



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



Update on Comptroller and Auditor General Report Chapter
on
Primary Care Teams
for
PAC Meeting

January 2012

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INTRODUCTION:

PCTs make a significant difference, not just in treating illness but also in supporting people to care for themselves and their families, improving wellness, preventing illness and supporting those with long-term problems, from a health and social well-being perspective. As primary care services are further developed more care will be provided locally and the focus of PCTs will extend beyond treatment and support services to include a more comprehensive disease prevention and health promotion approach. The aim is to provide up to **90% of the health and social care** in local communities through an increase of activity in a primary care setting and the redirection of health services away from acute hospitals to the community.

The development of Primary Care has, up until now, been focused on the establishment of PCTs. With almost 87% of the Teams in place there is now a need to look at their effectiveness in terms of team-working, communication and patient management processes. This will prepare the groundwork for capacity building in relation to shifting of specific work from hospitals and the execution of much of the chronic disease management programme. Much of the work which will be undertaken in Primary Care Teams will be determined through the development and roll out of programmes devised by the Clinical Strategy and Programmes Directorate.

The HSE welcomes the audit carried out by the Comptroller and Auditor General on Primary Care Teams and accepts the recommendations included in the report. The HSE has already made significant progress in addressing some of the shortcomings highlighted and implemented many of the recommendations.

The following is a response to the principal points raised in the C&AG report on PCTs. It is set out by extracting the main comments from the report as they appear in sequence followed by comments and data that will assist in responding to potential queries.

Comptroller & Auditor General Report 2010 - Extract

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.

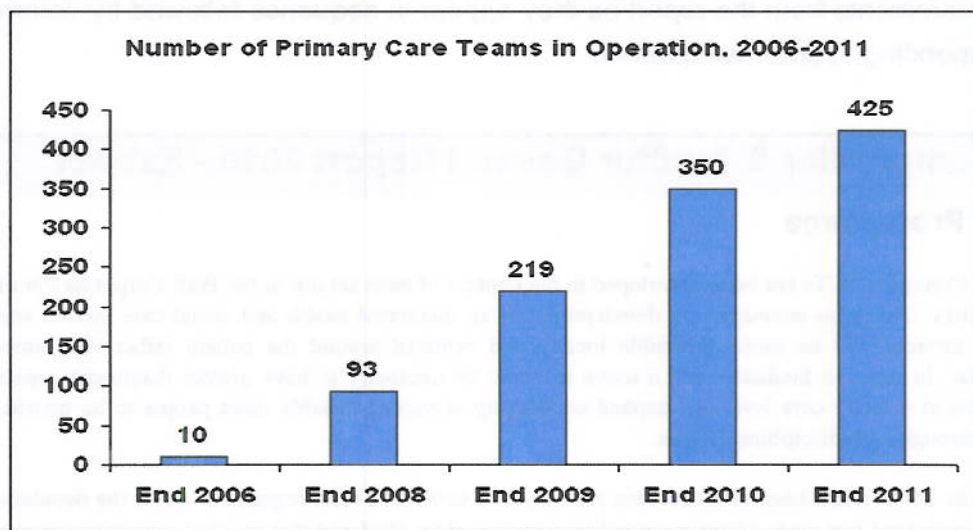
43.8 In January 2009, the HSE stated its aim was to have all teams in place by December 2011. According to the HSE, following a mapping exercise, PCT population size ranged from approximately 7,000 to 10,000 depending on the location, with an average population size of 8,000 and the indicative team size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

HSE Observations

43.7 The development of Primary Care Teams follows the strategic direction set out in the **Primary Care Strategy 2001** which estimated that as many as 1,000 Primary Care Teams were required to cover the population. It was envisaged that by 2011 two thirds of the targeted number would be in place with an additional staff resource requirement of 500 GPs, 2,000 nurses/ midwives and a significant number of health and social care professionals, administrative staff, home helps and health care assistants. The additional cost was estimated in 2001 at €615 million to 2011. The total additional funding allocated to date is €50m which funded the recruitment of 600 posts.

At the outset 3,341 staff (core and other) were identified for reassignment to Primary Care Teams. At the end of December 3,707 staff were assigned (both fully functioning Teams and Teams in development) so the HSE has exceeded the original target.

43.8 The HSE has continued with the roll out of Primary Care Teams since the publication of the Strategy. Since the commencement of the Strategy, up to the end of 2006 the number of Teams in operation was **10**. Commencing in 2007 and up to the end of 2009 there was **219** Teams in place and we have continued to progress rapidly and now have **425** Teams in operation at the end of 2011. These 425 Primary Care Teams provide services to a population of over 3.4 million with 3,117 staff members and over 1,592 GP participating. However, the pace of development has been slower than anticipated, due in part to less than €50m being allocated over the past 5 years and 600 additional staff members compared to the investment needed as outlined in the Strategy (see Appendix 1).



43.9 There needs to be an acknowledgment that existing Teams and the envisaged functioning of Teams will not be realised without designated ring-fenced funding for Primary Care Teams and services.

Resource allocation has historically been focussed on curative services at great costs, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden. By December 2011, 425 Primary Care Teams were in place which is 87% of the PCTs planned.

As provided for in the Programme for Government, a Primary Care Fund will be established by the Government as a matter of priority. Its early establishment will support the roll-out of free GP care

beginning in 2012. In line with the commitment in the Programme for Government to a significant strengthening of primary care services, additional funding of €20m has been provided for in the NSP2012 to fill as many vacancies as possible and to expand existing arrangements where sessional services are provided by allied health professionals. This will be increased to €25m if it can be established that there is scope for further savings of €5m in demand-led schemes.

Comptroller & Auditor General Report 2010 - Extract

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 PCTs³⁹⁸ 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.

HSE Observations

43.10 The Teams visited were Clones PCT and Carlow Town PCT.

Comptroller & Auditor General Report 2010 – Extract

Managing the Change

43.11 The key change in the creation of PCTs involves moving from the previous structure which was a care group³⁹⁹ 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.

