STRATEGY AND PROGRESS REPORT
2002-2007

Compiled by: Mary Kenny, Project Manager (September 2002 - February 2006)
Contents

ballymun
Primary Care Team

STRATEGY AND PROGRESS REPORT
2002-2007

Compiled by: Mary Kenny, Project Manager (September 2002 – February 2006)
Special thanks to John Timon, Eamonn Elliott and staff in Ballymun Regeneration Ltd. and to Declan Dunne and all the staff of Ballymun Partnership.

© Ballymun Primary Care 2006

Copies available from:
Project Manager, Ballymun Primary Care Premises,
Unit 6, Ballymun Shopping Centre.

Acknowledgements to photographers – Mick Quinn and Derek Speers

Graphic design by

jean@longley.ie 087 2219752
Contents

Foreword iv

The Ballymun Primary Care Team 1

Executive Summary 7

Section 1: Socioeconomic and health profile of the Ballymun population 17

Section 2: The role of the Ballymun pilot and the local service context 31

Section 3: Implementation of the Primary Care Strategy in Ballymun 41

Section 4: Progress Report 57

Section 5: Future Planning and Progress 103

Section 6: Future Rollout: The Way Forward 119
Foreword

In order to be effective in delivering high quality health services we must respond to the changes put before us as an organisation by the health service reform programme, demographic and technological trends and increasing consumer expectations. Meeting the challenges arising from these changes must revolve around the provision of person centred services, a focus on evidence-based quality health care and the development and delivery of services that are appropriate to client and community needs.

The Ballymun Primary Care Pilot was established, as one of 10 national projects, to develop a model of primary care service delivery, as outlined in the Primary Care Strategy, which is responsive and adaptable to local needs. I am pleased to present this report which details the process which commenced in September 2003 and measures its progress against agreed goals and actions and outlines further actions and recommendations for going forward. The Ballymun Primary Care Pilot has risen to the challenge of modernisation. New clinics and services, extended hours of working and greater interdisciplinary working have been introduced to meet client's needs.

Many people have been involved in the pilot project and I wish to thank them all for their very important contribution. The continuing willingness of all staff to identify opportunities, to embrace change and to engage in this process is critical to the success of the project.

Noel Mulvihill
Local Health Office Manager
Dublin North Central
Our Mission Statement

The aim of the Ballymun primary care team is to work in partnership with the people of Ballymun to support them in leading healthier and more independent lives in their own community. This aim will be achieved by the development of a strong local primary care service that operates to a standard of excellence, is responsive to local need and is highly accessible and available when needed.

The Ballymun Primary Care Team
Targeted Outcomes for Our Service Users

- Improved and speedier access to services.
- Access to a broader range of primary care services that are responsive to local needs.
- Reduced dependence on secondary and specialist care.
- Additional supports to facilitate the mentally and physically ill and disabled to remain in their own home and community whilst receiving appropriate care to a satisfactory level and standard.
- Increased empowerment of the local community to maintain good health through improved health information, promotion and involvement in the planning of services.

Our Strategic Goals

- The provision of critical support structure and resources to develop the primary care team structure in Ballymun.
- The development of a client-centred service based on a multidisciplinary team approach.
- The maximisation of local primary care capacity by an improvement in the range, accessibility and responsiveness of local health services.
- The development of structures and protocols to promote integration between primary, secondary and specialist services.
Our Achievements to date

- Development of a Multi-disciplinary team model incorporating the following features:
  - Intensive team interaction and a broad skill mix that is highly transferable to similar areas of concentrated deprivation.
  - Based on recruitment of local staff and maximisation of local experience.
  - Incorporates flat ethos guaranteeing parity of esteem and consultation to all disciplines. Provides alternative to traditional hierarchical model of decision making or team models dominated by a single discipline.

- Development of transferables to facilitate and expedite wider team building process including:
  - Job descriptions for disciplines entering primary care context e.g., psychology, community mental health nursing, occupational therapy and physiotherapy.
  - Broad and clear information sharing protocol.
  - Effective enrolment criteria and public information/application form.
  - Collaborative model of team interface with patients as piloted in Joint Consultation Model by primary care team and Royal College of Surgeons.
  - Protocols and tools for collaborative team working such as joint assessment and care plans.

- Effective Model of community participation in primary care development.

- Development of governance structures to drive integration and support multidisciplinary team working.

- Provision of evidence base for service planning and development of quality assurance framework including:
Our Achievements to date

- Independent evaluation of effectiveness of multidisciplinary team working conducted jointly by primary care team and R.C.S.I.
- Research on existing needs assessments in local area and analysis of findings
- Reproductive Health Needs Assessment for Ballymun area—conducted jointly by team and Womens Health Promotion
- Consultation and feedback involving patient focus groups conducted jointly by primary care team and R.C.S.I.
- Development of a blueprint for selection, development and implementation of an integrated information system for primary care teams in the L.H.O. area including:
  - Recorded requirements and business processes relating to selection of an I.C.T. system for primary care teams
  - Independent evaluation including Gap Analysis of all options
  - Recorded and comprehensive investigation of operational and developmental status of all systems currently in use by P.C.T.s
  - Inclusive selection and decision-making process involving all relevant heads of discipline and team members.
- Increased capacity in Primary Care including:
  1. Introduction of disciplines to the primary context that have traditionally been based on a community care/disciplinary alignment e.g. occupational therapy and physiotherapy
  2. Introduction of disciplines to primary care context that have traditionally been located in secondary care e.g. Community mental health nursing.
  3. Restructuring of referral processes accommodate self-referral and provide multiple access points.
Our Achievements to Date

- Reduction of recourse to secondary care and facilitation of early discharge by provision of broader range of services in primary care, including:
  - Multidisciplinary discharge planning and shared care protocols.
  - Intensive home help and family support service including out of hours provision.
- Development of additional services to meet unmet local need including the following clinics and services:
  1. Sexual health
  2. Minor surgery
  3. Muscular skeletal
  4. Dietetics
  5. Methadone – provided on out of hours basis
  6. Smoking Cessation

- Joint Consultation Model – Development of an early intervention model to address cases presenting with a complexity of health and social issues. This model is highly transferable to similar areas of concentrated deprivation.
Executive Summary

Introduction
This report maps the progress to date of the Ballymun Primary Care Pilot in the context of a five year strategic plan covering the period from 2002-2007. It tells the story of the development of a dynamic and intensive model of multidisciplinary teamworking in an urban area of concentrated deprivation. It outlines the major challenges faced by the developing team such as staff ceilings, the delay in opening the new health centre and the disruption in line management support resulting from the reform process. It also outlines the local strengths that empowered the pilot to overcome these challenges. In particular, there is a strong belief amongst participating G.P.s and local health service staff in the concept of multidisciplinary team working as an appropriate and necessary response to the complexity of issues presenting in Ballymun and similar areas of high deprivation. This belief and commitment has been the major strength that sustained the pilot in the face of major challenges and that underpins its success to date. The major contribution of the Ballymun pilot to the wider rollout of primary care teams is the development of a model of team working that is flat in ethos, intensive in operation, extremely broad in skill-mix and eminently suited to the implementation of the primary strategy in similar urban areas of high deprivation. Membership of the team emphasises the complementary role of medical and personal/social services in an area where high health and social needs are interlinked. It is an intensive form of teamworking underpinned by regular clinical meetings and joint consultations with families and individuals. It is a flat model of teamworking i.e. one that enshrines parity of esteem for all participating disciplines whilst recognising the varying levels of skill and accountability involved. As such the model represents a vibrant working partnership between G.P.s and H.S.E. staff whilst avoiding dominance by a particular discipline. As such this model represents a major departure from the disjointed and hierarchical mode of management and service provision...
in the health structure. In terms of future rollout the participative and flat structure governing this model of teamworking has particular potential for the empowerment of frontline staff in all relevant disciplines.

Section 1 – Socioeconomic and health profile of the Ballymun population.

This section outlines the socio-economic and health needs of the local population. In order to provide an evidence base for this analysis a review of existing needs assessment and research on local health needs was commissioned by the project manager. The findings of this research are contained in a report entitled 'Health Needs of the Ballymun Population: A Review of Existing Data' by Simon Brooke. This work outlines and collates the findings of several studies relating to the Ballymun population including the following:

- Ballymun: A Socio-economic profile
  2002 Ballymun Partnership

- Estimating the prevalence of opiate drug use in Ballymun
  1998 Foxe, G. for the Ballymun Local Drugs Task Force.

- Census 2002 – extrapolated statistics pertaining to Ballymun

- The Quarterly Household survey
  3rd Quarter 2001.

The input of health service providers also informs the profiling of the population health needs in this section.

The Emerging Profile

The profile emerging from these sources is that of a population with extremely high health and social needs. Ballymun is divided into four District Electoral Areas that cover a relatively small geographical area. The traditional form of housing in the area has been, until recently, exclusively local authority and much of this has consisted of high rise apartment blocks. This form of housing and the absence of a housing mix have resulted in a unique concentration of deprivation within a relatively small geographical area. All of the four D.E.D.s in Ballymun attain the highest score of 10/10 on the H.A.S.S.E. deprivation index which is widely used to measure deprivation levels according to specific indicators.
The population age profile is atypical in several respects. There is a disproportionately low number of people aged 65 and over (3.1% compared to the national average of 11.4%).

There is a disproportionately high number of females aged 20-49. These characteristics have implications for the planning of local health services.

The 2002 Census returned a population count of approximately 16,000 for the four Ballymun D.E.D.s. However the area is currently undergoing a massive regeneration process that aims to transform the physical, social and economic profile of the area. As a result of regeneration the local population is projected to increase to 34,000 within a decade. The changing size and profile of the local population presents both opportunities and challenges for the organisation of local health services.

The high deprivation levels manifest themselves in high health and social needs and a resulting demand on local health services. This section also highlights the high incidence of certain conditions such as asthma, coronary disease, blindness, deafness and cognitive impairment. The incidence of these and other conditions is approximately twice the national average and is an indicator of the challenge facing local health services. Other health issues of particular concern to health service providers include the high level of addiction to alcohol, heroin and prescription drugs such as benzodiazepines. Health professionals also report a high incidence of sexually transmitted diseases and crisis pregnancies amongst minors.
Section 2 – outlines the traditional organisation of local and community health services prior to the commencement of the pilot.

Traditionally the majority of primary and local health services have operated from the local health centre that is located in the heart of Ballymun. Disciplines including nursing, home help, family support, social work, general practice, dentistry, adult mental health and community welfare operate from the health centre. Other services such as the drugs/aids service and the Mater child and family psychiatric service operate from locations nearby. Other services, some of which are prescribed as primary care services in the strategy, are not located in the local context but are structured traditionally on an Area/disciplinary basis with a centralised rather than a local referral process. These services include occupational, physio and speech and language therapy.

A major aim of the pilot is to realign existing services in order to ensure that all services proper to primary care operate in that context thereby maximising the capacity of local primary care provision to respond to local need.

Service Weaknesses

Local primary care services in Ballymun display most of the weaknesses outlined in the primary care strategy including fragmented referral processes, a weak emphasis on health promotion and prevention, limited availability of out of hours services, poor information structures for planning and a poor range of services available in the local primary care context. Services also face significant challenges in that they operate in poor and overcrowded physical conditions. The high demand placed on services creates a crisis driven environment that tends to be reactive rather than proactive and this is compounded by the difficulty in engaging the local population in preventive services. Staff ceilings have also created a situation whereby staff resources have been reduced despite increases in demand generated by rapidly rising population figures.

Service Strengths

Local services have significant strengths including a history of long service and continuity amongst staff, a distinguished high level of commitment and morale, a strong tradition of good informal team working and a concentration of a broad skill mix under one roof.
Section 3 – outlines the main role of the Ballymun pilot and the key elements of the implementation strategy.

The Ballymun pilot shares a common role with the other nine pilots i.e. the implementation and testing of the primary care strategy in the local area including the development of multi-disciplinary team working, the introduction of enrolment, the conduct of a needs assessment and the development of enhanced capacity and accessibility in primary care services. A major aim of the pilot is to facilitate general rollout by identifying transferables. The pilot also aims to highlight issues and challenges emerging in the implementation stage and to explore solutions and adaptations that can be exported to other areas. In addition, the Ballymun pilot has particular strategic relevance for the rollout of the strategy in urban areas of high population density and deprivation.

The key elements of the implementation strategy are outlined and consist of a mission statement, outcomes for the client group, goals and associated actions, performance indicators and evaluation/quality assurance mechanisms.

Targeted outcomes for the enrolled population are outlined as follows:

1. Improved and speedier access to services.
2. Access to a broader range of services in the primary care context that are responsive to the needs of the local population.
3. Reduced dependence on secondary/specialist care.
4. Supports to facilitate the mentally and physically ill and disabled to remain in their home and community whilst accessing appropriate treatment in a local context.
5. Increased empowerment to maintain good health through improved information and health promotion.
Goals and associated actions.

Five goals are identified that will effect the required shift from the current model of service delivery to that outlined in the strategy and that will facilitate the delivery of outcomes for the client. These goals are outlined below:

1. The provision of structures and resources to support the team and pilot.

2. The development of a client centred service based on a multidisciplinary team approach.

3. Improvement in the accessibility, range and appropriateness of local primary care services.

4. The development of structures and protocols to promote integration between primary, secondary and specialist services.

5. The development of services in the area of health promotion, prevention and early intervention.
Section 4 - Progress Report.

Due to staffing restrictions the filling of fulltime posts on the team was delayed until January 2005. Prior to the filling of posts the momentum of the pilot was maintained by the commitment of the three G.P. practices involved, the project manager and the voluntary commitment of local staff who committed both time and energy whilst carrying full caseloads independent of the pilot. Many staff who engaged voluntarily in the pilot were recruited into fulltime posts on the team. The recruitment of local staff greatly expedited the team building process as it brought the benefits of extensive local knowledge and links, continuity of service and established working relationships to bear on the process. This is borne out by the considerable progress that has been achieved since the formal filling of posts in January 2005.

The greatest achievement and transferable of the pilot to date is the model of multidisciplinary teamworking developed. This model incorporates a broad skill mix and is in ethos and practice an exemplary model of multidisciplinary cooperation based on the principles of parity of esteem, transparency and consultation. The success of the model in practice is evidenced by the speed and ease in which information protocols, joint assessment and care plans and enrolment criteria were negotiated and agreed by team members. It is also evidenced by the clarity and breadth of cooperation apparent in information sharing amongst the team as practiced in the joint consultation model and clinical meetings. The team incorporates a broad skill mix that reflects the demand placed on local primary care services in deprived urban areas. In its membership, the Ballymun team emphasizes the essential linkage between medical and personal/social care services in providing an adequate response in areas where high health and social needs are interlinked.

The team work model is underpinned by the research project being conducted by the R.C.S.I. This is an independent research project located within the Ballymun pilot the aim of which is to evaluate the merits and impact of multidisciplinary teamworking in areas of high disadvantage. It is based on a model of joint consultation that involves appropriate members of the team meeting with families and individuals to discuss their case and negotiate a responsive care plan. This research achieves the twin aim of providing a structured process for team building and providing the primary care team with an independent evaluation of its effectiveness. Findings from this research should have important transferables and lessons for the rollout of primary care teams in similar areas.
The pilot has achieved substantial progress in improving access to services and in extending the range of services available in the local context. Services such as occupational and physiotherapy although identified as primary care services have hitherto been organized on a community care area/disciplinary basis with independent and centralized referral systems. These services have been introduced to the local primary care context in Ballymun and can be accessed immediately and locally by patients. Speech and language therapy, family support, dietetics and community mental health nursing are additional services introduced to the local primary care context in response to local need. This has facilitated patients in accessing a package of care appropriate to their need in a local setting rather than compelling them to process their needs through a multiplicity of independent referral systems or by recourse to secondary/specialist care.

