Chapter 43

Primary Care Teams

Primary Care Teams

43.1 A core element of the Health Strategy 2001 was the development of Primary Care as a basis for the delivery of health and personal social services. The concept was set out in Primary Care: A New Direction which was published alongside the Health Strategy. As the first point of contact that people have with health and personal social services it saw primary care as the appropriate setting to meet 90-95 per cent of service needs. It also noted that the provision of these services within a primary care setting had the potential to prevent the development of conditions that might later require hospitalisation and also facilitate the earlier discharge of people from hospital.

43.2 The general objective was to create an integrated primary care service which would lead to better outcomes, better health status and cost-effectiveness. Central to delivery of such an integrated service was the concept of a Primary Care Team (PCT).

43.3 A PCT is a group of healthcare professionals including general practitioners (GPs), public health nurses (PHNs), registered general nurses (RGNs), home helps, physiotherapists, occupational therapists, administrative personnel and other professionals. The team composition was to be determined through needs assessment.

43.4 In order to function at optimum effectiveness, it was envisaged that teams would

- be located on the same site or in close proximity
- have electronic communication and record storage systems
- be part of a wider Health and Social Care Network (HSCN) – these networks would comprise a range of health and social care professionals linked with at least three PCTs.

PCT Programme

43.5 Currently, PCTs are being developed in the context of aims set out in the HSE Corporate Plan for 2008-2011. That plan envisages the development of an integrated health and social care model, under which services will be more accessible locally and centered around the patient rather than around hospitals. In order to facilitate such a move it would be necessary to have greater diagnostic capacity available at primary care level and expand community services to enable more people to be treated at home through multidisciplinary teams.

43.6 In 2001, it had been estimated that as many as 1,000 PCTs were required to cover the population. It was envisaged that 40 to 60 teams would be operational by 2005 and that by 2011 approximately two-thirds of the targeted number would be in place.

43.7 In 2001, for the implementation of two thirds of the planned number of teams, the additional staff resources required to provide the service as envisaged were 500 GPs, 2,000 nurses/midwives and a significant number of health and social care professionals, administrative staff, home helps and health care assistants. These staff were required as more services were expected to be delivered at this level. No consequent savings at hospital level were identified. The additional cost was estimated in 2001 at €615 million per annum by 2011.

43.8 In January 2009, the HSE stated its aim was to have all teams in place by December 2011. According to the HSE, following a mapping exercise, PCT population size ranged from approximately 7,000 to 10,000 depending on the location, with an average population size of 8,000 and the indicative team size for planning purposes was 30 (including GP and GP support staff).

Chapter Focus

Moving to PCTs involves reconfiguring primary care in a way that moves from having a set of independent disciplines to one where those professional staff would function in a team setting. It would also involve linking the team to wider HSCNs and to the hospital system. This chapter reports the current status of development including

- how the overall change is being managed
- the arrangements for resourcing and locating of teams
- the linkage of PCTs with other services.

Chapter 44 reviews the arrangements for the provision of primary care centres.

Methodology

43.9 The methodology included the issue of a survey to the PCTs that were in operation in December 2010 and interviews with relevant personnel in the HSE. The survey gathered data on PCTs[338] such as staffing resources, diagnostic resources and information technology, the care plans in use and the development to date of PCTs. A designated person completed the survey on behalf of each PCT.

43.10 Two PCTs were also visited, in the course of which, interviews were conducted with key personnel including Transformation Development Officers (TDOs), GPs, PHNs, physiotherapists, and occupational therapists. A number of reports on this subject were also reviewed.

Managing the Change

43.11 The key change in the creation of PCTs involves moving from the previous structure which was a care group[339] model to a new configuration based around PCTs and HSCNs. This entails establishing the teams and networks, linking them to other services and coordinating service providers.

Establishment of HSCNs

43.12 The effective functioning of PCTs as envisaged would involve functioning as part of networks that include a range of specialists. These specialists in the wider network would include speech and language therapists, social workers, community pharmacists, dieticians, mental health staff, staff from the disability services, dentists, chiropodists and psychologists with each network supporting three or four PCTs.