HSE Observations

43.13 A total of 129 Networks have been mapped and alignment of services within those Networks is ongoing. However the formal structure for management and governance of Networks is in consultation with relevant stakeholders. This work is dependent on the agreement of the proposed Governance model. The governance model is “on hold” pending clarification of the future model of care by the DOH. A review of network boundaries was also undertaken, informed by the 2010 census. It is planned to have **50 Health and Social Care Networks in place by the end of 2012**

with a **further 79 HSCNs in development**. A Network will be considered in operation when the following have been met:

- Alignment of PCTs & Network services into identified Health and Social Care Networks areas on a local basis. This involves agreement and identification of staffing, specialist teams, facilities and services that are provided within the HSCN Area.
- Implementation of the national Management and Clinical Governance Structures for the Health area, when agreed.
- Roll out of the nationally agreed guidelines/processes in terms of:
 1. Referral Guidelines between PCTs and HSCN services;
 2. Nominated link person for the PCT in respect of each of the specialist areas.
 3. Care pathway and shared care arrangements for patients accessing network services

Comptroller & Auditor General Report 2010 – Extract

Establishment of PCTs

43.14 HSE Service Plans aimed to have 394 PCTs in place by 31 December 2010 and all of the 527³⁴⁰ 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 350³⁴¹ teams the HSE reported³⁴² 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 Areas³⁴³ and the recent census results.

HSE Observations

43.15 There are now 425 Primary Care Teams operating, with “operating” defined as *Teams which are holding clinical team meetings (CTMs), involving GPs and HSE staff*. It is important to clarify that this commencement state does not imply that they are functioning to an anticipated level but merely having commenced working together as a team. These 425 Primary Care Teams provide services for over 3.4 million of a population with 3,117 staff members and over 1,592 GPs participating. As their functioning and teamwork increases it is expected that their collective effectiveness will also increase resulting in better patient care. However, it is acknowledged that some Primary Care Teams are operating far more effectively than others and the HSE is working towards ensuring that all Teams work to their potential capacity. It is estimated that one third of Teams are working very well, a further

third are working well and the remaining third are operating not so well. For an example of a Team that is working well see appendix 4.

43.16 It is noted that the C&AG reports variations in the number of Primary Care Teams reported by the HSE as in place. The HSE already provided a significant response and reason for this variation and this justification was included in the C&AGs report which states *"The Accounting Officer 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."* The reasons for the above process have been determined and the analysis indicates that this is most evident in urban areas and in areas where there is a low staffing complement. The low staffing levels has inevitable consequences for team operation and staff members, particular Allied Health Professionals, work across a number of Teams and, in order to minimise the number of Clinical Team meetings requiring the staff members attendance, two or more teams may hold joint Clinical Team meetings. This measure takes place for efficiency purposes. Furthermore, the newly developed Integrated Services Areas have resulted in some changes to Team boundaries and these changes are currently being implemented. This will result in the merging of some Teams in order to reflect the new Service Areas. This is most pronounced in the North Dublin areas. All Team boundaries will need to be reviewed to ensure that they are appropriate and meet the service needs going forward.

43.17 As a result of team boundary changes the overall number of Teams targeted has changed from 530 to 489 Primary Care Teams. This indicates that 87% of planned Primary Care Teams have now commenced. As Teams are merging through a combination of experience, working arrangements and maximising efficiencies the numbers involved are fluid. This will be fully determined by March 2012 and it is anticipated that there will be no further Team merging beyond this point. It also needs to be acknowledged that existing Teams and the envisaged functioning of Teams will not be realised without designated ring-fenced funding for Primary Care Teams and services.

Comptroller & Auditor General Report 2010 – Extract

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.

HSE Observations

43.19 Community Consultation: While it is acknowledged that all Teams did not engage in comprehensive community/population consultation prior to Team formation, all Teams are now progressing this requirement. A Performance Indicator has been developed to capture the numbers of Community Representatives on each Local Implementation Group and a guide to progressing community participation/service user involvement has been developed and is being implemented. This will be reported on, measured, managed and supported in 2012. Significant progress is being made in addressing these deficits to ensure community participation needs are addressed in both Teams in place and Teams in development.

Community Health Needs Assessment: A Community Care Health Needs assessment toolkit has been developed and is currently being piloted in 7 areas (North Clare, Shannon, Cashel, Navan, Ashtown/Navan Road, Newtownmoutkennedy, Pearse Street). The completion of this needs assessment will involve consultation with all relevant stakeholders including community groups in the local Team area. When the pilots have been reviewed in 2012 all Teams will be requested to conduct a standardised Community Health Care Needs Assessment. This will assist in planning local, regional and national needs.

Undertaking robust Community Health Needs Assessment will enable Primary Care Teams (PCT)/Networks to plan and implement short, medium and long-term initiatives/actions targeted to meet community needs. This person centred approach within the local PCT area is central to the effective delivery of primary health and social care. A Community Health Needs Assessment is an essential aspect of the effective health planning which enables health services to deal with existing and future demands, as populations grow and change. A needs assessment has the potential to address health inequalities within populations through more effective targeting of responses. It

incorporates the wider, social and environmental determinants of health with a particular emphasis on reducing health inequalities. The Steps to Conducting a Community Health Needs Assessment are as follows;

- *Step 1- Assessment - Profiling* the collection of relevant information that will inform the state of health and social care needs of the population
- *Step 2 – Assessment – Information Analysis* of this information to identify the major health issues
- *Step 3 – Assessment - Deciding on priorities for action*
- *Step 4- Planning public health and health care programmes to address the priority issues*
- *Step 5 - Implementing the planned activities*
- *Step 6 - Evaluation of health outcomes*