Dedicated clinics responsive to local need have been initiated and have also relieved the reliance on secondary/specialist care. Clinics such as the sexual health clinic and the early morning methadone clinic are provided out of hours. The family support and home help services also have an out of hours dimension. The pilot is committed to increasing the range of out of hour's services in general.

Other additional clinics provided under the pilot include dietetics, a smoking cessation and a muscular skeletal clinic.

Enrolment of the combined practice lists of the three participating practices began in February 2005. The target population for enrolment is 7,000 and 4,000 have to date been enrolled. All parties involved have agreed to confine enrolment to practice patients resident within the boundaries of the four Ballymun District Electoral Divisions. Enrolment criteria agreed between all parties involved provides for the provision of services to marginalized groups who do not strictly meet the normal residency requirements such as travellers and the homeless. The population base agreed for the Ballymun primary care teams represents a compromise between participating G.P.s and the H.S.E. in that it confines enrolment to practice lists within certain geographical boundaries. As such it has significant transferability for the rollout of other teams in similar urban centres with a concentration of G.P. practices in close proximity.

Significant progress has also been made in relation to I.C.T. support for the team. The process for investigation and selection of an Information System included all relevant heads of discipline, line management and team
members in a thorough investigation and selection of an I.T. system best placed to deliver the maximum level of team and disciplinary requirements. The inclusive and democratic nature of the process was indicative of the excellent level of team relations. Health One has been the system selected subject to adaptations by that system to meet the needs of the primary care team.
Section 5 – deals with future planning.

These include service initiatives already underway. An on site youth health facility incorporating medical, health promotion, dietetics, counselling and sexual health services is currently being developed as a partnership between the primary care team, H.S.E. health promotion and the local youth services. It is planned that this service will be provided in the new youth facility in the area.

This development is regarded as critical in providing access to primary care services for a section of population that traditionally do not otherwise engage with local services in Ballymun and similar areas.

Another major development that will absorb much of the energies of the team from early 2006 will be the move to the new health centre and the increased opportunity for expansion of services associated with the new facility. The combination of the minor surgery clinic already in operation and the planned development of a minor injuries clinic when combined with the ultra sound and x-ray service planned for the new facility will further decrease the need for recourse to secondary care in the area. Discussions are currently underway to expand out of hours provision of existing and additional services in the new facility. Other major developments for progression include the implementation of an I.C.T. system, the development of a mental health and psychology service on the team, and the extension of the primary care team network to the remainder of the Ballymun population. The consolidation of existing services and the development of new ones particularly in the areas of health promotion and early intervention will also occupy the energies of the team. This schedule will require a fully resourced primary care team working to maximum capacity and challenges associated with staffing must be viewed in the context of this schedule.

Section 6 – deals with challenges and issues, some relating to the Ballymun pilot in particular and others with wider significance.

The section highlights lessons and transferables emanating from the pilot experience that can facilitate and influence the wider rollout of the primary care strategy. Finally the rollout of the strategy both locally and in the wider context is discussed and the factors contributing to successful rollout are outlined.
Section 1: Socioeconomic and health profile of the Ballymun population
Section 1:
Socioeconomic and health profile of the Ballymun population

General Demographic Profile

An area of concentrated deprivation

The Primary Care Pilot is located in Ballymun, a suburb of North Dublin located five miles from the City Centre. The target population for the pilot is contained within the four Ballymun D.E.D.s A, B.C, and D. The combined population of this area is currently 16,568. (1996 Census). This is the target population for the pilot. The geographical area of the four D.E.D.s is two square miles. The area is unique in terms of its population profile and levels of deprivation. It is an area of high health and social needs. Until quite recently the vast majority of the population were housed in Dublin City Flat Complexes. These consisted of 2,814 flats within 7 tower blocks and 29 spine blocks. These Flat Complexes were built in the 60's and 70's to accommodate families being rehoused from substandard Inner City dwellings. The main tower blocks have recently been demolished and the majority of the population is being currently rehoused under a major regeneration scheme. One of the principal aims of this scheme is to introduce a greater housing mix to the area.

All of the four Ballymun D.E.D.s are rated at the maximum score of 10 on the H.A.S.S.E. Deprivation Index (HASSE, T. 1996) This index measures deprivation in terms of educational attainment, housing and employment status. The Area is characterised by educational and economic disadvantage evidenced by the following points:

- High levels of early school leaving
- Widespread and persistent truancy
- Poor levels of educational attainment and personal expectation
- Very low levels of transfer to third level education
- 71% of the population rely on Social Welfare payments as their sole source of income.
- The highest unemployment rate of any partnership area.
Changes in population size and characteristics

The population that had been declining rapidly in the late 80's and early 90's was shown to have stabilised in the 1996 census. The period from 1991 to 1996 saw the number of lone parent families increase from 28% to 37%. In the same period the number of two parent families fell from 42% to less than 35%. The lone parent household is now the most prevalent household type. More than half of all children in Ballymun are now reared in lone parent households. The age profile is atypical in several other respects. There is a disproportionally high number of females aged 20-49. There is also a disproportionally low number of people aged over 65 (3.1% as compared to 11.4% in the state.)

Regeneration and impact on population size and profile

Ballymun is currently undergoing a massive regeneration process that aims to radically transform the physical, social and economic profile of the area. The current population of 16,568 for the target population is projected to increase to 34,000 within a decade as a result of the regeneration process. Greater variations in the socio-economic profile of the population are expected to result from the greater housing mix that forms part of the regeneration package.

Good Community Spirit

Despite its many difficulties, Ballymun is a community with many strengths. It has a strong sense of identity and community spirit. This is due in part to the homogeneity of the population in terms of socioeconomic and cultural background and to the high concentration of the population in a small and well defined area. Local services both statutory, community and voluntary are also concentrated and highly accessible in geographical terms. The community and voluntary sector is extremely active and motivated. Ballymun is a designated R.A.P.I.D. area and this together with a vibrant partnership provides an excellent forum for the involvement of local community and voluntary groups in the planning and delivery of primary care services.
Health Needs of the Ballymun Population

The Evidence Base

The primary care strategy obliged the area health boards to conduct a general health needs assessment of the population targeted for the pilots. This has not happened on a consistent basis for the ten pilots.

A needs assessment was not conducted in Ballymun prior to commencement of the pilot. However, in preparation for the commissioning of a general needs assessment and in order to provide the pilot in the initial stage with some evidence base for planning the pilot manager commissioned an independent researcher to collate all existing research on health needs in Ballymun. A combination of the findings of this research, a reproductive health needs assessment conducted recently by the pilot and Women's Health Promotion, research conducted by the R.C.S.I. with focus groups of patients in the pilot and the feedback from health service providers informs the outline of health needs as discussed in this section. This evidence base is not intended to compensate for the commissioning of a general health needs assessment. This evidence is already several years old and due to the projected changes in the size and profile of the population could become quickly out of date. The primary care team intends to progress a general needs assessment in the near future. The introduction of an integrated I.C.T. system for the P.C.T. if rolled out to the wider primary care area, should greatly assist in the generation of up to date statistics on health conditions, needs and usage trends.

Link between deprivation and ill-health

An association between poverty and ill-health has been well established for many years. A report from the Institute of Public Health states this both clearly and unambiguously:

'The link between poverty and health is strong and well established in Ireland and other countries. Poverty contributes to poor health directly through, for example, inadequate housing or dangerous environments and indirectly, for example, through poor diet.

Being poor or socially excluded makes it more difficult to access or afford health services.'

In Ireland, the gap in health between rich and poor is substantial. Mortality rates in the lowest socio-economic groups are over 100% higher than in the highest socioeconomic groups for all the major causes of death.

Important Aspects of health needs

Building up a picture of the health needs of a population requires more than an assessment of the health status of the population, in other words how ill people are. There are a number of separate but related aspects of health that need to be considered:

1. The health status of the population
2. Prevalence of groups within the population that have a particular association with ill-health
3. Aspects of lifestyle/environmental factors that may impact on health
4. Use of health services

Each are important in their own right because each provides a perspective on health needs. Three are discussed in this section and the third is discussed in Section 2 of this report on ‘Usage and organisation of health services in Ballymun.’
Health status of the population

'Ballymun socio-economic profile'

This survey was commissioned by Ballymun Partnership in 2003. The survey, which includes data on a range of socio-economic conditions, is compatible with data from national surveys such as the Quarterly National Household Survey and the Census, as well as a previous survey carried out in Ballymun in 2000. It includes a substantial section on health, and the results are reproduced here.

Disability

Table 1 below shows the percentage of the population of Ballymun affected by a number of different categories of disability compared with percentages from the State as a whole.

Table 1 Disability in Ballymun and the State

<table>
<thead>
<tr>
<th>Type of disability</th>
<th>Ballymun</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blindness, deafness, or a severe vision or hearing impairment</td>
<td>5.8</td>
<td>2.0</td>
</tr>
<tr>
<td>A condition that substantially limits one or more basic physical activities</td>
<td>12.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Difficulty in learning, remembering or concentrating</td>
<td>5.6</td>
<td>2.7</td>
</tr>
<tr>
<td>Difficulty in dressing, bathing or getting around inside the home</td>
<td>1.7</td>
<td>2.2</td>
</tr>
<tr>
<td>Difficulty in going outside the home alone</td>
<td>4.3</td>
<td>3.0</td>
</tr>
<tr>
<td>Difficulty in working at a job or business</td>
<td>6.6</td>
<td>4.6</td>
</tr>
</tbody>
</table>

Sources: Socio-economic survey Ballymun; Census 2002
Note: The bottom four rows relate to a condition that has lasted for six months or more.
A characteristic of disabilities is that their incidence increases with age. So, for example, of the 78,000 people in the State as a whole with blindness, deafness, or a severe vision or hearing impairment, 41,500, or 53% are 65 or over. This pattern is apparent in all categories of disability. However, the population of Ballymun is much younger than the population as a whole; there are only a third as many people who are 65 or over compared with the population of the State. Therefore, all other things being equal, you would expect to find significantly lower levels of disability in Ballymun than in the State as a whole. However, Table 1 shows that in all categories but one, the opposite is the case, and in the first two categories (blindness or deafness, and a condition that limits basic physical activities), the percentage of people in Ballymun who are affected is nearly three times the percentage in the population as a whole.

However, if you take account of the younger population of Ballymun, the difference is even greater, as illustrated in Table 2.

Table 2: Health conditions in Ballymun and the State

<table>
<thead>
<tr>
<th>Health condition</th>
<th>Ballymun %</th>
<th>State %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>9.3</td>
<td>5.0</td>
</tr>
<tr>
<td>Angina</td>
<td>3.7</td>
<td>2.3</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>3.7</td>
<td>3.8</td>
</tr>
<tr>
<td>Gastric/peptic/duodenal ulcer</td>
<td>3.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3.1</td>
<td>1.5</td>
</tr>
<tr>
<td>Hypertension</td>
<td>3.1</td>
<td>6.8</td>
</tr>
<tr>
<td>Heart attack</td>
<td>2.9</td>
<td>1.5</td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td>2.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Other cancer</td>
<td>2.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Gallstones</td>
<td>2.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Osteo arthritis (of the hip)</td>
<td>1.7</td>
<td>3.0</td>
</tr>
<tr>
<td>Kidney stones</td>
<td>1.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Stroke</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Leg ulcer</td>
<td>0.8</td>
<td>0.5</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>0.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Under active thyroid</td>
<td>0.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Skin cancer</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Other</td>
<td>13.0</td>
<td>9.2</td>
</tr>
<tr>
<td>One or more</td>
<td>35.7</td>
<td>30.4</td>
</tr>
</tbody>
</table>

Sources: Socio-economic survey Ballymun; Quarterly National Household Survey 3rd quarter 2001
An extra column has been added, showing what the incidence of different categories would be in the State as a whole if the population had the same age profile as that in Ballymun. This shows that taking account of age, the population of Ballymun has far higher levels of disability than the population as a whole. In particular in the case of the first two categories, the level is 4.5 times higher. The reason for doing this exercise is that if the existing population stays in Ballymun, it will get older, and as it gets older the incidence of disability will increase.

So, whilst you now find three times as many people in Ballymun with blindness, deafness, or a severe vision or hearing impairment, other things being equal, you can expect that to increase to 4.5 times as the age profile in Ballymun approaches the age profile of the rest of the State.
Specific health conditions

Table 3 shows the percentage of the population of Ballymun affected by a range of health conditions compared with percentages for the State as a whole.

Eighteen conditions are listed including 'other'. In twelve of these the percentage of those affected in Ballymun is greater than for the population as a whole; and in three of the others (rheumatoid arthritis, osteo arthritis of the hip, and osteoporosis) the condition is associated with old age, so one would expect a lower incidence than in the population as a whole.

The incidence of hypertension is less than half that of the population as a whole and has not as far as is known been explained.

Four conditions are found in more than twice as many people in Ballymun as in the population as a whole: gastric/peptic duodenal ulcer, diabetes, heart attack, other cancer.

S.T.D. levels and crisis pregnancies

In addition to these issues service providers such as G.P.s, practice nurses and public health nurses have voiced concern in relation to increasingly high levels of sexually transmitted diseases and crisis pregnancies amongst teenagers in the area. Health personnel are reporting crisis pregnancies amongst an increasingly younger age group.
**Prevalence of Groups associated with ill-health**

Some population subgroups are known to have a particular association with ill health. The association between poverty and ill health has already been discussed. Other groups includes:

A. Opiate users
B. People with serious alcohol dependency and/or other substance addictions
C. Travellers
D. Homeless people.

### A. Opiate users in Ballymun

Drug misuse is associated with a number of specific aspects of ill-health. Infectious diseases such as HIV and hepatitis C can reach a high prevalence among injecting drug users. Drug-related mortality is another possible consequence of some forms of drug use.

The most recent data on the extent of drug use in Ballymun is contained in a report by Greg Foxe from 1998. This survey found 683 known opiate users in Ballymun. Of these, 450 were male (66%) and 233 were female (34%).

Foxe compared the Ballymun results with similar research carried out two years previously in the south inner city and found that "...the Ballymun area has one of the largest problems with opiate use in this country".

Quigley in an examination of demographic and psychosocial features of 332 clients presenting to a new community addiction service in Ballymun, found:

- A mean age of injecting commencement of 18 years
- A 7-year period of injecting before treatment entry
- 80% hepatitis C infection rate
- 39% prevalence of heroin-addicted siblings
- 73% within-family substance misuse
- 39% living with other drug users
- 29% living with heroin using partner
- 80% male previous conviction rate and universal early school leaving.
B. People with serious alcohol dependency and/or other addictions

The Ballymun Local Drugs Task Force survey of 1998 did not include figures for those with alcohol addictions. However, both statutory health and social service professionals and community workers report that high levels of dependency on other drugs such as benzodiazepines are commonplace. However, all service providers in the area cite alcohol as the major addiction problem alongside heroin and the one that is the more widespread of the two. In his submission to a report on the socio-economic profile of Ballymun conducted by the Ballymun Partnership in 2003 Hugh Greaves, Co-ordinator of Ballymun Drugs Task force stated:

The drug which is most obviously consumed and which causes most unhappiness, violence and poor health in Ballymun is alcohol. Had there been no heroin problem, Ballymun would still have major addiction problems. The pattern is clear in socially excluded communities throughout the world.

