'Herlihy, Assistant Medical Director and Director of Women's Health
- Ms Patricia Patton, Assistant Librarian

Editorial Team

- Mr Fintan Foy, CEO
- Dr Diarmuid Quinlan, Medical Director
- Prof Claire Collins, Director of Research/Director of People & Culture
- Ms Aileen O'Meara, ICGP Communications Consultant
- Ms Gillian Doran, ICGP Librarian
- Ms Barbara O'Neill, Web & Digital Communications Executive

Appendix 2

GP Applications Data **Figure 1. Applications by year and citizenship showing an overall increase including from non-EU applicants**



Appendix 3
Practice Profiles

Practice Profile 1

A staff of nineteen in a catchment area of 70,000 people with increasing demands but retaining a sense of purpose.

NAME OF PRACTICE: GPs at Tallaght Cross.

LOCATION: Tallaght central, in south county Dublin.

YEAR PRACTICE ESTABLISHED: 2012 out of an already established practice of 25 years duration.

DESCRIPTION OF PRACTICE: Large practice in a deprived urban area.

CATCHMENT AREA: Tallaght with a population of 70,000.

STAFF BREAKDOWN: 8 GPs, 1 Practice Nurse, one phlebotomist, one social prescriber, 7 Admin.1 practice manager (19 in total).

TYPE OF PATIENTS: 80% GMS 20% Private. Younger patients in the most deprived end of the practice, older in more affluent end of the practice.

ABILITY TO TAKE ON NEW PATIENTS: We take on direct relatives only and have 500+ patients on a waiting list to join.

CHALLENGES FACING PRACTICE:

- Workforce especially Practice Nursing, and GPs as one of our senior GPs will retire in the next couple of years.
- Patient demand has gone through the roof and that gratitude we all got during Covid has been replaced with anxiety and demands.
- Even though we are fully computerised, we have a lot of demands for certificates for things like clothing grands, patient certs, referrals for hospitals.

POSITIVES: There is a sense of purpose in what we do that is very rewarding, and as a GP we have more control over our day and life than some other people.

Practice Profile 2

Caring for 11,000 patients in north Monaghan; delighted to be providing multigenerational care but struggling to take time off.

NAME OF PRACTICE: Swan Park Surgery

LOCATION: Monaghan town.

YEAR PRACTICE ESTABLISHED: 1965.

DESCRIPTION OF PRACTICE: Group practice covering both rural north county Monaghan and the more urban area of Monaghan town.

CATCHMENT AREA: north county Monaghan and Monaghan town. Specific catchment areas include Scotstown, Tydavnet, Castleshane, Clontibret, Smithboro and Knockatallon. These reflect the original dispensing lists held by original partners and the subsequent five outlying clinics that were run weekly until 5 years ago.

NO. OF STAFF: three partners. i.e., One fulltime GP employee, two part time GPs, two job sharing nurses, 1 manager, 4 admin staff and a daily cleaner.

TYPE OF PATIENTS: varied practice profile. Large older cohort reflecting the practice developed by the two older partners who retired in 2021 aged 86 and 71 respectively. Also, a large Eastern European practice cohort.

ABILITY TO TAKE ON NEW PATIENTS: closed to new patients for over 5 years. Despite this, the practice population has increased and remains almost 11,000.

CHALLENGES FACING PRACTICE:

- manpower- ongoing difficulty in recruiting new GPs and especially those willing to run a practice.
- increased workload transfer without necessary staff and new GPs.
- inability to take annual, sick, study and maternity leave for many GPs.

POSITIVES: GP involvement in whole family, multigenerational medical care. Continuity of care meaning both patient and doctor benefit.

Practice Profile 3

Dublin based practice privileged to have a life-long relationship with patients despite practice challenges.

LOCATION: Churchtown, Dublin 14.

YEAR PRACTICE ESTABLISHED: 2015 (amalgamation of two single handed practices).

DESCRIPTION OF PRACTICE: Small (but expanding) two doctor (husband and wife) suburban practice in South Dublin.

CATCHMENT AREA: Dublin 14, 16 and surrounding areas.

NO. OF STAFF: 2 GPs, two practice nurses (part time), 4 admin (part time).

TYPE OF PATIENTS: good patient mix between GMS and private, large over seventies and paediatric population too.

ABILITY TO TAKE ON NEW PATIENTS: No, closed to new patients for 1 year.