Integration with local secondary care: The implementation of the care pathways for chronic diseases will lead to an improvement in secondary care integration. However, in the meantime work is ongoing to improve the implementation of the Integrated Discharge Planning framework at a local level and measures are being progressed to effect better communication and standard processes in each area between secondary and primary care. Patients being discharged from hospital should receive a seamless transition from one stage of care to the next. A coordinated and patient centred approach to planning for discharge can lead to increased satisfaction with healthcare services, reduced length of stay and prevention of unplanned readmissions. A patient centred approach to integrated discharge planning occurs when hospitals, general practitioners and other Primary Care providers coordinate care for the patient from the hospital to the community. Effective integrated discharge planning supports the continuity of healthcare, between the healthcare setting and the community, based on the individual needs of the patient. A documented discharge plan should commence at or before admission to hospital. The discharge plan should be subject to ongoing assessment throughout the hospital stay to take account of changes in patient and carer health and social status. In addition, Electronic referrals are being developed from GPs to Hospitals for out-patient clinics. This is similar to the electronic cancer referrals that are currently in operation.

Team development Training Formal Team development training should be available for all Teams as part of the establishment process. Each TDO should engage with their local Training & Development Department to ensure this training is offered to all Teams prior to commencement. In relation to training on multi-disciplinary team working, lack of resources is impacting on the potential to provide adequate training for all Team members. In addition, there is a considerable number of GPs who are reluctant to and refusing to participate in certain team development activities. However, a resource pack has been developed for all Teams which includes an induction for new team members. All the relevant protocols and procedures are included in the pack. In addition, a DVD on Team working and maximising the potential of Clinical Team Meetings has been produced and disseminated which will serve as a useful tool for staff members, both new and existing.

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.

HSE Observations

43.20 The governance and management model for HSCNs and PCTs is currently being revised to ensure that the definitions of the management roles are clear and unambiguous to allow for effective implementation. However, informal discussions have taken place with the Department of Health and it has been decided to defer the implementation of the model until such time as there is more clarity on the models of care as proposed under the Plan for Government. Notwithstanding this, 4 ISAs have been identified for piloting the structures once consultation has taken place with all stakeholders and when clarity on the future model of care is received.

The proposed model represents a fundamental shift in service architecture from a unidisciplinary structure to a multi-disciplinary approach. In this context two key roles emerge:

- A *HSCN Service Manager* for a group of PCTs including Health and Social Care. The HSCN Service Manager will have responsibility for the delivery of direct and contracted services provided within a group of PCTs and Network.
- A *Professional Discipline Lead* e.g. Physiotherapy, Occupational Therapy, Nursing etc. The Professional Discipline Lead will provide an assurance function regarding professional standards and development and may, where appropriate, encompass responsibility across acute and primary care services.

In the service re-design the Primary Care Operations Manager has overall responsibility for all primary care services within the Health Area. The primary care professionals within the PCT and HSCN work together for the local population, reporting on a day to day basis to a HSCN Service Manager, with an assurance relationship with the appropriate Professional Discipline Leads. It is expected that the new model will see many of the existing discipline managers fulfilling either a HSCN Service Manager role for a Health and Social Care Network or the role of Professional Discipline Lead.

The Government has approved the drafting of legislation involving significant changes in the governance in the Health Service Executive. The proposed new Directorate structure involves the identification of clear areas of priority and the establishment of responsible directors for Service Lines. Primary Care will be one of the proposed directorates and will have a Director of Primary Care appointed.

Minister Shortall is currently convening an initial meeting of a project team of officials from the Department of Health and the HSE which will assist in the Programme for the Implementation of Universal Primary Care.

Comptroller & Auditor General Report 2010 – Extract

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 areas³⁴⁴. 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.

HSE Observations

43.21 Due to the introduction of ISAs and the current staffing constraints some TDOs have taken on expanded areas. However, there are still 3 areas without a TDO. All Area Managers are ensuring that the functions of the TDO role are being discharged by a nominated staff member either on a full time basis or part-time basis. There is an understandable reluctance to appoint personnel to positions that may not be in existence in the near future due to possible changes as flagged by Government. The HSE is awaiting clarification on these. In the meantime some staff are being requested to discharge the TDO role along with their own core function.

Comptroller & Auditor General Report 2010 – Extract

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 planning³⁶. For purposes of this report, a care plan was considered to be as set out below.

HSE Observations

43.26 There is some ambiguity in relation to the definition and interpretation of the terms "plans of care" and "care plans" due to the usage of the term "care plan" in other service areas, most notably disability services. Each patient discussed at a CTM will have a plan of care developed and this is standard practice at all CTMs. Work is ongoing within the National Primary Care Steering Group to work towards national agreement on a standard plan and this will be collated as a PI for 2012. The proposed definition, as per the C&AG report is, "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 CTM and take action based on a holistic review of the patient." This will involve a clear definition and a possible re-wording of the description attaching to the "care plan". As per earlier, a DVD has been developed to help Primary Care Teams to hold effective Clinical Team meetings where developing and agreed plans of care is a central component.

At Clinical Team meetings, Plans of Care are developed for each client discussed. The Plan of Care, as defined in the C&AG Report, 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 CTM and take action based on a holistic review of the patient. Some higher performing teams are discussing, on average, 16 patients per clinical team meeting with some teams holding weekly meetings. In order to demonstrate the capacity of the CTMs it is worth considering the following: if 16 patients were discussed by all 489 Teams per week, this would result in a multi-disciplinary plan of care in place for 407,000 people, almost 10% of the entire population within one year, 75% of all people estimated to have a chronic disease. This would represent most of the patients in the country with the greatest and most complex needs as not all patients require a multi-disciplinary input into their care. This example hopefully, signposts the targeted approach needed and the capacity of the PCTs to deliver it. Clearly, we have some way to

go to achieve this by all teams but the higher performing teams are leading the way and pointing to what is possible. In order to deliver on this potential we are striving to get the basic building blocks correct firstly before advancing, all of this is being carried out under the prevailing fiscal challenges.