43.13 At 31 December 2010, no HSCNs were in place. The HSE stated that the development of HSCNs would be progressed in 2011.

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338 Data was compiled from 279 replies.

339 The five main Care Groups are Children and Families, Older Persons, Mental Health, Disabilities and Social Inclusion.

Establishment of PCTs

43.14 HSE Service Plans aimed to have 394 PCTs in place by 31 December 2010 and all of the 527[340] PCTs to be operational by the end of 2011. According to National Primary Care Service Office, a number of mapping workshops were held in three Regional Director of Operations (RDOs) areas which resulted in further refinement of boundaries, with a reduction to 518 in the number of PCTs to be operational by the end of 2011.

43.15 The survey conducted as part of the audit found that a considerable amount of overall coordination remains to be done. In particular, it found that

- The reported number of teams did not appear to exist. Of the planned number of 394 which were to be in place by end 2010, an estimated 319 were in place.
- It appears that of the 350[341] teams the HSE reported[342] as functioning, a number have already merged with others. 31 such situations were identified in the course of the audit.

43.16 The Accounting Officer has stated that, following a review, he has established that the reason for this variation is that while two teams may hold joint clinical team meetings they still operate as two separate teams. He stated that each of these teams have separate staff assigned to each, especially GPs, PHNs and RGNs. The population coverage is not affected by these mergers.

43.17 He also stated that the HSE is in the process of reviewing the current team boundaries, particularly in terms of the newly formed Integrated Service Areas[343] and the recent census results.

Change Process

43.18 Managing substantial change of the order required to embed a new way of working requires a change management plan backed by focused actions. Central to successful establishment of a PCT would be

- team building activities and joint planning involving PCT members in order to develop effective partnerships, team identity and a shared understanding of roles and boundaries between members
- engagement with communities, involving them in development proposals for their area
- awareness of their community's health needs
- adequate team briefing sessions on how the PCT should operate
- coordination and integration between primary and secondary care services.

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340 The projected number of teams was reset at 527 in 2010.

341 62% of the population is served by these teams.

342 According to the HSE Performance Report for December 2010, 350 teams were holding clinical team meetings at December 2010. Holding such meetings is regarded as the primary indicator that a team is operating.

343 Integrated Service Areas will be the basic units within which healthcare will be managed across both primary and secondary care.

43.19 The survey conducted in the course of the audit suggests that a considerable amount of work needs to be done to achieve cohesive functioning and establish new relationships. It found that, for PCTs holding clinical team meetings at 31 December 2010

- 27% of those that replied, reported that there had been local community/population consultation when developing the PCT
- as low as 15% of the PCTs that replied reported that a community health needs assessment had been carried out prior to the PCT's first clinical team meeting and of the remaining PCTs that replied, 7% indicated a community health needs assessment was carried out after the PCT's first clinical team meeting
- only 18% of those that replied believed that integration with local secondary care has improved since the PCT was established
- 71% of teams that replied considered that there were adequate briefing sessions provided to the team on the operation of the PCT prior to commencing work in a PCT
- 60% of those that replied had formal team development activities in advance of the PCT coming into operation
- only 31% of teams that replied considered that adequate additional training was provided to staff on working in a multidisciplinary team prior to holding the first clinical team meeting.

43.20 Central to the management of change are resources to coordinate the process. There is currently no single manager for each PCT or a standard management structure. However, the Accounting Officer has informed me that the HSE management team recently approved a management and clinical governance structure for PCTs which includes the introduction of the role of manager for PCTs. Each manager will be responsible for between three and five PCTs. These managers are expected to be in place by December 2011 pending consultation with relevant unions.

43.21 The intention was that 32 Transformation Development Officers (TDOs) would assist in change management on an area basis. TDOs are managers who are responsible for the development of PCTs, development of primary care initiatives, coordination of services and developing integration with hospitals. At national level, there are currently 25 TDOs and three primary care specialists covering 32 local health office areas and the four RDOs areas[344]. The three primary care specialists provide support to the National Primary Care Office, the RDOs and the TDOs.