C. Travellers

There is no available data on travellers health in Ballymun. A report conducted by the N.A.H.B. in 2002 addressed the use of health services by travellers as opposed to their health status. The completion of a Traveller Health Status and Needs Assessment Study is currently awaited. However, it is well documented in research on travellers generally, that this group experiences worse health than the population as a whole. The most recent health status data comes from a survey carried out in 1987 and quoted in Traveller Health: A National Strategy 2002-2005.

Key findings of this study included:

- Travellers of all ages have much higher mortality rates than the settled population.
- The infant mortality rate for travellers in 1987 was 18.1 per 1000 live births compared to a national figure of 7.4.
- Stillbirth and perinatal mortality rates are much higher than for the population as a whole.
The only halting site existing in Ballymun is St. Margaret's Halting site. A dedicated public health nurse visits the site regularly in relation to infant and child developmental health and maternal health. All of the health issues affecting the general traveller population are evidenced in the population of St. Margaret's. The issue of most urgent concern is the collapse of the infant and child immunisation schemes on the site and the primary care team and P.H.N.s involved are currently addressing this issue. Good family planning practice and womens health are ongoing issues engaging the energies of health providers on the site.

Residents Group – St. Margareths Halting Site.
Lifestyle/environmental factors impacting on health

Quigley P, in an examination of demographic and psychosocial features of 332 clients presenting to a new community addiction service in Ballymun, found—

Examination of case records showed that many clients had reported at some stage that a parent was addicted to one or more of alcohol, tobacco, benzodiazepines, tricyclics, opiate analgesics or heroin. The most common stereotypes reported were the binge-drinking father, perhaps regularly engaged in domestic violence, and the mother who was dependent on prescription sedatives. A significant minority reported sexual assault within the extended family. Many clients reported heavy street drinking and benzodiazepine misuse in early adolescence, progressing later to heroin use in the company of the same peers. Multiple instances of injecting multi-drug use were reported within the same family, while the extension of the problem through other branches of the extended family was noted, with cases of HIV disease in addition. Many clients reported patterns of conduct disorder and ADHD-like behaviour in adolescence, with general delinquency and risky behaviours resulting in accidents, imprisonment or pregnancy. A history of teenage sex work, deliberate self-harm or even homicide was reported by some, while the overdose death of a sibling or peer was a pervasive theme. Previous contact with psychiatric services had usually taken the form of an emergency assessment after an episode of actual or threatened deliberate self-harm in prison or in the community, although a minority had been referred through general practitioners or through the education system.

Section 2:
The role of the Ballymun pilot and the local service context
Section 2: The role of the Ballymun pilot and the local service context

Usage trends and Organisation of local health services in Ballymun

This section looks at the traditional alignment of local primary health care services and patterns of usage in the early stage of the pilots history. As such it establishes benchmarks against which the development of the pilot can be assessed. It is important to outline the traditional context of service provision in order to appreciate the challenges and supports that exist for the implementation of the primary care strategy in the area.

Location of services

The Ballymun pilot is located in Community Care Area 7 which was one of the three C.C.A.s that came under the remit of the former N.A.H.B.

Local health service provision has to date been extremely compact and centralized in Ballymun with a broad range of services operating from the current health centre. The health centre is located in the shopping centre in the heart of Ballymun. Services operating from the health centre include three G.P. practices and practice staff, Public health nurses, R.G.N.s, Social workers, community welfare officers, the psychiatric and community mental health service, dentistry, family support and home help. Services are provided through a mixture of clinics and home visits by the various disciplines. These professionals are supported by the following staffs that are located in sites other than the health centre: occupational therapist, physiotherapist, speech and language therapist, dieticians, and the child and adolescent mental health service.
Patterns of service usage

To date use of health services in Ballymun has displayed the following trends:

- The high level of health and social needs as evidenced in the area place a high demand on the service.

- This high level of demand combined with the fragmentation of primary care services has resulted in individuals expecting a service at a level of skill (quite often the highest level) that is inappropriate to their needs.

- This demand tends to be crisis driven. The population tends to contact clinic and institutionalized health services mostly in times of crisis but is slow to entertain preventative or early intervention treatments.

- This results in preventative and early intervention services reporting difficulties in engaging the local population. For example the Speech and Language service has a historical difficulty in ensuring that patients keep appointments in the area.

- A significant percentage of the population is completely or partially housebound due to addiction and mental or physical ill health. This places a high demand and importance on domiciliary services as clinic based services are resorted to mostly in a crisis situation.
Strengths and opportunities in local service organization.

The traditional organization of local health services in Ballymun presents several opportunities for the primary care pilot. These are outlined below:

- The concentration of a broad range of health disciplines under one roof or in close proximity.
- A good working spirit amongst health personnel and a dedication to working with the target population. This is evidenced by the low turnover of staff in key disciplines.
- A good, longstanding informal tradition of interdisciplinary working.
- An unusually close working relationship between G.P.s and H.S.E. disciplines facilitated by location ‘under one roof’.
- A strong commitment by G.P.s in the health centre to work with the socio-economic group represented by the Ballymun population.
- A low turnover in key primary care disciplines such as nursing and home help resulting in an intensive knowledge of the target population and good working relationships with the community generally.
- The link between poor health and socio-economic problems is evidenced in issues presenting to services in the area and has necessitated collaboration between health and social care professionals. The complexity of cases presenting has strengthened the belief in multi-disciplinary working as a necessity rather than an option.
- Professionals in the area believe that the current configuration of local health services does not maximize the opportunity for multi-disciplinary team working.
- A new state of the art Health Care Unit is planned to open in Ballymun in 2006. This Unit will house all the local primary care and some relevant network services in the one location and should greatly facilitate the process of teambuilding and network integration that is at the core of the pilot.
- Network services such as the Mater Child and Adolescent service, the drugs treatment service in Domville House, the community mothers programme, the adult mental health service, dentistry and community welfare are all located in close proximity to each other and the pilot premises and have been very supportive of the primary care pilot to date.
Inadequacies in current primary care service provision in the area.

Notwithstanding the many strengths of the Ballymun health services as outlined above, many of the structural weaknesses identified in the primary care strategy are evident in Ballymun as they are in primary care services nationwide. The strategy identifies six principal inadequacies in general primary care service provision. These inadequacies as outlined below are measured in the context of primary care service provision in the Ballymun context.

Poorly developed primary care infrastructure and capacity.

- The range of services accessible in a primary care context to date has not reflected the needs of the Ballymun population or the level of demand.
- The prescribed team in the primary care strategy includes disciplines such as G.P.s, P.H.N.s, R.G.N.s, practice nurses, occupational therapists, physiotherapists, community mental health nurses, family support and home helps. The definition of a primary care service implies that a service is locally based and easily accessible. By this definition, only the G.P. services, P.H.N.s, family support and home helps have traditionally operated in a primary care context.
- Some services such as Community Mental Health nursing, psychology, occupational therapy or physiotherapy can traditionally only be accessed via secondary or community care structures.
- Referral systems for occupational and physiotherapy services are highly centralized within C.C.A. structures. Referrals from the Ballymun area are placed on a central waiting list that prioritizes cases according to need. Due to staff ceilings the current ratio of O/Ts and physiotherapists to population served is not conducive to speed of access. The average waiting time for the largest category of patients i.e. category 3 to access occupational or physiotherapy is currently eight to twelve months.
- Inadequate capacity and a lack of appropriate clinic space have restricted occupational therapists and physiotherapists in providing group and clinic based services for certain conditions. For example prior to the commencement of the P.C.T. patients presenting to G.P.s
with muscular/skeletal problems could not access treatment by a H.S.E. physio as no treatment facility existed for these conditions. This treatment could only be accessed via private physiotherapy. Income limits restrict this option to a small percentage of Ballymun residents.

Current system fragmented from users perspective and organized around needs of providers.

- Services have been traditionally fragmented and disciplines have operated in a silo fashion.

- Core primary care disciplines such as Occupational and Physiotherapy have traditionally been organized on a Community care area basis as opposed to a local basis appropriate to their primary care role.

- Patients and families requiring a combination of care i.e. G.P. Physiotherapy and Speech and language would have to access these services through separate referral channels and negotiate separate priority lists. Faced with long waiting times or an absence of certain treatments G.M.S. patients have resorted to the private sector as in the example given for muscular skeletal conditions above.

Emphasis on diagnosis and treatment at the expense of health promotion, prevention and early intervention.

- Many of the diseases and health problems in the area are associated with lifestyle factors. This would indicate a need for intensive health education, prevention and early intervention.

- However although initiatives in these areas are present most health professionals admit to being overwhelmed by the crisis nature and high level of demand exerted by the client. This has led in spite of their best efforts to an imbalance in emphasis on diagnosis, treatment and crisis intervention to the detriment of health promotion, prevention and early intervention.

- Collaboration tends to be motivated by the pressure of demand and is not of a proactive but rather reactive 'fire fighting' nature.

- Prior to the commencement of the pilot there was no tradition of structured multi-disciplinary team working involving joint assessment, joint referral and consultation, key working, shared care and discharge plans etc. Informal multidisciplinary networking is unpredictable,
inconsistent, over reliant on personalities and working styles of personnel involved and can lead to gaps and oversights in integrated service provision. It also tends to lack direction and is therefore difficult to evaluate.

Limited availability of many professional groups and underdeveloped out-of-hours services.

- Family support and home help services provide the most comprehensive out of hour's service in the area. Most H.S.E. disciplines operate largely within traditional office hours. G.P. out of hours services are grossly underdeveloped for Ballymun and the wider North County Dublin region. Where an out of hours facility exists such as in the public health nurse service it tends to be more of an emergency operation rather than a genuine out of hours service.

Limited team working.

- Prior to the commencement of the pilot there was no tradition of structured multi-disciplinary team working involving joint assessment, joint referral and consultation, key working, shared care and discharge plans etc. Informal multidisciplinary networking is unpredictable, inconsistent, over reliant on personalities and working styles of personnel involved and can lead to gaps and oversights in integrated service provision. It also tends to lack direction and is therefore difficult to evaluate.

- Disciplines tend to collaborate when a case reaches crisis point and this can be dependant on an individual professional voluntarily taking the lead.

- Collaboration tends to be motivated by the pressure of demand and is not of a proactive but rather reactive 'fire fighting' nature.

- This style of informal team working is too inconsistent to meet the complexity of challenges emerging in the community.

- Structured multi-disciplinary team working involving early intervention and cooperation at all stages of the continuum did not exist prior to the pilot.

- Protocols and working tools associated with structured multidisciplinary teamworking such as joint assessments, joint referrals and consultations, key working, shared care and discharge plans etc were not developed.
Limited evidence for planning, development, evaluation and quality assurance

- Prior to the commencement of the pilot the general perception amongst health service providers in the area was that the Ballymun population were over researched. In its initial stages the pilot commissioned an independent researcher to collate all existing health research in the area and to report on its quality and relevance. This report concluded that health research in the area was scarce. It also concluded that the existing body of research would quickly become out of date as a result of the regeneration process and the changing population profile.

- The report mentioned above recommended that the conduct of a general needs assessment for the area should be given priority.

- The public health and P.H.N. service covering the area rely completely on manual recording systems. These services are vital repositories and generators of public health information and the absence of information technology in this area has serious implications.

- Other systems that exist within local health services tend to be designed for the service needs of a single discipline. As such they are not conducive to tracking a client through the primary care system nor do they facilitate multidisciplinary team working.
Section 3

Implementation of the Primary Care Strategy in Ballymun
Section 3
Implementation of the Primary Care Strategy in Ballymun

The purpose of the Ballymun pilot is to effect a model of service delivery that is in line with the recommendations of the primary care strategy and that is responsive and adaptable to local need. Sections 1 and 2 have provided an analysis of existing service levels and organisation and also an insight into the health and social needs in the Ballymun area. This evidence base drawn from a combination of local research and service providers input facilitated the primary care team in establishing benchmarks and developing a strategy for the short to medium term development of the pilot. The team used this evidence base to identify the major strategic and operational developments required in order to develop the new model of primary care in the local context. This section describes the Ballymun pilot and its role both locally and nationally and outlines the local implementation strategy for the short to medium term development of the pilot.

Description of the Pilot

Location and staffing

The Ballymun pilot has been providing services from early 2004 and has become fully operational since January 2005 with the filling of the majority of core posts on the primary care team.

The new health centre that is located in the Civic Centre in Ballymun is intended as the permanent accommodation for the primary care team and also for all wider primary care disciplines in the health centre. The primary care project began in September 2003 with the appointment of the project manager. The equipping of the new health centre has been delayed and is now due to open in March 2006. The project manager acquired temporary premises for the primary care team in the Ballymun shopping centre. This location is extremely central and adjacent to the...
health centre. The appointment of full-time staff was delayed due to staff ceilings but most of the core disciplines are represented by full-time posts since January 2005. The membership of the team at present consists of the following: Occupational, Physio and Speech and Language Therapists, a Public Health Nurse, a family support worker, a home help, a community mental health nurse, a two practice nurses and seven G.P.s (three practices). Two dieticians also work closely with the team and provide clinics from the project premises. Community Welfare and social work are important services in the area and ones that interact closely with other health services. These services are not represented by full-time posts on the team but representatives from both services attend team meetings and work closely with the team. Three G.P. practices consisting of seven doctors participate in the pilot.

The team is supported by a project manager (Grade viii) a clerical officer (grade iv) and in the case of the G.P.s a practice manager and three practice staff.

The primary care team has is located dedicated premises in Ballymun shopping centre adjacent to the health centre and services and clinics provided by the team operate from both locations.

Target population

The target population for the pilot is outlined in detail in Section 1. Currently the target population for the pilot is 16,000 and projected to rise to 34,000 in the next decade. This area of coverage for the pilot is the four Ballymun D.E.D.s A. B.C.D. The enrolled population for the current primary care team is based on the combined practice lists of the three participating G.P. practices and amounts to approximately 7,000. 80% of these patients are in the G.M.S. scheme. The formation of further teams will be required to service the remaining Ballymun population and this rollout should be informed by the experience of the pilot team and the commissioning and findings of a general health needs assessment.
Role of the Pilot: the national and local context

The Primary Care Strategy: Objectives and Actions

The two documents governing the strategic development of the primary care pilots are ‘The Health Strategy 2001’ and the primary care strategy entitled ‘Primary Care: A New Direction.’

The Health Strategy and the consultation process that preceded it defined the type of health services expected by the public. The strategy emphasized ease of access, improved quality, responsiveness and timeliness of treatment and care as the major service principals that should underpin a modern primary care service. It also stated that health services generally should support individuals to lead healthier and more independent lives in their own communities. This ethos placed an obligation on community and primary care services that required a new strategic approach.

The Primary Care strategy provided a blueprint for the change management process required in the national and local primary care context.

Objectives

Three major goals/objectives are outlined in the strategy:

- The development of a primary care system that will play a central role as the first and ongoing point of contact for people with the health service.

- A highly accessible, integrated, inter-disciplinary, high-quality, team based and user friendly set of services for the public.

- An enhanced capacity for primary care in the areas of disease prevention, rehabilitation and personal social services to complement the existing diagnosis and treatment focus.
The overarching vision of the strategy was a strengthened and improved primary care context that had the capacity and range of services to deal with the maximum number of appropriate health issues emerging in the local community. This strengthened model of primary care was intended to reduce recourse to secondary care by preventing admissions wherever possible and facilitating early discharge.

Recommended Actions

The strategy identified several actions at both national and local level that required implementation in order to address weaknesses in the area and to increase the capacity of primary care to meet additional needs. These actions addressed several key developmental areas:

- The formation of structures to progress integration and multidisciplinary working i.e. the development of primary care teams and networks.
- The introduction of a service model based on primary care teams servicing an enrolled population.
- The development of a human resource and communications strategy and infrastructure to underpin the new service model.
- The development of academic and training programmes to promote interdisciplinary working.
- The development of an evidence base for future service planning to include the conduct of needs assessments in the pilot areas.
- To explore and develop models of community involvement in service planning.