Comptroller & Auditor General Report 2010 – Extract

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.

HSE Observations

43.29 The HSE advocates that each Primary Care Team holds a Clinical Team meeting at least monthly and recommends weekly, if possible. The National Primary Care Office recently revised and expanded upon Clinical Team meeting guidelines and this will shortly be disseminated to all Primary Care Teams. It is hoped this will improve the effectiveness and frequency of CTMs for PCTs. In addition, a DVD on Team working and clinical Team meetings has been produced which will serve as a useful tool for staff members, both new and existing. This has been disseminated to all Primary Care Teams.

Comptroller & Auditor General Report 2010 – Extract

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.

HSE Observations

43.33 In the absence of defined cost centres assigned to Primary Care Teams and continuous movements of staff across and between PCTs it is difficult to identify the totality of staff on specific

Teams. The HSE's census data for Primary Care, which was used by the C&AG, includes a number of staffing categories that will not be reconfigured into Primary Care Teams (e.g. Community Nursing Units EHOs, Primary Care Unit staff, AMOs, Ophthalmologists etc) and, therefore, it is not accurate to include such staff when deriving such figures.

It is advised that all appropriate and available staff have been reconfigured to Teams and Networks. The remaining piece of work is to align specialist, care group and voluntary services to Health and Social Care Networks. This will effectively mean each Team will have linkages with these network services in their area. There are now 425 Primary Care Teams operating, with "operating" defined as Teams which are holding clinical team meetings (CTMs), involving GPs and HSE staff. These 425 Primary Care Teams have 3,117 staff members and over 1,592 GPs participating. All identified Primary Care staff have now been assigned to Primary Care Teams.

The deficits in staffing on Primary Care Teams continue to cause difficulties for Primary Care Team development. The loss of staff and the inability to replace staff on leave being a major one. A June 2011 analysis of staff vacancies has shown that:

- 105.69 (WTEs) staff on PCTs have resigned or retired (permanent vacancy)
- 163.16 (WTEs) staff are on Maternity Leave (temporary vacancy)
- 53.6 (WTEs) staff are on long term sick leave (temporary vacancy)
- 38 (WTEs) staff are on parental leave (temporary vacancy)
- 92.5 (WTEs) staff are availing of other types of leave (temporary vacancy)

This represents a total of over 453 (WTEs) posts which had been either permanently or temporarily assigned to Teams but were at the time vacant and are unable to be filled due to the moratorium. This is having a significant impact on both existing Teams and Teams in development. As stated earlier, the NSP 2012 has provided funding of €20m to fill as many vacancies as possible and to expand existing arrangements where sessional services are provided by allied health professionals. This will be increased to €25m if it can be established that there is scope for further savings of €5m in demand-led schemes.

General Practitioners and PCTs

43.36 According to the Irish College of General Practitioners (ICGP) there are over 3,000³⁴⁶ GPs in Ireland. GPs are independent practitioners and self-employed³⁴⁷. 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 participate³⁴⁸ 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.

HSE Observations

43.37 There is a distinct lack of GP participation in particular areas of the country. GPs are self-employed and they have no obligation to join a PCT or attend Clinical Team meetings. Work is ongoing to show GPs the benefits of PCTs but there are still approximately 180 GPs that are refusing to join PCTs with many others reluctant to engage for many reasons, mostly un-related to Primary Care Team development but rather IR and local historical issues (See Appendix 2 for list). This figure includes a minority of GPs that have withdrawn from Teams due to recent FEMPI cuts. In the **North East 111 GPs** recently notified of their intention to withdraw from PCTs to the Minister of Primary Care. The GPs did not notify the HSE of their intention in this regard, however, it should be noted that only 6 PCTs in the NE could possibly be affected by this decision as many of the GPs listed are not currently in Primary Care Teams.

The report states that 54% of PCTs reported that all GP practices in the PCT had a representative regularly in attendance at CTMs. However, it should be noted that not all GP Practices are required to attend all CTMs. Only GP practices where their patients are being discussed will attend a CTM.

GPs are invited to attend each relevant CTM taking place and every effort is made to ensure GPs recognise the benefits of attending these meetings. CTMs are also arranged at a date and time suitable to GPs (for example lunchtime) and the venue for such meetings take place in GP practices on a rotational basis. Furthermore, as programmes of care are rolled out in the community, it is envisaged that periodically the CTMs could have an educational element or separate Team meetings may be organised for this purpose. The HSE are working with the ICGP to facilitate the awarding of CME and PC credits for such meetings following the introduction of mandatory Continuing Professional Development.

Comptroller & Auditor General Report 2010 – Extract

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.

HSE Observations

- 43.40** A key issue in the development of Primary Care is the availability of diagnostic services to PCTs, particularly to GPs. In order to provide better services to patients GPs need to be able to directly access certain diagnostic services and refer patients for consideration for other types of diagnostics. However, in assessing whether it is viable to procure and provide such expensive services it is necessary to maximise usage of existing equipment, principally based in hospitals. Work is underway in developing proposals for direct-access facilities by GPs to hospital-based diagnostic equipment for certain procedures under pre-determined protocols. This will assist greatly in a smoother patient experience with greater empowerment of the GP in the management of such patient care.

Comptroller & Auditor General Report 2010 – Extract

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

HSE Observations

43.41 Below is a table outlining the current position for all PCTs both in place and in development. However, it should be noted that all Private Sector Lease Agreements may not materialise due to difficulties with planning, developers, banking etc.