43.22 In the context of PCT development, the role of the TDO is principally

- to initiate and develop the PCTs and associated primary care services
- to manage the human and monetary resources of the PCT
- to work with GPs and HSE staff on the training and change management of multidisciplinary team working and
- to promote a coordinated approach to the delivery of the Primary Care Strategy with both providers and users of the service.

43.23 The audit survey found that 53% of PCTs reported having a designated full time TDO.

43.24 There is one consultant with a general practice background advising the HSE on the development of primary care services, including PCT development.

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[344] Regional Directors of Operations have responsibility for the management of health services in the four regions of the HSE.

Functioning of PCTs

43.25 PCTs have a set of core members. These usually consist of GPs, PHNs, RGNs, physiotherapists, occupational therapists and administrative personnel. A person nominated by the members usually chairs the meetings. In order to set the process in motion the TDO attends the initial meetings. The chair is usually rotated after a fixed period. Other health professionals such as speech and language therapists, dieticians, social workers and community mental health professionals were expected to be assigned to work within the HSCNs which would have linkages to the PCT and have formal working relationships with each of its members.

43.26 A PCT is considered to be operational when it is holding clinical team meetings. Clinical team meetings are the forum for the development of care plans for patients and for the assignment of a Key Worker who is the patients' single point of contact for health services. A primary function of clinical team meetings is to draw up patient care plans for individual patients. This is central to the move towards patient centered care. Based on the survey conducted in the course of the audit, 48% of PCTs reported they had no care plans.

43.27 The Accounting Officer has informed me that each patient discussed at a clinical team meeting will have a plan of care developed and that this is standard practice at all clinical team meetings. He stated that some ambiguity does exist in relation to the definition and interpretation of the terms 'plans of care' and 'care plans,' as in the disability sector, the term 'care plan' refers to a far more comprehensive process involving case conferences and very in-depth care planning[345]. For purposes of this report, a care plan was considered to be as set out below.

Care Plan

A care plan is developed from a review of patient's needs at the clinical team meeting. These discussions generally demand multidisciplinary participation. A care plan will outline what care is required for the patient, what health professionals are responsible for that care and what actions are required. It allows for all relevant health professionals to discuss the patient together at the clinical team meeting and take action based on a holistic review of the patient.

43.28 All core members are expected to attend each meeting with at least one representative from each participating general practice. Other service professionals (such as mental health professionals) attend if their expertise is required in relation to a patient's care plan.

43.29 The audit survey found that 76% of the teams were meeting monthly or less frequently. This would militate against timely coordination of care planning.

43.30 As part of the Primary Care: A New Direction documentation, extended working hours were envisaged for teams. The audit survey found that 11% of HSE staff that replied operate extended weekday hours i.e. hours that were in excess of those operated before the PCT structure was put in place and that 3% of HSE staff that replied operate extended weekend hours.

[345] Monthly performance reports in 2009 and 2010 recorded the number of patients/clients with a care plan. However as the Accounting Officer pointed out there is considerable ambiguity about their content. In 2011 the performance indicator used is the number of patients/clients discussed at a clinical team meeting.

Conclusion – Change Management

There appear to be considerable gaps in the arrangements to manage the change and reconfigure the service in a way that evolves the new way of working and relating envisaged in the Health Strategy.

The audit survey results suggest that there are information deficits about the number of teams and to what extent they are functioning. Without active dynamic participation of members there is a risk that the structure and functioning envisaged will not become embedded in practice.

The HSE needs to consider how best to cost effectively facilitate the change distinguishing the appropriate resources for permanent support and those for once-off team building exercises.

It would be useful if a clear definition of a care plan in the primary care setting could be established in order to ensure that there is no ambiguity in its implementation or reporting.