The implementation of the primary care strategy represents a radical change in the configuration, practice and delivery of primary care services. In order to test the strategy ten pilots' sites were identified nationally.
Role of the Pilots

The National Context

The ten national pilots have an important strategic role to play in the rollout of the new primary care model. The pilots aim to evaluate the benefits of multi-disciplinary team working in terms of improved capacity and improved service provision in a primary care context. The implementation of the primary care strategy represents a radical change management process. The pilots allow these changes to be managed on a phased basis and in a confined and safe context. Successful transferables can be identified and challenges and problems arising can be resolved and/or modified in the light of operational experience and prior to general rollout.

The pilots also fulfill an important motivational role in relation to inspiring support for rollout amongst staff in the wider primary care area.

The ten pilots were selected with a view to testing the strategy in varying social/demographic and regional contexts. The Ballymun strategy occupies one extreme end of this continuum in that it is placed in a densely populated urban area of high deprivation (80% G.M.S.) and the Cavan/Virginia pilot occupies the other extremity in that it is placed in a rural area with a dispersed population including a large majority of private patients (80%). Although all the pilots share a common set of features in terms of team composition, ethos and goals an element of local adaptation is increasingly obvious in the mix of services provided. The mixture of service delivery models emerging in the pilots is a direct response to the varying social and health needs of their target populations. These locally adapted models of service delivery are particularly relevant to the rollout of the primary care strategy in areas of similar social demographics.

Strategic Role of the Ballymun Pilot

The Ballymun pilot shares a common role with the other nine pilots i.e. the implementation and testing of the primary care strategy including the development of multi-disciplinary team working, the introduction of enrolment, the conduct of a needs assessment and the development of enhanced capacity and accessibility in primary care services. A major aim of the pilot is to facilitate general rollout by identifying transferables.
pilot also aims to highlight issues and challenges emerging in the implementation stage and to explore solutions and adaptations that can be exported to other areas.

The Ballymun pilot has, however, a particular strategic relevance for the rollout of the strategy in urban areas of high population density and deprivation.

The link between deprivation and high health and social needs is well established. The Primary Care Strategy prescribes the disciplinary representation for the teams and the maximum and minimum target populations to be served. However, it does not analyse the impact of socio-economic profile and the impact of local health needs on the configuration and capacity of primary care teams. It therefore remains to the operational experience of the individual pilots to explore issues such as the pressure exerted on primary care teams and services by the differing population profiles and associated need levels and the number, capacity and skill mix required to meet these needs in the varying local contexts.

Ballymun is distinguished amongst the ten pilots in that it has an extremely high target population of 16,000 projected to increase to 34,000 within the next five years and has the highest concentration of deprivation within its catchment area. Many such areas exist in the greater Dublin region particularly in the north Dublin area and also in urban and suburban contexts throughout the state. Lessons and transferables generated by the pilot will have particular relevance for areas with similar socio-economic and demographic profiles.
An implementation strategy for Ballymun

Ballymun was approved as a pilot site by the Department of Health in 2002.

Due to restrictions on staffing within the area Health Boards a project manager was not appointed until Sept. 2003. The project manager convened a management team to steer the pilot. This team consisted of managers of the core primary care disciplines and the relevant specialist and network services. Due to staffing ceilings none of the designated posts on the primary care team were filled until January 2005.

The project manager secured agreement from heads of discipline to form a consultative local team consisting of nominated representatives from each relevant discipline. The principle aim of this team was to maintain the momentum of the pilot and to lay the foundation for the fully released primary care team. A process began that involved the project manager, relevant heads of discipline and the local team in the development of a strategic plan for the Ballymun pilot that covered the period from September 2003 to December 2007. In developing this strategy the group took account of the goals, outcomes and actions as outlined in the primary care strategy and also the strengths and weaknesses of the local demographic and service context. It is, however, accepted by all those involved in its formulation that the outcomes of a general health needs assessment should inform future long-term planning and roll-out. This strategy has been informed by an evidence base of existing research on local health needs, by research commissioned by the pilot, the R.C.S.I. research in the area and by the input of the service providers. The primary care team are satisfied that this level of information provided a sufficiently accurate reflection of local health needs to inform and progress short to medium term planning. In formulating the strategy the team were also conscious of the urgent local need for certain service initiatives.

The implementation strategy consists of five components:

1. A Mission Statement that incorporates the vision for primary care in Ballymun.
2. Targeted outcomes for the enrolled population.
3. Five Strategic Goals for implementation of the strategy and associated action for each goal.
4. Performance Indicators.
5. Evaluation and quality assurance mechanisms.
Mission Statement

The aim of the Ballymun primary care team is to work in partnership with the people of Ballymun to support them in leading healthier and more independent lives in their own community. This aim will be achieved by the development of a strong local primary care service that operates to a standard of excellence, is responsive to local need and is highly accessible and available when needed.
Targeted outcomes for the enrolled population

1. Improved and speedier access to services.
2. Access to a broader range of services in the primary care context that are responsive to the needs of the local population.
3. Reduced dependence on secondary/specialist care.
4. Supports to facilitate the mentally and physically ill and disabled to remain in their home and community whilst accessing appropriate treatment in a local context.
5. Increased empowerment to maintain good health through improved information and health promotion.

Strategic Goals and associated actions

Five goals are identified that will effect the required shift from the current model of service delivery to that outlined in the strategy and that will facilitate the delivery of outcomes for the client. These goals are outlined below:

1. The provision of structures and resources to support the team and pilot.
2. The development of a client centred service based on a multi-disciplinary team approach.
3. Improvement in the accessibility, range and appropriateness of local primary care services.
4. The development of structures and protocols to promote integration between primary, secondary and specialist services.
5. The development of services in the area of health promotion, prevention and early intervention.
A detailed action plan for the implementation of the pilot was produced by the local and management teams in early 2003. Major actions aligned with the five goals identified are included in tables A,B,C,D,and E outlined in Section 4. Broad timescales are given for each action. In Section 4 progress to date is measured against these goals and actions. Actions still to be achieved are addressed in Section 5 on future planning. The pace and success of these strategic developments and actions are dependant on adequate resourcing under the headings identified in the primary care strategy such as physical infrastructure, human resources and information technology. In the present climate the provision of resources has been unpredictable and beyond the power of the project manager and local team to deliver. Timescales mentioned must be viewed in this context. It is also important to note that pilots have by their nature a strong experimental dimension and it is therefore important that planning is not over prescriptive but allows for ongoing adaptation in the light of operational experience.
### Performance Indicators

<table>
<thead>
<tr>
<th>Outcomes for enrolled population</th>
<th>Performance Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved and speedier access to services particularly those with traditionally long waiting lists.</td>
<td>Improvement in access/waiting times for occupational, physio and speech and language therapy. Reduced waiting lists for these services compared to those in wider C.C.A.</td>
</tr>
<tr>
<td>Access to a broader range of services in the primary care context that are responsive to the needs of the local population.</td>
<td>• Number of patients enrolled with team.</td>
</tr>
<tr>
<td>Reduced dependence on secondary/specialist care.</td>
<td>• Number and source of referrals to team</td>
</tr>
<tr>
<td>Supports to facilitate the mentally and physically ill and disabled to remain in their home and community whilst accessing appropriate treatment in a local context.</td>
<td>• Nos. presenting to clinics providing new services in local context – Muscular skeletal, sexual health, methadone, speech and language, dietetics.</td>
</tr>
<tr>
<td>Increased empowerment to maintain good health through improved information and health promotion</td>
<td>• Numbers presenting to clinics offering services previously accessed in secondary/specialist care including the following: Minor injuries, sexual health, muscular skeletal, x-ray, ultrasound, diabetes.</td>
</tr>
<tr>
<td></td>
<td>• Number of new services provided in P.C. context.</td>
</tr>
<tr>
<td></td>
<td>• No. of home care packages, shared care packages managed by team</td>
</tr>
<tr>
<td></td>
<td>• No. of domiciliary visits by Occupational therapist, public health nurse, Physiotherapist, home help, G.P.</td>
</tr>
<tr>
<td></td>
<td>• Number of initiatives in promotion, prevention and early intervention</td>
</tr>
<tr>
<td></td>
<td>• Numbers presenting to joint consultation/clinical meetings.</td>
</tr>
<tr>
<td></td>
<td>• Numbers presenting to activities organized in the area.</td>
</tr>
<tr>
<td></td>
<td>• Numbers receiving information booklet.</td>
</tr>
</tbody>
</table>
Evaluation

The strategy outlined in this report is a medium term plan covering a five-year period from the commencement of the pilot in Sept. 2003 to December 2007. The intensive implementation of the strategy began with the filling of team posts in January 2005. Although service provision is quite advanced the team is still in a stage of formation and development. Progress to date against the goals and actions outlined is provided in this report and some performance indicator data is provided. However this evaluation contained in this report is subjective in nature as it is project manager and team providing the service. An independent evaluation of the strategy will be commissioned at the end of the implementation period. This evaluation should include an analysis of benchmarks in relation to the service, organisational and demographic context in which the pilot commenced and an assessment of progress against these benchmarks. Progress should also be assessed in relation to the strategic goals, actions and outcomes outlined in this report. The evaluation exercise should include an assessment of the following:

- User satisfaction with team services.
- Usage levels and patterns.
- Referral and access routes to services provided by the pilot and a comparative analysis of before and after contexts.
- Success in relation to goals, actions and outcomes outlined in this strategy.
- Satisfaction of relevant G.P.s with the pilot.
- Satisfaction of wider primary care services with the pilot and the extent of its impact on these services.
- Impact of the pilot on the rollout of the strategy in the Community Care area.
- Satisfaction of other relevant interests groups: area line management, community care services, specialist and secondary care services.
- Satisfaction and involvement of the community and voluntary sector.

A detailed activity report on performance indicators should be included in this research.
Demolition of a tower block.
R.C.S.I. research in the Ballymun pilot
- An independent evaluation of impact

An R.C.S.I. research project has been in existence in the pilot since its commencement in 2003.

The aim of the research is to evaluate the impact of multidisciplinary team working on the population of a deprived area. The researcher is based in Ballymun and also operates part-time as a local G.P. in the pilot.

This research has already provided some benchmarks in relation to user satisfaction with existing services prior to the operation of the primary care team. It also provides an inbuilt and ongoing form of evaluation within the pilot. Independent evaluation of the merits of multi-disciplinary team working in primary care is rare in the national context and the outcomes of this research should have important implications for the adoption of multi-disciplinary team models in the wider primary care context.
Section 4:

The Primary Care Strategy in Ballymun

Progress Report
Section 4:
The Primary Care Strategy in Ballymun
- Progress to Date

Introduction
This section outlines the progress of the pilot to date to January 2006 in the context of the strategic plan outlined in Section 3. Progress is measured under each of the five major goals in the plan and against the actions required to achieve these goals.

Progress achieved to date should be viewed in the context of major challenges that have presented to the pilot namely the delay in filling the fulltime posts on the team and the delay in equipping and opening the new health centre. Although the resolution of these issues was not within the control of the project manager or local services much of the energy of the project manager in the initial stages of the pilot was employed in efforts to overcome these difficulties e.g. the securing of temporary premises and lobbying for the filling of posts. Despite these challenges the pilot has made significant progress and the momentum of this progress has greatly increased since the filling of most of the disciplinary posts in January 2005. The pilot has been fully operational since this date.

However, methods and structures employed by the pilot to overcome staffing problems and maintain momentum prior to the filling of fulltime posts have important lessons and transferables for the wider rollout of the strategy in a climate of resourcing restraints. There were also limitations to progress in certain areas during the period prior to the filling of posts and these lessons must also be considered in deliberating the resourcing of future primary care teams and their potential to deliver on the outcomes outlined in the primary care strategy.

Actions are coded according to progress achieved as outlined below and a summary of progress under each action heading is also provided.
### Table A.

- **Actions that have been delivered** - pink box
- **Actions that have been progressed but are not completely delivered** - purple box
- **Actions that are undelivered** - white box

## Goal 1.

**The provision of structures and resources to support the team and pilot.**

<table>
<thead>
<tr>
<th>Action</th>
<th>Time-frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Filling of the project manager and team posts</td>
<td>2003-Dec 2003</td>
</tr>
<tr>
<td>3. Development of governance structures to support the team and project manager</td>
<td>Sept 2003-Dec 2003</td>
</tr>
<tr>
<td>4. Tendering, acquisition and implementation of an I.C.T. system for the primary care team</td>
<td>Jan 2005-Jan 2006</td>
</tr>
<tr>
<td>5. The provision of an evidence base and evaluation/quality assurance mechanisms for the pilot</td>
<td>Dec 2004-ongoing</td>
</tr>
</tbody>
</table>
Bringing The Team Together

Action 1.

The filling of the project manager and team posts

Most of the core primary care disciplines are now represented by fulltime posts on the Primary Care team. These posts have been filled since January 2005 and the pilot has been fully operational in terms of service provision since that date. Posts now filled on the primary care team are as follows: occupational therapy, physiotherapy, P.H.N. Speech and language, family support, home help and community mental health nursing. A social work post has been approved and a job description for the post is currently under negotiation.

The pilot was funded from January 2002. Due to staff ceilings imposed on the area health boards during this period the post of project manager was not filled until September 2003 and the core disciplinary posts on the team remained unfilled until January 2005. Fourteen posts were included in the original submission for the pilot and have been funded in subsequent budget allocations. In the first 12 to 15 months of the pilot, much of the energy of the project manager was employed in lobbying for the filling of these positions and in efforts to maintain momentum and support for the strategy amongst local disciplines in the absence of fulltime posts on the team.

Table A.1. outlines the current status of the 14 approved posts. A temporary clerical support worker was also recruited to assist with the recruitment process and is currently employed in the pilot. Due to the problems encountered with staff ceilings within the H.S.E. Service the G.P.s agreed to recruit and employ this clerical worker and the post is jointly funded by G.P.s and the H.S.E. Social work remains the only discipline prescribed for the core team that remains unfilled. Approval has been given for this post and a suitable job description is currently under negotiation with that service. The full staffing quota for the team remains unfilled although funded in the current budget. Posts remaining unfilled besides social work include a nursing post, a psychologist, a social worker and a Grade V administrative assistant. Failure to fill these posts could have serious implications for the future progress of the pilot as staffing quota were originally agreed on the basis of a rough estimate of the needs and size of the target population according to traditional ratios in operation. For example the normal target population for a public health nurse is 3,500. The target population for the first primary care team in Ballymun is 7,000 and there is only one P.H.N. on the team.
Table A.1.

Staffing of pilot to date:

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Number of posts allocated</th>
<th>Filled to date</th>
<th>In recruitment</th>
<th>Awaiting approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational therapy</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses: C.M.H.N. R.H.N. or R.G.N.</td>
<td>4</td>
<td>2 (R.H.N. and C.M.H.N.)</td>
<td></td>
<td>1 nurse (speech/lang post substituted for post in nursing quota)</td>
</tr>
<tr>
<td>Care Assistants (Homehelps substituted)</td>
<td>2</td>
<td>2 homehelps</td>
<td>1   homelhel</td>
<td></td>
</tr>
<tr>
<td>Family Support Workers</td>
<td>2</td>
<td>2 family support workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
<td></td>
<td></td>
<td>1 Psychologist</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Grade V</td>
<td>1</td>
<td></td>
<td></td>
<td>1 Grade V</td>
</tr>
<tr>
<td>Receptionist Grade IV</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech and language therapist</td>
<td>1</td>
<td>1 reduced for nursing post</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Primary Care Team premises in Ballymun Shopping Centre.
The Ballymun Primary Care Team – Securing a Base

Action 2:

Acquisition of temporary premises for the primary care team.