Figure 173 Updated	% of Overall
Team fully co-located (all members of the team in the same building)	11%
PCT not fully co-located while awaiting the completion of a centre under development (including early Private Sector Lease Agreements)	30%
All HSE staff members co-located but GPs not in the same building	18%
HSE staff not co-located and GPs not co-located	32%
Other (HSE staff and GPs located in more than one building)	9%
Total	100%

In parallel with the development of Primary Care Teams the HSE is progressing an initiative to procure appropriate Primary Care Centres to accommodate these Teams. As per the Primary Care Strategy, modern, well-equipped, accessible premises will be central to the effective functioning of the primary care team. While for practical purposes teams are likely to operate out of more than one premises in the short term, the development of locally accessible primary care centres that allow many of the services being delivered to be made available on a single site, providing a single point of access for the user and encouraging closer coordination between providers, is a key longer-term implementation objective of the new model.

The centres that have been opened to date have been very well received by all stakeholders including service users. It is widely acknowledged that the present infrastructure is outdated and inadequate for the provision of modern services, in particular the provision of chronic disease management by multi-disciplinary teams. Traditional single-handed GP premises are not fit for purpose when dealing with chronic diseases that require multiple professional on-site input. International evidence points to such Primary Care Centres as being an important factor in the successful provision of chronic disease management in the community.

Having all Primary Care Team members located in one Primary Care Centre is the preferred option as it has advantages for both service users and professionals working within teams. The advantages for service users include a high visibility facility which provides an easily accessible one-stop-shop. A range of services provided in one location also facilitates a degree of anonymity for users of some specialised services such as Mental Health services while providing economies of scale. Well designed and adequately resourced premises will facilitate outreach hospital and specialist services and diagnostic services in the service users' own community. This will in turn relieve the burden on overstretched hospital facilities. Advantages also accrue for the professionals as it facilitates inter-disciplinary communication, team building and the development of mutual support networks resulting in better quality services. The operation of public private partnerships, which is being progressed, is one way of providing the necessary accommodation for primary care teams and the wider networks.

Generally, HSE Primary Care Team members are accommodated in several different locations, often in very substandard accommodation. Accordingly, we must ensure that the HSE Team members have suitable accommodation. While a minority of Teams (approx. 11%) may have already acquired suitable accommodation through existing infrastructure or lease agreement, there is still a significant proportion of Teams whereby accommodation has not progressed via the various options. There are currently 39 Primary Care Centres accommodating 55 Primary Care Teams in place or due to open imminently. (See Appendix 3).

Comptroller & Auditor General Report 2010 – Extract

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.

HSE Observations

43.42 Service Integration: Effective integration of care is easier to achieve where Primary Care Team professionals assume key significance in the healthcare system through their role as gatekeepers to specialist referral. This gatekeeper approach is built on effective collaboration, common purpose, mutual respect, clear communication and preferably, co-located professionals. The Primary Care Programme is committed to an 'integrated health system' through an increase of activity in a primary care setting and the redirection of health services away from acute hospitals to the community.

Hospital avoidance and the promotion of capacity building in the community so that patients can be cared for at home in their community is core to service integration and has, through similar models internationally, demonstrated a reduction in the burden of acute admissions without reducing quality of care or patient satisfaction. Patients should not have to attend hospital unnecessarily with all the added stresses and possible complications that such attendances involve.

Chronic Disease Management: The establishment of Primary Care Teams creates a supportive environment to facilitate structured approaches to **chronic disease management**, enhanced multi-disciplinary working, shared care arrangements and integration between primary, secondary and tertiary services. The challenge of improving quality and reducing cost will initially be focused on five chronic diseases, which account for 70% of healthcare spend (stroke, heart disease, asthma/COPD, diabetes, depression). These conditions are common and in the majority of cases have internationally agreed best practice guidelines. There is no doubt that implementation of the internationally agreed models of care for these five chronic diseases would result in significant reductions in morbidity and mortality with the potential to substantially reduce cost. This goal has become the primary focus of many healthcare systems internationally.

Implementation of chronic care programmes are at the heart of the current HSE Corporate plan. The development of integrated services, prevention and management of chronic disease and promotion of patient self care are all priority areas. Chronic disease management programmes are initiatives which are designed to address the systemic barriers to effective care and establish evidence based standards of care for particular conditions. Data from the US has shown that chronic disease management programmes can achieve a 50% reduction in unplanned hospital admissions as well as a 50% reduction in bed day rates for these conditions. This has been achieved with greater than 95% family and carer satisfaction rates with the chronic disease management programme. The focus of these programmes is to prevent the health of an individual deteriorating, thus preventing the occurrence of acute episodes, which may require hospitalisation. This will be almost wholly primary care based.

Chronic disease management programmes typically evolve from shared care programmes (a model of care that is developed jointly between primary care and specialist services). They are anchored in primary care rather than being hospital outreach programmes. The focus of disease management is on prevention, early detection, basic self care and management all designed to minimise the burden of chronic disease and its complications including to minimising the risk of acute exacerbations occurring. Evidence shows that systematic, structured care reduces morbidity and mortality.

It is intended that over time there will be a number of Chronic Disease Management programmes in place. It is very important as we move towards an insurance based model with primary care being provided by primary care teams that there is a generic model agreed which will allow diseases to be included. The model should involve shared care where roles and responsibilities between primary care and specialised medical care are clearly understood and supported by clinical protocols consistent with the national clinical effectiveness framework. Primary health care has the central role to play in the management of a chronic disease.

It is proposed that a Chronic Disease Watch programme will be developed to provide structured care for patients with a major chronic disease in a manner that will improve quality, improve access and reduce costs to the health service. A set of indicators for both clinical and organisational activities are being developed in consultation with the relevant programmes of care. Clinical indicators are been chosen on the basis of evidence of effectiveness in achieving outcomes. The need of patients with multi-morbidities should be prioritised. 2012 will see the roll out of an

Integrated Care Package for Diabetes as par of this Chronic Disease Watch Programme and €2m has been made available for this development in 2012.

- 43.43** The Out of Hours GP services communicate the results of consultations to GPs in respect of their patients by start of business on the morning after the consultation. The GP will, if required, engage with other members of his/her Primary Care Team for additional support and services if required. The GP, in this case, acts as a link between the OOH services and the rest of the Primary Care Team. While there is no formal link with the Primary Care Team each participating GP is fully empowered by timely information transfer to refer to other team members.