Resourcing and Location of Teams

43.31 The full implementation of PCTs would entail the reorganisation of existing staff working in the primary and community services areas from a care group model into PCTs, HSCNs and community services. At 31 December 2010, 52,348 staff worked in these three areas. 9,490 of those staff were recorded by the HSE as working in primary care. However, the primary care figures understate the extent of reconfiguration that remains to be effected as staff in other care groups such as those caring for older people will also need to be reassigned to the new primary care structure as more teams and HSCNs are resourced.

43.32 All staff, whether reassigned to PCTs or not, continue to report within the existing management structure. This indicates that much of the assignment to date has not created self organising teams but is rather a virtual organisation structure which may in time develop into a team based mode of delivery. At the accountability level there are no cost centres for PCTs. The HSE has stated that it is progressing work on the governance of PCTs and HSCNs and consulting with staff representative bodies.

43.33 It is acknowledged that all the primary care staffing categories will not be reconfigured into PCTs. However, although two-thirds of the projected number of PCTs have been established at December 2010, only 29% of staff categorised under primary care have been assigned to the new structures which would include PCTs, HSCNs and Community Nursing Units.

43.34 At 31 December 2010, the status of assignment in the four HSE regions was as outlined in Figure 170.

Figure 170 Extent of Assignment to PCTs at 31 December 2010

Staff description	Current resources	Reconfigured resources				
		West	Dublin Mid Leinster	Dublin North East	South	Total
Primary Care Teams						
Public Health Nurses (PHNs)	**1,575**	278	234	210	217	**939**
Registered General Nurses (RGNs)	**560**	87	88	56	68	**299**
Physiotherapists	**468**	93	63	46	64	**266**
Occupational Therapists	**476**	70	63	49	44	**226**
Home Helps [a]	—	22	220	—	—	**242**
Other Health and Social Care Professionals						
Speech Therapists [b]	**478**	44	39	37	27	**147**
Social Workers	**381**	34	21	18	5	**78**
Dieticians	**60**	7	5	4	8	**24**
Psychologists	**220**	7	18	11	2	**38**
Porters		—	11	—	—	**11**
Health Care Assistants		—	28	—	—	**28**
Administration						
Administration/Clerical Staff	**3,025**	17	12	20	9	**58**
Other Staff						
Medical/Dental	**521**					
Director of Nursing	**28**					
Social Care Grades	**202**					
Community Mental Health Nurses	—	20	—	2	1	**23**
Director/Asst. Director PHN/Manager	**242**	29	36	17	5	**87**
Other [c]	**1,254**	99	23	108	40	**270**
Total	**9,490**	**807**	**861**	**578**	**490**	**2,736**

Source: HSE Census Unit

Notes: a Home help staff are not included in the census returns.

b Speech therapists can be members of teams in some cases.

c These include other health and social care professionals and general support staff.

43.35 Based on team norms set in August 2008 which exclude GPs and their support staff for accommodation purposes, the actual resources in place falls well short of that projected as outlined in Figure 171.

Figure 171 Primary Care Team Staff Resources at 31 December 2010

Staff description	Planning norm	Average team resources[a]	Proportion of resources in place
Public Health Nurses/ Registered General Nurses	5	3.54	71%
Physiotherapists	1	0.76	76%
Occupational Therapists	1	0.65	65%
Speech Therapists[b]	1	0.42	42%
Home Helps	3	No figures available	
Social Workers	1	0.22	22%
Health Assistants	3	No figures available	
Administration/Clerical Staff	5	0.16	3%

Source: Health Service Executive

Notes: a Actual resources are derived from data supplied by the HSE as set out in Figure 170.

b Speech therapists are normally members of the HSCN rather than the PCT.

General Practitioners and PCTs

43.36 According to the Irish College of General Practitioners (ICGP) there are over 3,000[346] GPs in Ireland. GPs are independent practitioners and self-employed[347]. Currently, GPs join PCTs on a voluntary basis. Achieving 100% GP involvement and enrolment in existing and new PCTs does not appear imminent. The HSE estimate that 100 GPs have declined to join a PCT. Reasons cited to the audit team for this non-engagement was lack of time, funding and IT communication.