Initial plans for the pilot included the development of a new primary care unit to underpin the rollout of the strategy in the area. This unit was intended to house all the primary care core and network disciplines in the area and to replace the current health centre that has become overcrowded and inadequate to meet the demands placed on the service. Considerable delay and uncertainty has surrounded the progress of this centre in recent years but a commitment to open early in 2006 has now been secured. The development of this centre will be dealt with in the next section under future progress.

The delay in progressing the permanent premises for the primary care team resulted in the project manager sourcing temporary accommodation for the team in the Ballymun shopping centre. Two phases of accommodation have been leased by the pilot to accommodate the expanding primary care team. This accommodation consists of a ground floor and first floor premises in the Ballymun shopping centre.

The presence of dedicated and well signposted premises providing team services in the commercial heart of Ballymun has given the pilot and team a vibrant and visible presence in the area. The location of the majority of new team posts ‘under one roof’ has contributed to team building. The premises is located extremely to the existing health centre and this proximity has greatly facilitated integration and close cooperation between the primary care team and the wider disciplines.
Towards a Management Structure

Action 3:
Development of governance structures to support the team and project manager.

Prior to the formation of the H.S.E. the pilot was located in Area 7 of the Northern Area Health Board and had a regional brief for the piloting and rollout of the primary care strategy in the board. Since the establishment of the H.S.E. the pilot is now located in the Local Health Office for Dublin North Central. Due to its national and regional dynamic it is expected that there will be close involvement by the general manager, the L.H.O. manager and regional management in the strategic development of the pilot.

Since the beginning of the pilot the reform process has generated many personnel changes affecting the line management of the pilot at area and health board level. Despite this turbulence the pilot has maintained dynamic and direction due to strong leadership from the project manager and two local governance structures: a management committee and the local team.

Both structures have been developed with the twin aim of providing governance for the pilot and promoting integration.

Membership of the management committee consists of the general manager, the project manager, the G.P.s, managers of the relevant core primary care disciplines and managers of the relevant network services such as Community welfare, dietetics, the mater child and adolescent psychiatric service etc. This structure provides a useful forum for promoting integration between network and core primary care services and also provides disciplinary managers with a degree of ownership of the pilot. It's principal aim is to provide a forum to discuss issues arising and to provide guidance and sound decision-making to support the development of the primary care team.
The Local Team

In the period prior to the filling of fulltime posts a consultative team was convened to maintain momentum and progress the pilot. This team consisted of representatives from all the relevant core disciplines, G.P.s and significant network services. This structure has evolved to include the fulltime post holders in the team, representatives from network services such community welfare and representatives from the core disciplines as yet not released to the team. This local consultative team maintained the momentum of the pilot prior to the filling of fulltime posts and evolved into the primary care team proper. The team is the main decision-making body for frontline staff involved in the pilot. The inclusion in this structure of all disciplines involved in the implementation as well as the full time members of the team has provided and assisted in maintaining the interest and commitment of network services and of disciplines as yet not released to the team. This forum has acted as a critical vehicle for integration.

As the primary care team grows and the pilot evolves it may be necessary to review these governance structures. Proposed developments in this area will be dealt with in Section 5 on future progress and planning.
Developing an effective communications structure

Action 4:

Tendering, acquisition and implementation of an information/communications system for the primary care team.

The primary care team and project manager invested considerable time in the 2004/2005 period in exploring options for a suitable I.T. system. The team undertook a lengthy and methodical investigation of existing systems and their suitability. This investment of time was deemed necessary by all involved as an I.T. system was viewed as a critical component in promoting integration both amongst the team and between the team and other services and the user population. Experience of some other pilots has shown that the adoption of a system that was underdeveloped for team use could be extremely disruptive, particularly to a team in the formation stage, and could in fact militate against team building.
The team adopted a three pronged approach to the investigation and selection process for an I.T. system:

1. An independent consultant Clarion Consulting was commissioned to develop a functions specification i.e. a list of individual disciplinary and team requirements relation to an I.T. system. This process was overseen by the project manager and was conducted in close collaboration with the team and disciplinary heads. This specification of requirements was then used to conduct a comparative gap analysis with the two main accredited systems in the market i.e. Health One and G.P. Dynamic.

2. The team viewed the two systems above and also other systems such as Tiara 9.

3. The team and project manager visited some other pilot sites to view systems in use and contacted the disciplines on the pilot teams to assess use and satisfaction of the system.

The consultant met with the team and disciplinary heads both collectively and in individual disciplinary meetings to discuss their requirements of an I.T. system. Apart from the requirements of the individual disciplines on the team the collective team requirements were stated as follows:

- An effective and safe referral system between team members.
- An effective system for integrated case management including:
  i. The ability to track a client through the various disciplines
  ii. A multidisciplinary care plan that could capture and provide an overview of all disciplinary interventions with a client.
- An integrated appointments and waiting list management system.
- A facility to generate up to date statistics and reports for evaluation and planning purposes.

The consultant then conducted a gap analysis that measured the relative ability of Health One and G.P. Dynamic to deliver on the majority of requirements outlined in the functions specification with particular emphasis on the collective team requirements. Linkage between Tiara 9 and one of the above systems was also explored.
Findings from this process are outlined below:

- The accredited systems in use or available to primary care teams in Ireland are not designed for multidisciplinary use. Health One and G.P. Dynamic were designed solely for G.P.s.

- An enormous degree of adaptation is required to render these systems suitable for multi-disciplinary use.

- Primary care teams that went 'live' whilst attempting considerable adaptation of a system risked considerable disruption to service provision and to the team.

- I.T. companies involved expected primary care teams to expend considerable time and energy in assisting the adaptation of these systems to their requirements.

- Despite the two main systems mentioned being in place for some considerable time in some pilots there was very minimal interaction between the non-G.P.s team members and those systems.

- There is no unifying national or regional I.C.T. strategy in place to support primary care teams. This has resulted in each team tendering individually and a fragmented, inefficient and uneconomic approach to I.C.T. support for the strategy being adopted.

- The lack of a national framework has resulted in a lack of a structured collaborative approach to developing a multi-disciplinary system suitable for P.C.T.s.

- To illustrate the above point despite I.T. systems being present for some time in some of the national pilots the complete adaptation of a multi-disciplinary system that could be exported to other pilots has not taken place. Instead each pilot is expected to start from scratch with the two major systems. This is an unreasonable duplication of effort for developing primary care teams.
Tiara 9 is a U.K. system that meets the requirements of the therapeutic disciplines to a very high standard. It does not meet the requirements of G.P.s and nursing grades and is therefore not a unifying system for a primary care team.

The results of the Gap analysis concluded that Health One was slightly in the lead due particularly to its proven wide range network facility. This factor has important implications for the rollout of the system over a wide network of P.C.T.s.

Neither systems had the facility developed to immediately deliver on the main functional specifications for team integration such as interteam referrals and care plans.

Having taken all of the above considerations into account the Ballymun team decided that they were not prepared to commit to a system that could not satisfy both team and disciplinary requirements. Both Health One and G.P. Dynamic indicated that they had the potential to deliver on the required functions and were prepared to work with the team to progress matters. The team decided to test this commitment by engaging one of its therapists and a G.P with both systems with a view to assessing the potential of each system to meet both team, medical and individual therapeutic requirements. The team postponed a decision pending the outcome of these options. G.P. Dynamic did not engage in this process despite several approaches from the team.

Health One collaborated with the physiotherapist from the team. This resulted in Health One demonstrating considerable progress in relation to both team and therapeutic requirements. Whilst acknowledging that more work needed to be done the team were impressed with the amount of progress achieved relative to input from the team member involved.

At a special joint meeting of the management and local team a decision was taken to commit to Health One providing certain conditions were agreed. The level of support provided by the I.C.T. section of the H.S.E. and the provision of adequate staffing support to the pilot will also be critical factors in determining the successful implementation of an information/communications system for the team. These and other issues are currently under negotiation prior and will be agreed prior to the signing of a contract with Health One.
Setting the scene –
Current state analysis and quality control

Action 5.

– The provision of an evidence base and evaluation/quality assurance mechanisms for the pilot.

The development of an evidence base was identified earlier in this report as essential to effective and responsive planning and resourcing in the area. An independent report commissioned in the initial stage by the pilot concluded that existing health research conducted to date in Ballymun was patchy and out of date. Given the projected change in population size and profile the team views the commissioning of a general needs assessment as a priority for 2006. Progress in relation to this issue is outlined in ‘Section 5 on Future Progress and Planning.’

Pending the commissioning of a general health needs assessment in the area a significant evidence base has been developed to inform short to medium term planning in the pilot. Essential research pieces commissioned or supported by the pilot are outlined below:

Health Issues in Ballymun – A Collation of Existing Research
Simon Brooke.

This research was commissioned by the pilot in its early stages and provided a valuable insight into health issues recorded in the Ballymun area up to 2000. The findings of this research are outlined in Section 1 of this report entitled ‘Local population and health need’

Research by the Royal College of Surgeons

The R.C.S.I. Research involved in the primary care pilot has also provided some initial evidence and benchmarks in relation to user satisfaction with the service. This research was confined to focus groups of practice patients. The aim of the research was to elicit patient’s views of existing local health services and to provide benchmarks for the future evaluation of the primary care team services. Research was completed in 2004 and findings presented to the primary care team in December of that year.

A Reproductive sexual health needs assessment

The primary care teams collaborated with the Health Promotion Section of the former N.A.H.B. to commission and oversee the production of a Reproductive Health Needs assessment. The high number of crisis teenage pregnancies and S.T.D.s in the area and the obvious high level of early sexual activity made this aspect of needs assessment a priority. The research was conducted by Dr. Claire Collins and completed in early 2005.
Table B  Actions that have been delivered – pink box
Actions that have been progressed but are not completely delivered – purple box
Actions that are undelivered – white box

Goal 2.

<table>
<thead>
<tr>
<th>Action</th>
<th>Time-frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Team building including:</td>
<td>Sept. 2003-ongoing</td>
</tr>
<tr>
<td>• Introduction of skill mix appropriate to local needs</td>
<td></td>
</tr>
<tr>
<td>• Piloting of joint consultation model</td>
<td></td>
</tr>
<tr>
<td>• Introduction of structured clinical meetings</td>
<td></td>
</tr>
<tr>
<td>• Development of annual service plan outlining collaborative service initiatives</td>
<td></td>
</tr>
<tr>
<td>• Development of interdisciplinary training programme for team.</td>
<td></td>
</tr>
<tr>
<td>and</td>
<td></td>
</tr>
<tr>
<td>Development of practices and protocols to underpin effective team working:</td>
<td>Sept. 2003-Sept. 2005</td>
</tr>
<tr>
<td>• Terms of reference for team and management committee</td>
<td></td>
</tr>
<tr>
<td>• Enrolment criteria and public/information form</td>
<td></td>
</tr>
<tr>
<td>• Information sharing protocol</td>
<td></td>
</tr>
<tr>
<td>• Joint assessment and care plans, shared care and discharge plans, key working systems.</td>
<td></td>
</tr>
<tr>
<td>3. Enrolment of combined patient lists of three participating practices in health centre. (6,000-7,000 registered patients)</td>
<td>June 2006-Dec. 2007</td>
</tr>
<tr>
<td>4. Extension of team network and enrolment to wider Ballymun population – informed by outcome of general health needs assessment. (9,000-10,000)</td>
<td>Feb. 2005-Dec. 2005</td>
</tr>
</tbody>
</table>
Building a dynamic primary care team -
The teambuilding process

Actions 1 and 2
- Development of a fully operational primary care team serving an enrolled patient population.

Despite the delay in filling full-time posts in the pilot, substantial progress has been made to date both in relation to service provision and team building. Processes and protocols that have proved challenging in a number of other team contexts and pilots have been negotiated and agreed with relative ease and without recourse to facilitation or outside intervention in the Ballymun model. This is evidenced by the decision-making process that led to the selection of an I.T. system, the generous and clear information sharing protocol, the agreement on joint assessment and care plans, the enrolment criteria and the smooth enrolment process to date. The success of team functioning is further emphasized when the ease in securing progress on the above fronts is viewed in the context of the broad range of disciplines represented on the team. There are twenty members of the primary care team including a broad skill mix of health and social care professionals, G.P.s and practice staff and clerical/administrative staff. The teambuilding process to date has been underpinned by the Joint Consultation Model and weekly clinical meetings both of which involve a collaborative form of service to individual clients and families. Both these processes involve the agreement of packages of care based on joint assessment and care plans and employ a key working system where necessary. The form of teamwork that has evolved in the area is both dynamic and intensive. The intensity of contact and collaboration as evidenced in the Joint Consultation Model may not be suited or necessary in other areas with different population profiles but is regarded by the Ballymun team as an effective form of working in an area of concentrated disadvantage. As such, the Ballymun model of team working has important lessons and transferable factors for teams struggling to provide effective primary care services in similar contexts throughout the country. It is therefore worth noting the structures and critical success factors that contributed to teambuilding in the pilot.
A united front – towards a holistic approach

The Joint Consultation Model

The purpose of this model is to test and evaluate the effect of multidisciplinary team intervention in families presenting to G.P.s in a deprived area. The model concentrates on families with children under 16. The initiative is jointly funded by the H.S.E. and the Royal College of Surgeons. A fulltime researcher is in place on the team. This researcher is also a working G.P. and fulfills the twin function of operating as a locum for G.P.s in the pilot to release them for team activities and also leading the Joint Consultation process. The mechanics of the process involve the team meeting on a regular basis to discuss cases referred through this process. The team member referring provides a referral form with appropriate details of the case and the main presenting issues. The team then discusses the case and decides on the appropriate disciplines to meet with the family at the consultation. The consultation can take place in the family home or in a clinic setting. Having met the family and discussed several treatment and intervention options the disciplines involved then develop a care plan. The effect of team intervention is evaluated at a six and twelve month period subsequent to consultation. The wider team is provided with broad feedback in relation to all consultations that have taken place. The researcher involved is responsible for the correct ethical procedures being followed.

This initiative is important for several reasons:

- It provides a model of multidisciplinary intervention and case conferencing that is based on early intervention rather than the traditional practice that is crisis driven.

- It facilitates the development of tools for effective team working such as joint assessment, care plans and information sharing protocols.

- It specifically aims to evaluate the impact of multidisciplinary team working in the context of a deprived area and as such its findings should produce transferables and lessons in what works best for multidisciplinary team working in similar contexts. As such it has important implications for rollout in these areas.
Community Mothers Programme, Geraldstown House

Community Welfare
Development of a Dynamic Primary Care Team
- Critical Success Factors: The Ballymun Experience

There is a strong commitment amongst all health professionals and G.P.s in the area to the concept of multidisciplinary teamworking. This commitment was evidenced in the period prior to the filling of fulltime posts on the team when all local disciplines voluntarily nominated representatives to form a consultative team. These representatives gave of their time and energy while carrying traditional caseloads and attending meetings in their lunchbreaks.

- This commitment is fuelled by the complexity of cases presenting in an area of concentrated deprivation and the understanding by all disciplines of their limitations in resolving issues as a single service.

- The Ballymun primary care team is not a standalone team but one that evolved from local primary care services and maintains strong links with these services. This evolution was not accidental but resulted from deliberate decisions made and tactics employed in the team building and recruitment stage.