Similar to the OOHs, the CITs do not have a single formal contact point with each Primary Care Team but as a matter of course the CIT would engage consistently with Primary Care Team members. This would happen in regard to ongoing management of the patient, communication of progress and discharge from the CIT to the Primary Care Team. The CITs protocols involve active engagement with the members of the PCT in adhering to best practice. There are currently 6 CITs in place nationally (Dublin North, Dublin South, Cork, Limerick, Clare and North Tipperary).

Comptroller & Auditor General Report 2010 – Extract

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.

HSE Observations

- 43.45** It is envisaged that Primary Care Teams will operate on the basis of sharing patient clinical information on a **patient management system** which will interact with existing GP patient

management systems. A critical component of such a system will be a unique patient record with a unique identification number. This patient record and number will be shared with hospital services and all health providers. These records will contain core data which will be available to all team members. Other data items will be shared on a need to know basis as per clinical requirements and subject to patient consent. Primary Care Teams will operate most effectively using a system which will facilitate mobile computing with remote access to the databases. This will reduce "office time" and increase clinical time for Clinicians.

The patient management system will incorporate a module for a Patient Plan of Care for patients presenting with chronic disease and particular clinical requirements. The Patient Plan of Care will be an integrated plan with hospital consultant direction, agreed by the Primary Care Team and coordinated by a Key Worker on the Primary Care Team who will act as advocate for the patient and liaison person and will be responsible for follow up. Each time a patient consultation is undertaken by a Primary Care Team member the consultation result will be recorded on the patient's electronic record on the patient management system. This update will be available to all Clinicians including GPs with the approval for such access. The GP patient management system should interact seamlessly with the HSE system(s) and results of consultations should be updated to their files with notifications of same posted to their system.

In addition to patient consultations the system should accommodate referral systems (with capacity for receipt of such consultation feedback/reports/data) to other Primary Care Team members, specialist services in the community e.g. community mental health teams, stroke rehab teams, diagnostics, Out of Hours Services etc, and hospital services (admissions & discharges etc). Consideration in the design of such a system should be given to appointment systems, reminders for patients.

Emphasis on the patient management system should be placed on vital patient data being shared by all team members with core clinical results being updated to the patient's record. Individual team clinicians may access complementary professional software packages to augment their clinical care and decision making but these packages would not be available to all team members. Typically, a physiotherapist would have access to a specific physiotherapy package such as Tiara 9 which would help with their clinical work but the key results would be updated to the patient management system, accessibly to the wider PCT where appropriate.

A number of patient management systems which allow inter-referrals have been identified and evaluation of each is currently underway to determine if any meet the needs of PCT members. This will be progressed in 2012.

The **Healthlink secure messaging system** now provides electronic services between 32 Hospitals and 2,532 GPs, operating from 1,091 GP Practices. This has been hugely successful and has provided scope for expansion of the messaging system from laboratory only information to other services. As a consequence the Healthlink service has been developed to provide GP referrals to Hospitals for cancer services under the National Cancer Control Programme for Breast, Prostate and Lung referrals. Referrals are generated directly from within the patient file on the GP IT system and are delivered to the cancer team in the Hospital who will respond within five working days. Acknowledgments are available immediately indicating if the referral has been successfully delivered.

Responses from the cancer team are integrated with the patient file providing a complete record of the referral/response process for the GP.

Work is nearing completion on the development of electronic referrals from GPs to Hospitals for outpatient clinics using Healthlink. This system will allow GPs to generate electronic referrals from their existing GP software packages to hospitals using the standard HIQA referral form. This will be piloted in Tallaght and Cork and Kerry initially.

Central to the development of Primary Care Services is timely communications between members of the Primary Care Team. In this context the requirement for a secure clinical transfer of information has been flagged and agreed as an urgent business priority. A project is currently underway whereby the Healthlink system in use for cancer referrals would be mirrored in a Primary Care Team context. PCT members will be issued with security certificates allowing web-based access to Healthlinks. Using the generic messaging system PCT members will use Healthlink online as a secure messaging system for referrals between such PCT members. The project will be used to trial the use of Healthlink for use by Primary Care Teams and provide a basis to identify barriers that need to be addressed before progressing further.

This referral process will replace a multitude of discipline-developed forms with one common set of information and makes referrals simpler and easier for service providers, and refines the referral process to maximise efficiency of care. The benefits for service users include improved access to services overall, increased efficiency, shorter time from identification of need to service delivery, and reduced communication failure. The benefits to professionals include improved flow of patient information, improved quality of information, and subsequently improved triage, prioritisation and management of patients and services.

Furthermore, a **secure email solution** is currently being advanced that will allow all PCT members, including GPs to transfer patient clinical information in a safe secure environment. An option appraisal document on secure email has been developed and the project is being progressed under the GPIT group with Department of Public Expenditure and Reform.

APPENDIX 1

BREAKDOWN OF PRIMARY CARE TEAM POSTS 2007

Grade	SOUTH	WEST	DML	DNE	TOTAL
Dietitian	6	1	0	0	7
Occupational Therapist	19.5	23	15	20	77.5
Physiotherapist	20.5	26	15	19	80.5
Counsellor	1	0	0	0	1
Psychologist	4.6	1	9	9	23.6
PHN	1	3	2	1	7
S & L Therapist	14	9	17	13	53
Social Worker	8	13.5	17	13	51.5
Totals	74.6	76.5	75	75	301.1