43.37 The HSE statistics record a PCT as operating when at least one GP has agreed to participate in the team and attends a clinical team meeting. Participation is dependent on the GP formally agreeing to participate[348] and to having the GP's patients discussed at clinical team meetings. PCTs continue to be counted as an operating PCT, even if the GPs have ceased to attend the clinical team meeting. Consequently, the number of functioning PCTs is likely to be overstated since only 54% of PCTs reported that all GP practices in the PCT had a representative regularly in attendance at clinical team meetings at 31 December 2010.

43.38 A number of PCTs have no GP involvement. However, notwithstanding the non participation of GPs, HSE staff may operate as a team in their absence. Such teams are not included in the statistics for operating PCTs and are regarded as under development. In December 2010, there were 31 teams holding clinical team meetings without any GP involvement. Apart from encouraging greater GP participation there is considerable change demanded of HSE staff who have, heretofore, worked in their separate care groups.

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346 ICGP estimate that their membership would include over 90% of practicing GPs in the Republic of Ireland.

347 The General Medical Services (GMS) Scheme was introduced in 1972 to provide free GP services for public patients. The scheme was last revised in 1989.

348 As part of this process, a GP may have attended development meetings and introductory team meetings prior to the commencement of first clinical team meetings.

43.39 There are certain resourcing anomalies in that a further set of staff involved in primary care are employed by GPs. GPs may employ staff nurses and administration staff. They receive allowances from the General Medical Services scheme towards the cost of secretarial and nursing staff. Grants may also be provided towards the cost of practice premises.

Conclusion – Resourcing of Teams

The assignment of staff to teams has not been fully progressed. As yet, there does not appear to be sufficient resources assigned to teams especially in the areas of occupational therapy, speech therapy, social workers and in administration.

The HSE should definitively decide the categories of staff that will be assigned to the new configuration based on a detailed analysis of its employment census reports. There has not yet been a change at the level of control and management that would put PCTs at the centre of primary care delivery. Most staff are still managed through existing structures.

Thought needs to be given to the future direction, coordination and control of teams. It is unlikely that fundamental change will occur in the absence of a new management structure.

Some GPs have not joined a PCT and some that had initially joined do not take part regularly. It would be necessary to ensure that changes required to facilitate team based primary care be taken into account in future contractual arrangements.

54% of PCTs reported that all GP practices in the PCT had a representative regularly in attendance. In the remainder, it is difficult to see how team effectiveness would not be affected by their absence. It would be useful to monitor the extent that GPs are attending clinical team meetings.

Diagnostic Resources

43.40 In order to be the appropriate setting for the bulk of the health service needs of the population, a key requirement would be that a PCT be in a position to access a wide range of diagnostic and treatment services. It was noted from the survey that 50% of all PCTs that replied provided some minor surgery. In the course of the audit, the range of services that are currently provided by PCTs, either within a Primary Care Centre or through direct access to other local facilities (for example a local hospital) was established. Figure 172 sets out the detail.

Figure 172 Services available to PCTs at 31 December 2010[a]

Diagnostic and treatment description	Equipment located in PCTs own base[b]	Direct access at other facility (Including hospital)	No current direct access[c]
	%	%	%
X-Ray	3	84	13
Ultra-sound	5	78	17
CT Scan	—	68	32
Bone Density Measurement	8	67	25
Spirometers	27	49	24
Phlebotomy	37	49	14
STD Screening	22	62	16
ECG	35	51	14

Source: Survey of PCTs

Notes: a The number of teams responding ranged between 209 and 250.

b The PCT base refers to the Primary Care Centre, GP Surgery or Health Centre in which the PCT is based.

c Direct Access means that a GP can have direct access to the diagnostic facilities in a hospital or other facility without consultant input.

Conclusion – Diagnostic Resources

Most PCTs rely for the bulk of diagnostics on local hospitals. Even then, a good proportion reported that access to these services is through a consultant.