- Wherever possible and appropriate local staff was recruited onto the team. This greatly expedited the team building process as it allowed the pilot to capitalise on the local tradition of good interdisciplinary working relations. The continuity of service, experience and local knowledge that local staff brought to the pilot has proved invaluable and has greatly assisted in forging a continuity of linkage between the primary care team and the community and wider health services in the area.
• The Ballymun team represents a broad skill mix including disciplines that were not prescribed for the core team in the primary care strategy. However, given the high level of deprivation in the area and the complexity of issues presenting, additions to the core team were regarded as necessary in order to provide an appropriate response to local needs.

• The pilot represents a strong partnership between H.S.E. staff and independent services such as the G.P. practices and the Ballymun Homehelp and Family Support services. This partnership has been nurtured and sustained by the project manager and all the parties involved and is underpinned by the principles of transparency, inclusiveness, integrity and parity of esteem as enshrined in the terms of reference for the primary care team.

• The flat ethos of the team provides an alternative model of decision-making and operation to the traditional hierarchical line management structure. The flat and inclusive nature of this model is attractive to frontline staff.

• Governance structures were created that gave heads of disciplines and managers of network/specialist services a major stake and decision making role in the pilot. The management committee includes this group in its membership and has been served as an effective structure for maintaining commitment to the pilot at this level and throughout the wider disciplinary and service groups.
Lessons and transferables from the teambuilding process in Ballymun

- Appropriate governance structures and the recruitment of local staff increases the local connectivity of primary care teams, safeguards against standalones and increases their potential as motivational models for further rollout. The Ballymun team is not a standalone model but one that is highly transferable and with particular significance for areas with similar population profiles.

- The intensity of team interaction and the breadth of skill mix will and should vary according to the health and social need of the local population. A broader skill mix will most likely be required in areas of high deprivation.

- The research based on joint consultations currently being conducted by the R.C.S.I. in collaboration with the Ballymun primary care team is an extremely critical transferable as it represents independent third party research on multidisciplinary teamwork in primary care and its impact on the most vulnerable section of the local population. Findings from this research should influence the future membership and operation of primary care teams in similar socio-economic contexts.

- All team members need extra capacity in excess of that absorbed by normal caseloads to engage in the teambuilding process in the initial stages. Good teambuilding requires a substantial initial investment of time and energy. However, the development of effective structures, protocols and working tools leads to more effective team work and service provision in the long-term.

- A teamwork model based on a flat ethos and guaranteeing parity of esteem for all disciplines is both reassuring and motivational for frontline service providers and is an attractive model for rollout.

- Teams in development stage need intensive facilitation and management by a dedicated and appropriately senior manager.

- The development of successful primary care teams requires a top down, bottom up approach.

- Structured team working is not entirely dependent on the health of personal relations between team members but is underpinned by agreed job descriptions, protocols and working tools that sustain its effectiveness despite personnel changes.

- Other Transferables:
  - Intensity and effectiveness of team working via joint consultations, clinical meetings etc.
  - Information sharing protocol, joint assessment and care plans, enrolment criteria, enrolment application form,
  - Adaptation and implementation of I.C.T. system for primary care teams including listing of business processes etc.
The joint consultation model in action: delivering a multidisciplinary early intervention service.

Joan, a 19 year old single mother presented to a G.P. on the team with a chest infection and had back pain. She has 3 month old twins and had recently developed problems in breastfeeding her babies. She has no family support and no support from the child's father. She expressed a feeling of being 'overwhelmed' to her doctor. She was smoking heavily and had done so throughout her pregnancy. She had used a contraceptive device in the past that did not suit and was currently using no form of family planning.

At Joan consented to participate in the joint consultation programme a consultation was arranged for her with the Physio, the P.H.N, the family support worker and the G.P. from the team. A care plan was agreed with Joan that involved the following steps. The physio agreed to assess Joan that week at the Muscular Skeletal clinic and to address her back problem. The P.H.N. agreed to visit Joan on a weekly basis and arranged for a mother from the Community Mother's programme to visit Joan and give advice and support her in breastfeeding. The Family Support worker agreed to visit Joan every second day and support her in caring for her twins. An appointment was made for Joan at the smoking cessation clinic. Joan was referred to the sexual health clinic for support and advice on contraception.
Action 3 – Enrolment of combined lists of three participating practices in health centre.

The pilot has an overall target population of 16,000 in the four Ballymun D.E.D.s. This population is projected to rise to 34,000 as a result of the regeneration process. There are two stages to the enrolment process: the first stage is currently underway and aims to enrol the patient population of the three practices involved in the pilot. This population is approximately 7,000. 80% of these patients are in the G.M.S. This population is being served by the existing primary care team. The second phase will begin on completion of a general health needs assessment for the area and will be informed by the outcomes of that research and negotiations with local management, staff and G.P.s. The second phase will involve the extension of the primary care strategy to the wider population of Ballymun and will begin approximately in June 2006. The strategy for further rollout is dealt with in Section 5 on Future Planning and Progress.

Factors critical to the success of enrolment in Ballymun – lessons and transferables

The first phase of enrolment began in January 2005. This process was delayed due to the delay in filling fulltime posts on the team. The enrolment of the target population of 7,000 began in March 2005 and to date 4,500 people have been enrolled. Enrolment in the pilot to date has been a relatively easy process and has so far avoided the difficulties encountered by some other pilots. In planning the enrolment process the team were cognisant of challenges encountered in other pilots and developed criteria and measures to reduce the risks as identified. Key features of the enrolment process in Ballymun are outlined below:

- The importance of good quality information provision was emphasized in the approach to enrolment in Ballymun.
- The enrolment process is underpinned by an agreed information sharing protocol, agreed enrolment criteria with the G.P.s involved and a public enrolment form. It is essential that groundwork in relation to these issues is completed and agreed.
before the commencement of the public enrolment process. The team must be clear on such issues in order to transfer accurate information to the public.

- Due to the nature of the local population it was agreed that a mailing approach would not be productive. Instead, it was agreed to adopt an opportunistic approach to enrolment and for the team members and clerical/reception staff to enroll patients at point of contact with the service. This approach had the advantage of providing a human and often-familiar face to information being provided.

- Criteria governing enrolment and agreed with participating G.P.s confine the enrolled population to those patients on the lists that reside within the four Ballymun District Electoral areas. The enrolment criteria include a conditional clause that only clients who have been attending participating doctors for a minimum of twelve months will be enrolled. In the case of patients seeking to be enrolled who do not satisfy this condition the consent of their previous doctor is required. These measures were adopted to minimize disruption of local G.P. practices that are not in the pilot and to prevent seepage into the primary care team from outside the target area.

- The enrolment criteria guarantees a team service to vulnerable groups that may not satisfy the residency rule such as some travellers and the homeless.
Table C  Actions that have been delivered – pink box  
Actions that have been progressed but are not completely delivered – purple box  
Actions that are undelivered – white box

**Goal 3.**

Improvement in the accessibility, range and appropriateness of local primary care services.

<table>
<thead>
<tr>
<th>Action</th>
<th>Time-frame</th>
</tr>
</thead>
</table>
| 2. Expansion of additional services/clinics to address gaps in local health needs and reduce recourse to secondary care. Including development of the following clinics:  
  • Sexual Health  
  • Minor Surgery  
  • Dietetics clinic  
  • Methadone maintenance programme  
  • Muscular/skeletal clinic  
  • Dedicated spoken and language for enrolled population  
  • Collaborative mental health initiative in primary care  
  • Off site youth health facility: including mental health  
  • Diagnostic facility: x-ray, ultrasound  
A Speedier Route to Services

Action 1 – Realignment of referral procedures to

Improve speed of access

An important outcome for the enrolled population is an improvement in speed of access to services. This is particularly relevant to services with long waiting periods such as Physiotherapy and Occupational Therapy.

These services have traditionally been organized on an area basis. There is a substantial waiting list for these services in most areas and particularly in areas with high deprivation levels and G.M.S. lists. Factors contributing to this delay include: The low ratio of staffing numbers to population served, the centralized nature of the referral process and the positioning of these disciplines outside of the primary care context. The location of these services in the primary care team and the lowering of the target population served has facilitated a realignment of referral procedures with a resultant substantial improvement in speed of access for the local population. Waiting lists for these services are traditionally prioritized into three categories according to prioritized need. Categories 1 and 2 are cases of most urgent need and category 3 represents the bulk of cases that are deemed less urgent. However the definition of urgency employed is relative to the ability of the services to respond. Many cases in Category 3 can have serious conditions requiring the attention of a physiotherapist or Occupational Therapist. For categories 1 and 2 the average waiting time is several days or weeks and the waiting time for Category 3 varies from 8 to 12 months. There is no waiting list for the occupational therapist or physiotherapist on the primary care team to date. Patients in all categories are seen within days of referral.

Speech and language is a critical service in Ballymun given the young profile of the population and the high level of social, developmental and health needs. This service is also traditionally organized on an area basis, outside of the primary care context with a centralized referral procedure similar to Occupational and Physiotherapy. The recruitment of a speech and language therapist to the primary care team has resulted in referrals being processed locally and a substantial improvement in access to this service.
Meeting local needs - toward a greater range of primary care services

Action 2 -
Provision of Additional services/clinics to address gaps in local health needs and reduce recourse to secondary care.
Including development of the following clinics:

The Ballymun Sexual Health clinic. Developing a model of best practice.
This clinic was established in response to the concerns expressed by service providers as to the high number of sexually transmitted diseases and crisis pregnancies presenting. The clinic is staffed by a G.P. from the pilot and a practice nurse. The public health nurse on the team fulfills an outreach function for this clinic. The clinic operates on a weekly out-of-hours basis from 5 to 7 p.m. and addresses issues such as contraception, sexually transmitted diseases, cervical smears and menopausal conditions. Formal links and a working protocol have been agreed with the Infectious Diseases service at the Mater Misericordiae Hospital. Both G.P.s and nursing staff involved have been provided with special training to improve expertise in this area and the team have visited sexual health clinics in the U.S. and elsewhere. This clinic is quickly becoming a model of best practice in relation to the provision of sexual health in a primary care context. G.P.s involved have embarked on a process of sharing expertise developed in this area with their colleagues through the broader academic and professional channels.
The Minor Surgery Clinic – Reducing recourse to secondary care

This clinic provides surgical intervention for conditions such as ingrown toenails, warts, minor skin lesions, changing moles and lipomas. Prior to the establishment of this clinic patients in the area were referred to secondary care for these procedures and could wait for a minimum period of six months before the procedure was performed. A long waiting period in relation to some of these conditions has the potential to turn them from minor to major health issues e.g. skin lesions can be an indicator of skin cancer and moles may not be benign. This clinic fulfills a vital role in reducing recourse to secondary care and in providing timely intervention for conditions presenting.
The primary care team in action.
Delivering a person-centred preventive service.

At a postnatal visit the Public Health Nurse discussed contraceptive options with Margaret who has five small children. Margaret was interested in the contraceptive implant. The P.H.N. referred her to the sexual health clinic where the practice nurse discussed the pros and cons of the implant with her. Margaret decided that this was a suitable contraceptive method for her and the doctor inserted the implant that evening. Margaret normally found it difficult to visit the health centre during the day but found the evening clinic suited as her husband could mind the children.
The Dietetics Clinic – Spreading the word on eating for health.

The current community dietetic service commenced in March 2004 and is provided through the Primary Healthcare Project in Ballymun. Two dieticians work with the pilot and provide one to one clinical services and health promotion respectively. The health promotion function involves an outreach service to local community and youth groups in the form of presentations and demonstrations in relation to cooking and preparing healthy food. Dieticians in the pilot have also worked with local youth drop-in centres in the development of the menu for their café services.

The Early Morning Methadone Clinic – Tackling the heroin problem.

This clinic is operated by G.P.s and practice nurses on the primary care team. It is one of a number of services developed in response to the high level of heroin use in the area. However, this clinic is distinct in that it is aimed at full-time workers on methadone maintenance programmes and its aim is to facilitate patients to stabilize and continue to conduct a normal lifestyle whilst following a maintenance programme. The clinic operates on a weekly out of hours basis from 7 a.m. to 9 a.m. The aim of this clinic is to facilitate methadone users in full-time employment to comply with treatment without disruption to their normal working day. As such the clinic assists these patients to maintain stability in their lives.

The Muscular Skeletal Clinic – Meeting a high demand.

This clinic is conducted by the physiotherapist on the team to address muscular skeletal issues. There is a high demand amongst the enrolled population for this service. It is a new service in both the Ballymun and community care context. To date physiotherapists in the community care services have been unable to provide this service due to a lack of dedicated and specially equipped clinic premises and inadequate staffing. Prior to the development of this clinic, patients in Ballymun requiring treatment for muscular skeletal conditions were referred to a hospital based physiotherapy service. Access to this service normally involves a long waiting period. The other option was access to a private physiotherapist. Given the economic circumstances of the majority of Ballymun residents this was not a realistic option.
The Speech and Language Clinic and outreach service—Working with parents and children in Ballymun

A dedicated speech and language clinic operates as part of the pilot and an outreach service to creches in the area has recently been developed. Due to the high level of developmental problems associated with children in the area, this service is in high demand.

• Joint consultation and clinical care packages provide a good model of a client centre multidisciplinary approach.

The primary care team in action. Delivering integrated family care

Noreen is 25 years old. She lives with her 27-year-old partner who is the father of her two children aged 3 and 4. Her partner is unemployed and the family’s sole income consists of social welfare payments. She presents to her G.P. on the team complaining of sleeping problems. In the course of the consultation, the G.P. learns that Noreen’s partner has become an active heroin user in the past year. He is spending all of the household money on heroin and the family are coming under increasing financial pressure. Noreen has been forced to resort to illegal money lenders. Although it is midwinter, both Noreen and the children are wearing inappropriate light clothing. In his brief interaction with the children, the G.P. suspects that the three-year-old has extreme behavioural problems and the four-year-old’s speech development is slow.

Noreen and her partner are long standing patients of the G.P. He prescribes a short course of mild sleepers for Noreen and impresses on her the need to address the underlying issues contributing to her anxiety and sleeping disorder. He asks Noreen if she can convince her partner to attend the surgery with a view to discussing methadone maintenance. She agrees to try. The G.P. also requests her permission to discuss her case with appropriate named disciplines on the team. Her husband attends the G.P. surgery some days later and agrees to embark on a methadone maintenance programme. The G.P. raises Noreen’s case at a clinical meeting of the team. A care plan is agreed including the following...
interventions. The C.W.O. agrees to visit Noreen with a view to issuing an emergency clothing payment and in conjunction with the local credit union and M.A.B.s to agree a budgetary and loan plan with Noreen. The speech and language therapist agrees to make an appointment to assess Noreen's four year old.

The G.P. makes an appointment with the Mater Child and Family psychiatric service to assess her three year old's behavioural pattern.

The Home help and family support service  
- Providing support in the home.

The family support service
A family support and homehelp service operates as part of the Ballymun primary care team.

The family support service provides an important aspect of social support to families with special needs or who are undergoing temporary difficulties. Support provided by this service is extremely critical in the Ballymun context given the strong link between social and health problems. The family support worker forms an important link in the continuum of care that is central to the multidisciplinary approach in the community and by her intervention often prevents a crisis situation developing that could require recourse to secondary or specialist services. The service has a history of quick response and families are usually seen in a matter of days. The following is a sample list of intervention provided by family support:

- Liaison with families to ensure children keep health appointments.
- Assisting mothers with learning disabilities to access support in addressing the learning and developmental needs of their children.
- Empowering parents with a history of poor parental skills to improve these skills.
- In cases where a parent is having difficulty coping with the needs of a sick child or one who has special needs the family support worker assists by providing support to other children and relieving pressure on parents.
- Assisting parents with addiction issues or who are recovering from addiction to fulfill their parenting functions.
The home help service

The home help service in Ballymun is an independent service that is provided to an extremely high standard. The home help service on the primary care team substitutes for personal care assistance as prescribed in the strategy as the Ballymun home help service combines personal care as well as home help functions. This service plays an important role in facilitating early discharge from hospital and in preventing admissions. The following is a sample list of the many duties performed by home helps in the Ballymun service:

- Providing personal care, cooking and performing light housework for individuals incapacitated due to disability, terminal, chronic or acute illness.
- Providing support to the mentally ill.
- Providing support to individuals and families with addiction/alcoholism issues.