BREAKDOWN OF PRIMARY CARE TEAM POSTS 2006

Grade	SOUTH	WEST	DML	DNE	TOTAL
Addiction Counsellor	0	1	2		3
Adolescent Health Nurse	0	2.5			2.5
Chiropodist	0.5		0.5		1
CMHN	0			2	2
Dietitian	11	3	6	1.5	21.5
HCA	0		1.5		1.5
Occupational Therapist	8.5	17	13.5	15	54
Physiotherapist	21	23	17	18	79
Counsellor	0		1		1
Psychologist	2.25		6.5	1	9.75
PHN	16.5	9	10.5	8	44
RGN	7	10	3	7	27
S & L Therapist	9	5.5	10	6.5	31
Social Worker	1	1	9.5	7	18.5
Staff Nurse Psych	1				1
Substance Abuse Counsellor	1				1
Clerical Officer	1				1
Totals	79.8	72	81	66	298.8

APPENDIX 2

PRIMARY CARE TEAM DEVELOPMENT - ENGAGEMENT BY GENERAL PRACTITIONERS					
RDO Area	ISA	No. PCTs Where GP Engagement Not Progressing	No. GPs Not Engaging	No. GPs Withdrawn From Attending CTMs	Reasons For Non-Engagement/Participating In CTMs
Dublin North East	Meath	4	0	8	Reduction in funding for services provided (2 GPs); No reasons given (6 GPs)
	Cavan/Monaghan	7	20	1	Do not wish to attend. Have individual contact with Team members (15 GPs); GP partner/practice nurse attends CTMs on behalf of practice (2 GPs); Will attend once located in PCT building (4 GPs)
	Louth	10	23	2	GPs met and written to but no engagement to date (5 GPs); Do not wish to attend CTMs, have individual contact with Team members (12 GPs); Teams not set up as required and system will not benefit patients (2 GPs); Support development of PCTs but unable to involve themselves (3 GPs); Involved in Centre discussions (3 GP);
	North West Dublin	3	4	1	Stretched - cannot take on extra commitments (1 GP); Unknown (3 GPs); Too busy (1 GP)
Sub Total DNE		24	47	12	
Additional Notes: In NW Dublin some GPs more engaged than others. Many GPs attend meetings sporadically but cannot get to them all due to work commitments. No response received from North Dublin & Dublin North Central.					
Dublin Mid Leinster	DS Central (Dublin South City)	8	15		Never engaged. Not interested in participating in CTMs
	DS East Wicklow (Dublin South)	3	2	1	Not good use of time - meetings not necessary (1 GP); Never engaged (2 GPs)
	DS East Wicklow (Wicklow)	8	3	6	Mainly payment issues. Have not referred any patients for discussion at CTMs. (9 GPs)
	DS West Kildare (Kildare/West Wicklow)	6	0	All GPs	No payment for attendance at CTMs.
	Midlands (Longford/Westmeath)	1	Not indicated	0	Issues around Centre - currently being resolved
Sub Total DML		26	20 GPs (identified)	7 GPs (identified)	
WEST	Mayo	4	0	11	Dissatisfied with HSE cuts in GP fees, etc.
	Galway/Roscommon (Galway)	2	0	11	Reduction in payments (10 GPs); Distance to meetings (1 GP)
	Galway/Roscommon (Rosc)	4	0	24	Not known - not attending meetings
	Mid West (Clare)	4	0	4	Lack of Benefit (3 GPs) Location of PCT in Ballyvaughan versus his base in Lisdoonvarna (1 GP)
	Mid West (Limerick)	6	0	14	No reasons given (10 GPs); GP never got involved, never attended CTMs (2 GPs); Time consuming (1 GP); Not interested (1 GP)
	Mid West (North Tipp/East Limk)	1	0	1	Time constraints

Sub Total WEST		21	0	65	
Additional Notes: Data not clarified for Thurles					
SOUTH	South Tipperary	7	28	0	Awaiting co-location (10 GPs); Geographical issues (10 GPs); Time constraints (2 GPs); Not convinced of merits of PCT process (1 GP); Disillusionment with HSE (1 GP); Not interested in PCT process (1 GP); Needs to be part of contract before getting involved (3 GPs).
Sub Total SOUTH		7	28	0	
OVERALL TOTAL		78	95	84	

APPENDIX 3

Area	No	ISA	LHO Name	No of Centres in Place/opening	No of PCTs located in the centres	Locations of Centres
DML	1	Dublin South Central	Dublin South City	2	2	Irishtown; Peare Street
			Dublin West	2	5	Ballyfermot (due to open); Incichore
	2	Dublin South East Wicklow	Dublin South East	1	1	Ballyogan
			South Dublin	0	0	N/A
			Wicklow	1	1	Newtownmountkennedy
	3	Dublin South West Kildare	Dublin South West	0	0	N/A
			Kildare/West Wicklow	1	2	Naas
	4	Midlands	Laois/Offaly	2	2	Mountmellick; Portarlington
			Longford/Westmeath	3	3	Longford Town; Kinnegad; North Westmeath/Coole
				12	16	
DNE	5	Cavan/Monaghan	Cavan/Monaghan	2	2	Cootehill; Cavan (due to open);
	6	Dublin North City	Dublin North Central	1	2	Ballymun
	7	North Dublin	Dublin North West	1	1	Mulhuddard (due to open)
			Dublin North	0	0	N/A
	8	Louth/Meath	Louth	1	1	Carlingford (due to open)
			Meath	3	4	Trim; Dunshaughlin; Kingscourt (due to open)
				8	10	
South	9	Carlow/Kilkenny	Carlow/Kilkenny	3	4	Carlow Town; Callan; Kilkenny City
	10	Kerry	Kerry	1	1	Kenmare (due to open)
	11	Cork	North Cork	2	4	Mallow; Mitchelstown
			North Lee	1	2	Macroom (due to open)
			South Lee	1	3	Blackrock/Mahon (due to open)
			West Cork	0	0	N/A
	12	South East	Tipperary South	0	0	N/A
			Waterford	2	3	Waterford City; Tramore (due to open)
			Wexford	1	1	Gorey
				11	18	
West	13	Donegal	Donegal	2	4	Letterkenny; Glenties (due to open)
	14	Galway/Roscommon	Galway	1	2	Galway City East
			Roscommon	2	2	Roscommon Town; Strokestown
	15	Mayo	Mayo	2	2	Ballina; Achill
	16	Midwest	Clare	1	1	North Clare
			Limerick	0	0	N/A
			Tipp/East Limerick	0	0	N/A
	17	Sligo/Leitrim	Sligo/Leitrim	0	0	N/A
				8	11	
Total:				39	55	