Co-location of PCTs

43.41 A prerequisite to optimal functioning of PCTs is that all services are located at a common centre. At 28 February 2011 the accommodation status of the PCTs that are holding clinical team meetings is set out in Figure 173.

Figure 173 Primary Care Team Status at 28 February 2011

Description	% of Overall
Team fully co-located (all members of the team in the same building)	8%
PCT not fully co-located while awaiting completion of a centre under development	21%
All HSE staff members co-located but GPs not in the same building	19%
HSE staff not co-located and GPs not co-located	45%
Other (HSE staff & GPs located in more than one building)	7%
Total	**100%**

Source: Health Service Executive

Conclusion - Location

Only 8% of PCTs are currently fully co-located. It is estimated that 29% will be co-located if current accommodation development projects are completed.

In some circumstances, geographic and population dispersal factors may dictate that a PCT may need to operate from a number of different locations. The accommodation and operating implications in such situations (e.g. rotation and timetabling of services) should be articulated.

Chapter 44 reviews the development of accommodation to support PCTs in more detail.

Linking Primary Care Services

43.42 The integration of primary care would entail linking

- GPs with other team members
- PCTs with other PCTs
- PCTs with members of the HSCNs
- PCTs with hospital services
- Out of Hours services with the PCT to the extent possible
- Community Intervention Teams (CITs) with the PCT.

43.43 Matters noted on audit included

- IT infrastructure is seen as a major block for sharing of information between GPs and other team members. For instance, GPs physically write a referral to other PCT members.
- Communication with hospitals is still not seen as adequate in that only 13% of PCTs reported that there was adequate communication from the hospitals regarding discharge and 43% reported that there is a liaison nurse/officer in place at the local hospital with responsibility for channelling communication to the PCT.
- No formal linkage between PCTs and the Out of Hours service has been established.
- Less than half of the PCTs that have a CIT in their areas reported that formal communication channels had been set up between the CIT and the PCT.

43.44 Communication continues to be an area needing development as is indicated by the survey results set out at Figure 174.

Figure 174 Level of ICT Development [a]

Description	Yes %
PCT (GPs, GP staff or HSE staff) able to electronically refer patients to a hospital	23
PCT has the facility to send X-Rays electronically to hospitals or other primary care professionals	1
PCT has the facility to receive X-Rays electronically from primary care professionals or service providers	13
PCT has electronic/other communication channels set up with the local hospital to relay urgent information (for example to indicate when the hospital emergency department is at maximum capacity)	6

Source: Survey of PCTs.

Note: a The number of PCTs responding to each question ranged from 255 to 259.

43.45 The capacity to share information is a prerequisite to efficient working. 6% of PCTs that replied to the audit survey reported that electronic files were stored on a shared server network within the PCT. Only 28% were reported as having secure email.

Conclusion – Linking Primary Care Services

Considerable work remains to be done in order to ensure that primary care services are coordinated, team members linked through secure electronic communication that protects patient confidentiality and linkage with hospitals improved.

One possibility identified in the course of the audit was extending the use of the Healthlink system. The Healthlink system is a secure electronic communications system funded by the HSE and available free of charge to all GPs. Its services include the electronic communication to GPs of laboratory results and outpatient appointment updates. GPs can also send referral notices to secondary care providers over the system. The Accounting Officer has informed me that the HSE is now piloting the use of the Healthlink system for PCTs.

Conclusion

The change involving movement from care groups that are structured as separate functions into primary care teams and networks is progressing slowly with the bulk of primary care staff not configured into the new mode. Currently, PCTs are designated as operational when they are holding meetings but the team basis of working has yet to take effect with only

- 54% of teams reporting that all GP practices in the PCT had a representative at meetings on a regular basis
- 52% of teams reporting that they have care plans in place.

In general, a considerable amount of work remains to be done to ensure that primary care

- is managed on a team basis
- has embedded systems of team working
- moves to a model that achieves efficiencies and effectiveness through improved shared care arrangements.

It is estimated that 29% of teams will be co-located if current accommodation developments are completed. Chapter 44 reviews the arrangements for the provision of primary care centres.