Both the family support and the home help service play a vital role in the multidisciplinary interventions and care plans emerging from joint consultation/clinical meetings.

Out of hours services – expanding availability

Action 3 – Expansion of out of hours services/increased availability of primary care disciplines – family support, sexual health, methadone

In developing additional clinics the team has been mindful of the need to extend access times to services. The sexual health, minor injuries and methadone clinics are operated on an out of hour's basis. The family support and home help services that operate as part of the project also perform an out of hours function.

There is a need for further expansion of out of hour's service by the team and this will be dealt in the section on future progress.
Towards a model of community participation in service planning

Action 4—Development of mechanisms to facilitate involvement of local community in development, planning, and operation of local health services.

Despite its many challenges as a community Ballymun has maintained an excellent community spirit. This is reflected in an extensive and concentrated network of community and voluntary services. The area has a vibrant partnership group which together with the local R.A.P.I.D. structure and the Ballymun Neighbourhood Council provides a good umbrella structure for the involvement of community and voluntary groups and residents in the planning and development of services. The primary care team has used these forums to inform and involve the local community in the development of the pilot. A number of approaches have been adopted to keep the local community involved and informed.
President Mory McNeese attends graduation ceremony for Primary Health Care workers on St. Margarets Halting Site, Ballymun.
A Community Working Group on Health

A consultative group of relevant community and statutory services has been convened by the pilot manager to advise on the progression of a general health needs assessment for the area. This forum is seen as a good first step approach to working in partnership with the community to prioritize need and develop and plan local health services accordingly. The community Organizations represented on this group include the following:

- Ballymun Regeneration Ltd, Dublin City Council, a representative of school principals in the area, Ballymun Partnership, R.A.P.I.D. Ballymun Neighbourhood council, B.R.Y.R. (the local youth service), the St. Vincent de Paul society, the Drugs Task Force, primary health care workers from the travelling community, representatives of local crèches and representatives of practice patients.

A Consumer Group

A consumer group of patients was formed as part of the R.C.S.I. research initiative in the area with the purpose of assessing their views in relation to current services.

Outcomes of this process will be used as benchmarks for assessing the impact of the primary care team.

Working with the community towards a childcare strategy

A representative group of major statutory and voluntary agencies has been convened under the auspices of the Ballymun partnership to develop a ten year strategy for childcare services in the area. The project manager for the primary care pilot represents the H.S.E. on this committee and the primary care team have been actively involved in these developments. The initiative has encouraged good intersectoral collaboration in the area.

A model of social inclusion in primary care

A primary healthcare initiative funded by the H.S.E. has been developed amongst the travelling community on St. Margareths Halting Site. This is the only halting site in the area. The project manager is an active member of the steering committee for the primary care initiative. The aim is to train local traveller women to act as primary health care support workers who will liaise between their community and the local primary health care services. Five women have already graduated from this course and formal
and close working relationships have been developed between these women and the primary healthcare team.

An enrolment criterion for the Ballymun team guarantees the right of homeless people in the area to access team services.

Information sharing and dissemination
The team views the provision of accurate information as an important factor in empowering the community to participate in health service planning and delivery. To that end a number of measures have been developed to facilitate information dissemination:

The development of structures and protocols to promote greater integration between primary, secondary and specialist services.

Actions that have been delivered – pink box
Actions that have been progressed but are not completely delivered – purple box
Actions that are undelivered – white box

Goal 4.

<table>
<thead>
<tr>
<th>Action</th>
<th>Time-frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Development of mechanisms to facilitate integration between the primary care team and network specialist services.</td>
<td>Sept 2003-ongoing</td>
</tr>
<tr>
<td>2. Development of protocol driven links with secondary and specialist care including shared care, discharge plans and protocols to support specialist clinics operated by team</td>
<td>Jan 2005-ongoing</td>
</tr>
</tbody>
</table>
Action 1 - Development of mechanisms to facilitate integration between the primary care team and network/specialist services.

As outlined in Action 3, Goal 1, the governance structures of the pilot play an important role in integration. The management committee for the pilot consists of heads of the core primary care disciplines as well as managers of relevant network and specialist services such as community welfare, the Mater child and family service, services for the elderly etc. This structure acts as a good mechanism for integration and provides a forum for the development of protocol driven care between all services involved. As the team structure evolves and broadens this network will be progressively expanded. Progress in this area will be outlined in the section on future planning.
Reducing reliance on secondary care

Action 2 -

Development of protocol driven links with secondary and specialist care.

Maximizing primary care capacity

The primary care strategy emphasizes the importance of the primary care services in the prevention of illness and the promotion of good health and recommends a more balanced approach that emphasizes health promotion and prevention as well as treatment and diagnosis. It also recommends a strengthened primary care service with increased capacity as an antidote to over reliance on secondary care. The Ballymun team views this recommendation as the core of their service ethos and delivery. Since their establishment the team has endeavoured to respond to local need by collaborative initiatives and the development of additional services in order to address health issues presenting in a community context and thereby preventing recourse to secondary care. Discharges from hospital occupy a substantial percentage of the teams capacity. However, the team gives priority to adopting a proactive rather than a reactive role in relation to reducing reliance on secondary care. This in effect means that a large element of team capacity is devoted to developing services and preventative initiatives that reduce recourse to secondary care. The list of services outlined in Actions under Goal 3 exemplifies this ethos.

Facilitating Early discharge

The team facilitates early discharge by the provision of multi-disciplinary care packages in a domiciliary context. Discharge cases requiring multi-disciplinary intervention are discussed at clinical meetings and joint assessments and care plans are developed in collaboration with the relevant services in secondary care. Protocols to support shared care arrangements have also been put in place and protocols to address the shared care of specific chronic illnesses e.g. diabetes will be progressed in the near future and are dealt with in the section on future planning. A large percentage of the home help capacity in the pilot is engaged in facilitating early discharge or in preventing discharge.
Protocol Driven Care

Protocols with secondary and specialist services have also been established to support dedicated clinics provided by the team. For example, a protocol has been agreed with the Genito-Urinary section in the Mater Hospital to support the work of the Sexual Health clinic in the pilot.

The team in action
- Interface with secondary care

Joe, a 67-year-old widower was admitted to Beaumont Hospital with a mild stroke. He still has some weakness in his right arm and arthritis in his right hip. He formerly lived independently in his own home. His only daughter lives abroad. He expressed a strong wish to continue living independently when discharged.

The discharge nurse contacted the nurse on the primary care team to plan in advance for Joe's discharge. The nurse organised a meeting between the occupational therapist, the physiotherapist and the home help worker on the team. The discharge nurse from Beaumont attended this meeting. The team developed a plan that included regular visits from the physiotherapist, daily support from the home help who provides both home help and personal care support. The P.H.N. initially visited on a twice weekly basis but reduced this to fortnightly visits as the patient's condition improved. Six months later Joe is still living independently in his own home.
Table E. Actions that have been delivered – pink box
Actions that have been progressed but are not completely delivered – purple box
Actions that are undelivered – white box

Goal 5.

Promotion of initiatives in the area of health promotion, prevention and early intervention

<table>
<thead>
<tr>
<th>Action</th>
<th>Time-frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of initiatives in the area of health promotion, prevention/early intervention including:</td>
<td>Jan 2005-ongoing</td>
</tr>
<tr>
<td>1. Immunisations</td>
<td></td>
</tr>
<tr>
<td>2. Nutritional advice and health promotion</td>
<td></td>
</tr>
<tr>
<td>3. Smoking cessation clinic</td>
<td></td>
</tr>
<tr>
<td>4. Sexual health</td>
<td></td>
</tr>
<tr>
<td>5. Early intervention in the form of joint consultation and multidisciplinary approach</td>
<td></td>
</tr>
<tr>
<td>6. Dedicated speech and language preschool service</td>
<td></td>
</tr>
<tr>
<td>7. Falls prevention</td>
<td></td>
</tr>
<tr>
<td>8. Training for teachers and crèche workers in screening and early detection of developmental problems</td>
<td></td>
</tr>
</tbody>
</table>

To date the pilot has developed several clinics and services with an emphasis on health promotion, prevention and early intervention.
Immunization

There are concerns from health service providers in the area as to the low uptake of immunization schemes. The primary care team are currently addressing this situation with all concerned i.e. G.P.s, the Senior Area Medical Officer and Public health nursing. Of urgent concern has been the collapse of the immunization scheme among the travelling community in St. Margareths Halting Site. A collaborative approach has been agreed and initiated involving G.P.s, Practice Nurses and and the P.H.N. on the primary care team to address this backlog. A training scheme is currently operating on the site the aim of which is to train women from the community as primary care workers to provide outreach and linkage between the primary care team and the St. Margareths community. Five women graduated as primary care workers in 2005 and it is intended to involve these workers in addressing health issues such as immunization uptake amongst their community.

Nutritional advice and health promotion

Two dieticians work closely with the primary care pilot and provide both a clinic service and a health promotion. Healthy eating courses including cooking demonstrations have been conducted for community groups and groups of selected patients attending clinics. The dieticians have also established information stands providing nutritional advice in the Ballymun shopping centre and other public areas.
Smoking cessation clinic
A smoking cessation clinic operates from the clinic premises on a sessional basis and members of the primary care team operate an outreach function in identifying and referring people to the clinic.

Sexual health
The sexual health clinic outlined in an earlier section of this report has a strong preventative and promotional function in that it provides advice on good sexual health practice and contraception in an attempt to prevent crisis pregnancies and sexually transmitted diseases in the population.

Joint consultation and multidisciplinary clinical meetings.
Both the joint consultations and clinical meetings conducted by the primary care team represent a strong form of early intervention using a multidisciplinary approach.

Dedicated speech and language preschool service
A preschool service for creches in the area is provided by the speech and language therapist in the team.

This is an outreach service the aim of which is to detect and address early speech and language developmental problems.
Section 5:

Future Planning and Progress
Section 5: Future Planning and Progress

The pilot has succeeded in overcoming major challenges in a difficult resourcing environment and made considerable advances in progressing the strategic shifts and outcomes outlined in the primary care strategy.

The work of the project for the remainder of the planning period to December 2007 will be concerned with consolidating developments already initiated and in progressing additional developments relating to the actions and associated goals outlined in Section 4. Future progress will be informed by the teams mission statement and underpinned by three major aims:

- The maximization of primary care capacity and a consequent reduction in recourse to secondary care.
- Increased emphasis on early intervention, health promotion and preventative services.
- Facilitation of early discharge.

The work of the pilot for this period can be divided into two main areas:

1. The strengthening of structures, resources and supports to improve service provision in line with the aims and goals outlined in the strategy.

2. The consolidation of existing service initiatives and the progression of new services.
Resourcing and strengthening the new model of service delivery

Areas for consolidation and development include the following:

- Consolidation of the existing primary care team including:
  - The filling of the prescribed staffing complement
  - The provision of the full disciplinary skill mix including social work, psychology and R.G.N.s.

- The strengthening of team relations including team identity and self governance.

- Establishment of a steering committee to link the new L.H.O. management structure and other stakeholders in overseeing the strategic development of the pilot.

- The implementation of an I.C.T. system for the primary care team.

- The commissioning and completion of a general health needs assessment for the Ballymun area.

- The extension of enrolment, informed by the findings of the needs assessment, to the remaining Ballymun population.

- The rollout of additional teams to the remainder of Local Health Office Dublin North Central area.
Consolidation of service developments
and progression of new initiatives –
Pushing out the boundaries

Development of new initiatives will include:

- The transfer of primary care services to the new health centre in the Civic Centre and the development of local diagnostic and related treatment services to reduce recourse to hospitals amongst the population of the region. These services will include ultrasound, x-ray and minor injuries.

- The consolidation and ongoing improvement of client multi-disciplinary team services informed by the experience, work practices and findings of the joint consultation model.

- The improvement in access to all disciplines on the teams including the expansion of out of hours services.

- The consolidation and appropriate expansion of newly established services such as the sexual health, minor surgery, muscular skeletal, methadone maintenance, dietetics and smoking cessation clinics.

- The establishment of new services and clinics in response to unmet local needs and to further reduce recourse to secondary/specialist care including:

  - The addition of a psychology and counselling service to the range of services provided by the primary care team.

  - The development of a collaborative service initiative involving the Community Mental Health, psychology and counselling services to address and process psycho-social and mental health issues presenting to the primary care team.

  - A multi-disciplinary diabetes service;

  - An offsite youth health facility – including a sexual health service;

  - Progression of measures and protocols including shared care, planned discharge and the piloting of a rapid response initiative to prevent admissions and facilitate early discharge from secondary care.
Strengthening resources and structures
- work for the future

Teambuilding
The primary care team in Ballymun has evolved into a dynamic, strong and increasingly self-governing model. Issues such as team leadership, structures, working protocols and tools are agreed and in operation. In line with this progression, the involvement of the project manager in the supervision and organization of the team will gradually be reduced to a minimum input in the coming year. Certain aspects of teambuilding such as training and governance principles will be developed in the immediate future.

Posts approved but as yet unfilled on the team include social work and psychology. The nursing complement on the team will need to be expanded in line with the growth in the enrolled population and operational service experience. It is important to note that although caseloads of individual team members may be low at present relative to those of similar disciplines in the traditional structures, considerable additional capacity is required by all team members in the initial development of a primary care team as the process of teambuilding and agreeing new job descriptions, work protocols and tools is extremely time consuming. In addition, the implementation of an automated information system for the team will require a considerable investment of time and energy on behalf of all team members and the team needs capacity additional to that absorbed by case management to ensure the successful progression of such developments.

Introduction of Health One
A major area of work involving the team in the coming year will be the adaptation and implementation of the Health One system. This is a critical area for progression. The development of an automated information and communication system adapted to the needs of a primary care team is essential to effective team work and the provision of a client centred service. In order to be successful the implementation process will require adequate resourcing and a high level of commitment and involvement by all the relevant parties i.e. Local Health Office line management, the project manager, the primary care team, G.P.s, Health One Staff and the I.C.T. section of the Eastern Health Shared Services. In particular, the allocation of a dedicated staffing resource from the E.H.S.S. I.C.T. section is
vital to the success of the implementation. The experience of other pilots has shown that if the process is not properly resourced and project managed it can be extremely disruptive to teambuilding and service provision. However, the successful adaptation and development of an automated system for the primary care team will be one of the major transferables and motivators to emerge from the pilot.

The commissioning and completion of a general health needs assessment for the Ballymun area that will inform the extension of enrolment to the remaining population.

The second wave of enrolment to the remaining Ballymun population of 10,000 will commence subsequent to the completion of a general health needs assessment and will be informed by the findings of same. The Ballymun population is projected to increase within a decade to twice the targeted population originally set for the pilot. The regeneration process is also projected to produce a change in population profile and needs. In this context a general health needs assessment will play a critical role in informing future rollout in the area. Findings of the needs assessment should inform the number and resourcing of primary care teams and their service emphasis. The second enrolment phase should be implemented between June 2006 and December 2007. This will involve the reconfiguration of existing disciplines in the primary care context into primary care teams and the realignment of disciplines currently organized on an area/professional basis with these teams.