APPENDIX 4

Ayrfield Primary Care Centre Kilkenny

ONE TEAM, ONE PLACE, ONE TIME
ONE AGREED PLAN FOR PATIENTS

One Team *Ní neart go cur le chéile!*



- Co-location of people and services
- Close working relationships
- Multi-disciplinary meetings
- Communication & co-operation
- Quick decision making
- One agreed plan of action
- Initiatives on Travellers
- Co-operation with St. Luke's General Hospital
- Outreach Clinics in Psychiatry
- Outreach Clinics in Geriatrics

One Place



Ayrfield Primary Care Centre

- State of the Art Purpose Built Primary Care Centre
- One Stop Shop for Patients' Health & Social Needs
- Parking, Coffee Shop, Pharmacy, Dentist, Consultant Rooms
- Built without Public Funding

One Plan





Meetings are held at lunchtimes, outside normal working hours.

For Patients

The Disabled The Very Young The Old
 Mental Health Patients Travellers
 Children at risk
 Those with multiple problems

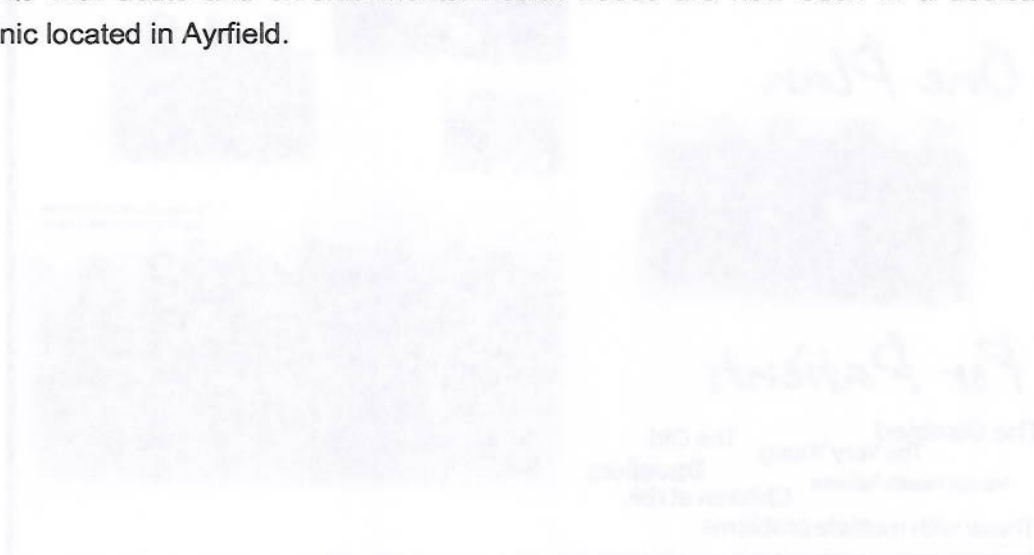


Ayrfield Primary Care Centre at Ayrfield Medical Park, on the city's Grange's Road, features GPs and practice nurses attached to the former Dean Street Medical Centre, working as part of a Primary Care Team with a range of HSE health professionals including public health nurses, physiotherapists, speech and language therapists, community mental health nurses, occupational therapists, dieticians and administration. The Park was developed and financed by the GPs as a result of the pressing need they felt for a primary care centre offering a full range of services to their patients.

Ayrfield Medical Park will also provide hospital based services at a local level, such as minor surgery and exercise stress tests for diagnosis of heart disease as well as facilities for infusions and intravenous treatments. GP trainees from the South East scheme will be facilitated as well as medical students from Irish universities. There will be access on site to private services such as psychology, chiropody, audiology, massage therapy and yoga/pilates. There will also be access to dedicated consultant clinics in plastic surgery, ear nose and throat, psychiatry, urology, ophthalmology and gynaecology. A pharmacy and dental practice also feature on site. The centre allows the provision of an extensive range of integrated services, all in the same building.

The practice, in 1997, was among the first in the state to engage with the HSE in developing a primary care team. Over the last number of years, the GPs have participated in regular team meetings with HSE professionals where individualised care plans are developed for patients, particularly those with chronic illnesses and other complex needs. The Ayrfield Primary Care Team share information and their respective skills to ensure that patients with greatest need receive services in a timely and coordinated fashion. If acute hospital care is required, the links and arrangements can be made through the team.

Ayrfield Medical Park Primary Care Team has already had achievements. In co-operation with St. Luke's General Hospital, in areas such as transfusion and intravenous treatment services and access to the Medical Assessment Unit at St Luke's, many of the traditional boundaries between primary, community and secondary (hospital) care have been broken down. Consultants psychiatrists and geriatricians attend regular clinics in Ayrfield, which builds on the initiative of the team to target vulnerable older persons (aged 80+) living in the community and to maintain them at home as long as possible. Innovation will also feature at the new facility. In a joint vision with the Department of Psychiatry at St. Luke's General Hospital, all Ayrfield patients with acute and chronic mental health needs are now seen in a dedicated psychiatric outpatients clinic located in Ayrfield.



Ayrfield Primary Care Centre at Ayrfield Medical Park, on the edge of George's Road, Ireland City and County Council, is the former Donaghadee Medical Centre, which is part of a Primary Care Team with a range of health professionals including public health nurses, physiotherapists, speech and language therapists, community health nurses, occupational therapists, dietitians and psychologists. The Park was developed and financed by the GPs as a result of a planning need for a primary care centre offering a full range of services in their practice.