CHALLENGES FACING PRACTICE:

- similar to practices around the country, increasing workload, complexity of work, demands on GP time, leading to inevitable increased waiting lists for appointments.
- our planned expansion from 2-5 rooms to increase capacity for doctors, become a training practice and open up to taking on more patients and cement the practice's future. However, there has been little HSE support to help us find solutions to house our practice during the renovations, and no financial supports/incentives available to help fund practice facility upgrades.
- recruitment and retention of GPs and support staff, including Locums, meaning at times have been unable to take planned annual/study leave due to lack of cover available.

POSITIVES OF BEING A GP: It is a privilege to have a lifelong relationship with our patients, with continuity of care providing a rewarding experience for GPs and patients alike. Flexibility in working practices and ability to take on a special interest, which provides variety to the working week but also the ability to manage more complex matters in the community rather than hospital system.

Practice Profile 4

Four-doctor training practice in Cork's north city suburbs in inadequate premises but making a difference.

NAME OF PRACTICE: Parklands Surgery.

LOCATION: Cork city.

YEAR PRACTICE ESTABLISHED: 1986.

DESCRIPTION OF PRACTICE: Four-doctor training practice, in deprived urban area.

CATCHMENT AREA: North city suburbs and commuter area.

STAFF BREAKDOWN: 4 GPs (3 FTE), three practice nurses (1 3/4 FTE), 4 admin (2 1/2 FTE) (11 in total).

TYPE OF PATIENTS: GMS 2500, Private 2500 approx. Ageing profile.

ABILITY TO TAKE ON NEW PATIENTS: Not for the past seven years, no plans to change.

CHALLENGES FACING PRACTICE:

- difficulties recruiting GPs/locums
- inadequate premise
- expansion limited by physical buildings
- overwork
- under resourced
- transfer of hospital work.

POSITIVES OF BEING A GP: Always interesting, no two days the same, patient appreciation, and knowing you make a difference.

GP-led practices are at the heart of their communities, with strong local connections, delivering timely comprehensive, high-quality patient-centred care.

Practice Profile 5

Belonging in a Community that values you.

NAME OF PRACTICE: Ballyvaughan Medical Centre.

LOCATION: Ballyvaughan, Co Clare.

YEAR PRACTICE ESTABLISHED: 1932.

DESCRIPTION OF PRACTICE: Rural GP practice co-located with HSE Primary care team in beautiful coastal village of Ballyvaughan in Co Clare delivering care to a wide rural hinterland.

CATCHMENT AREA: 600 sq./km of North and West Clare.

NO. OF STAFF: 3 part time GPs, two part time practice nurses, two part time receptionists, 1 FTE practice manager.

TYPE OF PATIENTS: Mix of GMS and Private and predominantly older farming population.

ABILITY TO TAKE ON NEW PATIENTS: No longer.

CHALLENGES FACING PRACTICE:

- Rapid increase in practice population due to arrival of over three hundred refugees in the village.

POSITIVES OF BEING A Rural GP:

- Be your own Boss from the moment you qualify
- and a clinician with clinical courage
- in a fascinating clinical environment full of variety
- where you will operate at the top of your licence
- and belong to a community which values you
- where you can effect change
- where you will be well paid and have a healthy work/life balance
- and have a short commute and lovely lunchtime walks/swims!

Practice Profile 6

Deep End practice with 1/3 of patients under 18; a practice population with challenges whose resilience keep us going.

NAME OF PRACTICE: Riverside Medical Centre.

LOCATION: Mulhuddart, Dublin 15.

YEAR PRACTICE ESTABLISHED: 1984.

DESCRIPTION OF PRACTICE: Deep End Practice.

CATCHMENT AREA: Blanchardstown.

STAFF BREAKDOWN: 5 GPs, 2 registrars, 2 practice nurses, 6 admin (15 in total).

TYPE OF PATIENTS: 80% GMS, lots of non-nationals, 33% of GMS patients under 18.

ABILITY TO TAKE ON NEW PATIENTS: No.

CHALLENGES FACING PRACTICE:

- This is a Deep End practice with huge challenges delivering care and accessing services, especially mental health and disability services for children which is a major issue as so many of our patients are young.
- Complex multimorbidity occurs much younger in our adult patients, and it's complicated by psychosocial problems.

POSITIVES OF BEING A GP: When there are such high needs sometimes what you do can make a big difference to someone's life and this is very rewarding. We have learned to work as a very effective team both in the practice and with local PCTs. The courage and resilience of some of our patients is what keeps us going when things get tough. And the endless variety of general practice is what keeps it interesting!

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