Teams will be based on a single D.E.D. or a combination of D.E.D. based on the size and needs profile of individual D.E.D. populations. The skill mix for teams in the area should remain similar but the disciplinary staffing quota may vary depending on variables in population size and profile.

The commissioning of a health needs assessment is seen as a priority for the immediate future.
Two groups have been convened by the project manager to progress this work: a steering group of relevant health and academic professionals and a consultative group of the relevant community organizations. These groups will develop the terms of reference for the research body conducting the assessment and will oversee the tendering, commissioning and conduct of the needs assessment.

The completed enrolment of the identified population.
The enrolment process for patients attending participating practices is midway to completion. To date 4,000 patients have been recruited opportunistically on contact with services. The team have decided that this approach has yielded its maximum capacity and in order to maintain the current impact of enrolment a doorstep approach is now required. Preparations for this initiative have been completed and door to door recruitment has recently begun. It is hoped that the vast majority of the target population will be recruited by March 2006 at the latest.
Towards a one-stop-shop approach  
- reducing recourse to secondary care

Transfer of services to the new primary care centre and the provision of local diagnostic services.
Sanction for the equipping of the new health centre was secured in 2005. The centre is projected to open in March 2006. The primary service function of the centre will be to act as an integrated primary care centre for the Ballymun area.

The centre will also provide administrative headquarters for Local Health Office Dublin North Central. Additional facilities planned for the centre such as x-ray and ultrasound combined with a minor injuries unit and the minor surgery clinic established by the pilot will provide an important diagnostic and treatment dimension to local services and should significantly increase the capacity of primary care services to diagnose and treat conditions and injuries presenting without recourse to secondary care. The centre will play a vital role in aiding the integration of primary care and key network services as it will facilitate the location of most of these services under one roof. As was outlined in Section 2 the location of primary care and network services in the area has been fragmented with services operating from the health centre, two pilot premises and various other locations in the area. The new centre will facilitate access to services under one roof and should therefore assist in the integration of services and the progression of the primary care strategy in the area.

The Centre will have the following facilities:

- General practice consulting rooms and support facilities for ten general practitioners.
- The full range of clinics and services provided by the primary care pilot.
- Dedicated facilities as follows:
  - X-ray
  - Physiotherapy
  - Occupational Therapy
  - Minor surgery
  - Nursing
  - Social Work
• Network and secondary services will include:
  - Dentistry
  - The adult psychiatric service
  - Community Welfare
  - The Mater Child and Psychiatric service
  - The Marte Meo family counselling service.

The improvement in access to all disciplines on the team
As outlined in Section 4 significant progress has been made in improving access for users to the services of the primary care team Additional clinics developed by the pilot including sexual health, muscular skeletal, minor surgery and dietetics were previously unavailable in a primary care context and the local population were required to access such services through secondary care, specialist or community care services. The provision of these additional services represents a significant improvement in access to these treatments for the local population.

The joint consultation process has also improved the quality of service to families and individuals with complex and high health and social needs as it brings the concerted efforts of the team to bear on case presenting.

Out of hours services
The primary care team acknowledges the lack of out of hour's services as one of the major weaknesses in the general primary care structure to date. In particular, Ballymun and similar areas with high health and social needs generate a high level of crisis situations at night and weekends many associated with high addiction levels, domestic violence and psycho-social issues. It is acknowledged by all service providers that a nine to five response is highly inadequate and contributing to unnecessary admissions to secondary care.

There has been some progress, as outlined in this report on the provision of services on an out of hours basis. However, the team will continue to concentrate on improving access with particular emphasis on out of hours services.

A major obstacle to the provision of out of hours services to date in the area has been the lack of suitable facilities and premises. However, the planned relocation of primary care services in the area to a new health centre with state of the art facilities presents opportunities and challenges
to service provision in the area. The extension of out of hours’ services will be progressed in order to maximize the potential and capacity of this new facility for the benefit of the local population. The agenda for change set out in the modernization clause of Sustaining Progress provides opportunities for change in ways of working, the development of skill mix and the development of extended opening hours which are all critical success factors for the development of the new primary care model.

Exterior – New Primary Care premises, Ballymun.
New Treatment Initiatives – Increasing the capacity of local primary care services.

Mental health and psycho-social issues – Towards a holistic response in primary care.

A Community Mental Health nurse has recently been recruited to work on the primary care team. A psychologist is due to be recruited in the immediate future and the services of a counsellor are also being progressed for the primary care team. A collaborative initiative between these services is currently being finalized. This initiative has been developed and supported by the primary care team, the G.P.s, the Community mental health nurses based in Ballymun, the nursing management attached to St. Vincent’s Hospital, Fairview and the psychology service in the North East region. A community mental health nurse has been recruited to progress this initiative. This development will include a collaborative service between G.P.s and the C.M.H.N. and other relevant team members. The service will provide a form of early intervention and triage for patients presenting with anxiety/depressions issues and provide a brief therapeutic intervention service. The aims of the service are as follows:
To deal with the maximum number of appropriate mental health issues presenting in a primary care context

to prevent unnecessary referral to secondary psychiatric services

to provide direct and swift entry to hospital for acute cases presenting

to offer a therapeutic treatment alternative to the medical model for all appropriate cases presenting

to develop a collaborative approach between mental health nursing, psychology and counselling services in order to actively promote good mental health in the community

To develop a collaborative approach between the above disciplines that offers a comprehensive and holistic service to cases presenting with a personality disorder and/or a psychosocial dimension.

A protocol defining the working relationship and respective service responsibilities between the C.M.H.N. on the primary care team and the secondary psychiatric service is currently being finalized.

A multi-disciplinary diabetic service: treating Diabetes in the community.

A multidisciplinary diabetic service has been planned by the primary care team and will be initiated in the near future. The service will involve G.P.s, chiropody, optomology, the dietetic service and a counselling service amongst others. The aim of the service will be to treat diabetic patients in a primary context that are currently attending hospital for treatment. Initially the team aims to work with the relevant hospital staff to identify and target non-compliant patients and to treat these patients in a local context and by a shared care arrangement with the relevant hospital services. Motivation therapy will be included in the service provided. Currently the majority of Type 2 diabetic patients in Ballymun are attending Beaumont, the Mater and James Connolly Memorial hospitals. The development of this initiative should relieve pressure on the diabetic services in these hospitals.
Bringing health services to the youth of Ballymun – Outreach in primary care

The primary care team is currently collaborating with the H.S.E. Health Promotion, B.R.Y.R, a local youth service organization and the Ballymun partnership to develop a dedicated off-site health service aimed at young people in the area. This service initiative was inspired by a growing concern amongst health service providers and community organizations in relation to the high level of S.T.D.s and crisis pregnancies evidenced amongst increasingly younger sections of the local population. In 2005 the primary care pilot cooperated with Women’s Health Promotion in the commissioning of a Reproductive Health Needs assessment for the area. This assessment has been completed and provides the evidence base to support the sexual health aspect of the service. It is intended to provide a holistic service that will include health promotion initiatives, sexual health advice and treatment and nutritional advice as well as other services normally provided by G.P.s and nurses. It is envisaged that personnel involved in the service will include G.P.s, practice and public health nurses, family support workers from the primary care team and outreach workers from the youth services. An offsite facility will be provided by B.R.Y.R. in its new purpose built youth centre that is soon to open. This centre will provide a dedicated recreational and drop-in facility for local youth. It has been the experience of health service providers in Ballymun and similar areas that local youth and particularly those on the margins are reluctant to engage with traditional G.P. and health services operating from health service premises and are more likely to access health services that are located in a dedicated youth service providing recreational facilities.

The development of further initiatives in the areas of health promotion and prevention.

Much of the work of the primary care team to date including the smoking cessation, the sexual health clinic and the joint consultation model has had a strong promotional and preventative emphasis.
The team has plans for further initiatives in this area including the following:

- An initiative to improve uptake of immunization schemes
- A falls prevention clinic
- A healthy eating initiative
- A collaborative training programme run by the speech therapist and P.H.N. for teachers and childcare workers in the early detection and screening of developmental issues.
- The youth health facility planned will contain a strong health promotion/prevention element in the areas of addiction, safe sex and nutritional information and advice.
Evaluation:
An action plan for the implementation of the pilot was produced by the project early in 2004. The timescales given for developments have been broadly adhered to. Delays in implementation have been associated with delays in resourcing. Pilots have by their nature a strong experimental dimension and it is important that planning is not over prescribed and allows for this dynamic. Outcomes and the means and timescales for their achievement cannot be absolutely predicted in pilot stage. Planning should and will adapt in the face of operational experience. The pilot is conscious that it is part of a learning experience for the wider primary care and health service structure. The body of research, templates and protocols developed will be made available to all interested parties. The project manager has already begun to provide presentations on the experience of the project to date and lessons learnt.

An independent evaluation of the pilot should be commissioned approximately two years after the establishment of the fulltime primary care team. As no posts were filled until January 2005 and the pilot is still endeavouring to fill other posts this evaluation should be commenced no earlier than January 2007. This is a reasonable period to allow for the full development of the team and its services.

Several issues have arisen in the course of development to date that is worth sharing with a wider audience. These issues have implications for rollout and will be discussed in the next section.
Section 6: Future Rollout: The Way Forward
Section 6:
Future Rollout: The Way Forward

The role of the pilots in testing transferables and innovative work practices prior to rollout has been discussed in detail in this report. The particular significance of the Ballymun pilot for rollout in areas of high health and social needs has also been highlighted. Another core function of the pilots is to motivate and inspire staff in the wider disciplines and by example to promote the rollout of the strategy. The resourcing of the pilots and the experience of staff in the initial teams is therefore extremely influential for the extension of the primary care model. The importance of motivational leadership is a vital component for the success of such a large change management process. Gaining the goodwill of staff is particularly important in attempting major change in a climate of constrained resources.
Several challenges face the rollout of the strategy at present. The delay in resourcing the pilots has delayed the learning schedule as prescribed in the Primary Care Strategy and this must be taken into account when planning the pace of future rollout. The national pilots are generating valuable lessons but these have yet to be assessed and recorded in a form suitable for wider circulation and comprehension. This report is a first attempt at a structured assessment of the experience of a pilot to date. It is not an independent evaluation and does not claim to be. However the joint Consultation research model currently being conducted by the Royal College of Surgeons as part of the pilot represents an independent evaluation exercise of multidisciplinary team working. The findings of this research should generate important lessons for the development of future models of teamwork. Further independent evaluation of the pilot is also necessary and should take place at a more mature stage of team development.

The extension of primary care teams requires a top down bottom up approach. National and regional leadership is required to support local rollout. However a certain amount of flexibility must be maintained in order to allow for adaptation to local variables e.g. urban/rural, concentrated versus dispersed populations and varying levels of social and health needs. The transition period in the reform process has resulted in a lack of direction at national and regional level in relation to the strategy and pilots. This is particularly evidenced in the fragmented approach to I.C.T. support for the pilots. There also seems to be confusion at high levels in relation to the direction and future extension of the strategy. There seems to be consensus amongst the major stakeholders that primary care should be strengthened and the team network extended but uncertainty remains as to the means of effecting this change and the extent to which it should be resourced.

In planning local rollout account should be taken of challenges presenting in the wider context and issues that need to be addressed nationally and locally should be identified. In planning rollout on the ground it is important that all concerned share a common vision and are mindful of the end goals as outlined in the strategy. Major change as evidenced in the primary care strategy is not an end in itself but a means to an end. The major aims of the strategy are to provide a greater range of services in primary care and enhanced accessibility to services. Reconfiguration of certain disciplines will contribute to these goals but their full achievement will require extra resourcing and capacity particularly in the early stages.
The experience of the pilots demonstrates that extra staffing capacity is required to develop team working in the initial stages. The additional capacity required for the development of future teams should not be at the same level as that required by the pilots. The experience gained by the pilots and templates, working tools and protocols produced should expedite future teambuilding. The lowering of the ratio of therapists to population/caseloads served has facilitated improvement in access to certain disciplines within the pilots such as O.T. and Physiotherapy. This raises the issue as to what is an acceptable waiting time or access standard for services and what ratio of disciplinary staff to population/caseload is required to deliver this standard. This issue required national and regional input and should be informed by the experience of the pilots as the services to enrolled population sizes increase.

The report issued by the E.R.H.A. in 2005 on the rollout of the primary care strategy in the region drew on the experience of the pilots and identified several elements that needed to be mobilised locally for successful rollout. These elements were as follows:

1. People (frontline and managers) – cohesive vision and commitment.
2. Physical assets
3. Finance
4. Leadership
5. Needs assessment
Role out in L.H.O. Dublin North Central

In relation to the rollout of the strategy in the local area the Ballymun pilot has already created important transferables under most of these headings.

In relation to mobilising staff and providing a suitable model of team working the pilot has contributed the following strengths:

- Development of governance and team structures that are inclusive of local managers and frontline staff and that have provided a positive experience of the strategy for these groups.
- Recruitment of local staff and the resulting maintenance of links with the local disciplines.
- The creation of a positive experience of partnership between G.P.s and H.S.E. staff.
- The creation of a flat team with parity of esteem for all disciplines.
- The creation of a skill mix model adapted to rollout in deprived areas of concentrated deprivation.

The pilot has also demonstrated the importance of strong leadership at project management level. In relation to the Ballymun team effective leadership at this level has kept the pilot on track despite external upheaval in the organisation. Local rollout in the initial stages will require dedicated leadership and coordination within the L.H.O. area for the network of primary care teams.

The primary care strategy and the E.R.H.A. Report on rollout emphasise the importance of needs assessment for the successful rollout of the strategy. The number and staffing of primary care teams should be influenced by need as well as population size. The experience of needs assessment soon to be piloted in Ballymun should provide a transferable model for use in similar deprived areas such as the north inner city.

The development and adaptation of an I.T. system for multidisciplinary use will be the single most valuable contribution to integrated team working to emerge from the pilots. National and regional leadership is urgently required in this area.

An efficient I.T. system will increase the capacity of existing staff and can facilitate both multidisciplinary and cross-sectoral integration. It can also support virtual teams where premises and locations are fragmented.
Preparation for rollout in Area 7 is already underway in Ballymun and has been dealt with in detail in this report. In relation to preparing for rollout in the rest of the area an assessment and mapping of the following elements should be conducted:

- health centres – location, skill mix attached, natural hinterland of health centre and catchment areas of staff.
- Identify disciplines aligned to health centre but not located there and their catchment areas/caseloads
- Identify homehelp and family support services – location and standard of service provided.
- Identify target population and catchment areas for PHNs and C.W.O.s (only H.S.E. disciplines with comprehensive local coverage)
- Identify where PHN and C.W.O. districts overlap.
- Identify D.E.D.s and grading on HASSE index – gives indication of need.
- Identify G.P.s by surgery location and also location of bulk of population served.

This exercise can be expedited in L.H.O. north central as the project manager has already mapped most of the above elements as part of a mapping exercise conducted by the N.A.H.B. The process of imputing and mapping this information electronically has begun. All of the above elements should then be analysed to identify opportunities that afford the most favourable combination of elements for the development of another primary care team in the inner city region. Disciplines already operating in a primary care context such as PHNs and C.W.O.s will require minimal reconfiguration into primary care teams and can operate as anchors for developing teams. Disciplines prescribed for P.C.T.s but not located in the primary care context will require realignment.

Managers involved in the process should be identified. Most of these managers are already involved in the management committee for the pilot and with the relevant additions this committee could form the consultative forum for rollout. The process should be graduated in order to build confidence and minimize disruption.