DEPARTMENT
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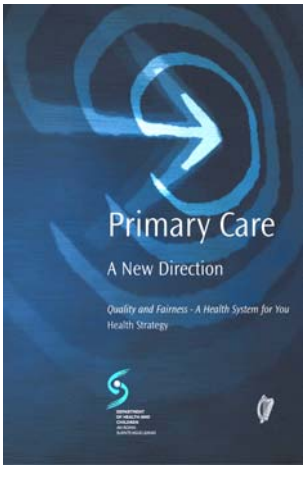
Framework to Guide Development of Primary Care Teams and Primary Care Networks

Primary Care

A New Direction



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Introduction

This document has been prepared to set out clearly the key principles underpinning the Primary Care Strategy (Primary Care: A New Direction) and to expand on the thinking underlying these. In particular it seeks to reflect on the debate that has occurred since the launch of the strategy. Experience gained through the evolution of the initial implementation projects is also reflected. The document sets out key principles to be considered when establishing a primary care team or primary care network.

Initial drafts of this document were circulated for comment and feedback to the National Primary Care Steering Group. The views of the Steering Group have been taken into consideration in the finalisation of the Framework.

Documentation and updates on progress with the implementation of the strategy are available on the website on the Primary Care Strategy established by the Department of Health and Children - www.primarycare.ie

Policy Context

The National Health Strategy '*Quality and Fairness - A Health System for You'* published in November 2001, in setting out the vision for the development of the Irish health services over a seven to ten-year period, identified primary care as one of the six frameworks for change under which a range of actions would be required during the lifetime of the strategy. To underline the importance of primary care, a more detailed strategy document, *Primary Care: A New Direction,* was also published. It represents the most significant development to have been proposed for primary care in Ireland. This strategy recognises the central role that primary care must play in a modern health system and will shape the future development of primary care and policy related to it over a period of ten or more years.

The Strategic Vision set by the National Health Strategy *'Quality and Fairness - A Health System for You'* states:

> *"A health system that supports and empowers you, your family and community to achieve your full health potential*
>
> *A health system that is there when you need it, that is fair, and that you can trust*
>
> *A health system that encourages you to have your say, listens to you, and ensures that your views are taken into account."*

The strategy highlighted the significant role that primary care services must play in tackling the health and personal social service needs of the population. As the central focus of the delivery of health and personal social services primary care is well placed to address and influence the determinants of health and tackle health inequalities. The health objective outlined in the National Anti-Poverty Strategy "Building an Inclusive Society" recognises the need to address the social factors influencing health, particularly those groups and individuals who experience poverty and social exclusion. One of the guiding principles of the National Health Strategy is that of a people-centred health system. This is reinforced in the Primary Care Strategy, which commits to an active, meaningful involvement by communities in service planning, delivery and needs assessment.

Primary Care as Central to Health Care Delivery

Primary care should provide comprehensive, effective, efficient and equitable services in local communities, capable of dealing with all but the most complex medical conditions. This means that primary care will be capable of coping with 90-95% of all health and personal social service requirements. The Primary Care Strategy aims to provide:

- a strengthened primary care system which will play a more central role as the first and ongoing point of contact for people with the health-care system;
- a service that is team-based, integrated, interdisciplinary, high-quality and user-friendly for defined populations;
- 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 principal advantages for service users will be:

- Improved access to primary care services, including out-of-hours services;
- An increased range of services, and an increased emphasis in areas such as prevention, health promotion and rehabilitation;
- Greater availability of Health Care staff thus allowing for increased consultation time to the benefit of both service user and practitioner;
- Delivery of services in a single location, where appropriate, so that a service user or family can access a number of health care providers in the one centre;
- Improved physical facilities;
- Increased community involvement and co-operation in shaping local primary care services and input to local needs assessment;
- Improved health outcomes.

This new model will also bring benefits for those providing the services. Professionals will work in multidisciplinary teams where they will have access to the advice and expertise of other professionals and can ensure that service users receive the services they need from the appropriate members of the team. Working together should mean that the primary care team amounts to more than the sum of its parts and that its members work across professional boundaries rather than in the relative isolation in which they may have traditionally operated. Development of direct access to diagnostic facilities, shared care arrangements, discharge and referral arrangements, supported by modern information and communication technology, will ensure that primary care develops in a modern and integrated way with the rest of the health system.

Health Service Reform

One of the principal objectives of the plans for the modernisation of health service structures announced by the Government in June 2003 is that the system should be structured to enable the Health Strategy, including the Primary Care Strategy, to be delivered. As part of the reform process therefore, the system for the planning and delivery of primary care services, at national, regional and local level, will need to be organised so that it will function as the driving force for the development of this model of service delivery. As resources permit, additional investment in staffing and services will occur.

Physical Infrastructure

It is recognised also that the physical infrastructure to support the roll-out of the new team-based model of primary care delivery will need to be significantly improved. Therefore one of the Government's key objectives is to facilitate and encourage the development, where appropriate, of modern, well-equipped, user-friendly buildings from which the broad range of primary care services, including general practice, can be delivered. While the State may contribute towards such developments, because of the scale of what will be required, it is necessary to explore a range of different approaches to the financing and provision of these facilities.

The Department of Health and Children will develop policy in such a way as to encourage innovative approaches that have the potential to result in the provision of appropriate facilities to support the development and operation of primary care teams on a widespread basis. Such approaches might, for example, involve independent developers, or groups of health professionals, possibly in partnership with the statutory health authorities, developing facilities for the delivery of integrated primary care services. Partnerships with providers in the voluntary and community will be explored, as will inter-agency initiatives such as integrated public services centres.

Incremental and evolutionary development

The process of reorganising primary care and community services to meet the objectives of the strategy will be an incremental and evolutionary one. The Department of Health and Children has requested the health service delivery system to prepare for the establishment of further primary care teams and networks by reviewing the current configuration of services and developing measures to give more widespread effect to the teamworking model described in the strategy.

This Framework document is a further stage of evolution of policy following on the publication of the strategy document *Primary Care: A New Direction* and should serve to inform the further development of primary teams and networks. Further policy documents on specific aspects of the model will be developed as the process of implementation proceeds.

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The Primary Care Strategy *Primary Care: A New Direction* (Department of Health and Children 2001) – contains an extensive Bibliography

Section 1

The Primary Care Team and Primary Care Network

1.1 Composition

1.1.1 Key Principles

- The number and composition of Primary Care Teams and Networks will be determined by local needs assessments, geographical location and catchment area, population size, primary care practitioners in the service area etc.

- The primary care team will involve the full range of professional competencies as described in the Strategy, viz.

    - general practitioner(s)
    - nursing
    - midwifery
    - health care assistants
    - home helps
    - occupational therapy
    - physiotherapy
    - social worker
    - administrator
    - receptionist/clerical officer(s)

- The primary care network will involve the following professions

    - Chiropodist
    - Community Pharmacist
    - Community Welfare Officer
    - Dentist
    - Dietician
    - Psychologist
    - Speech and language therapist

- The composition of the primary care team will be as set out above. However assessed needs of the population to be served may indicate additional service requirements. The relevant professional competencies to meet such needs are likely to be accessed in the wider health service – network, community services, acute services and continuing care.

1.1.2 Discussion

Primary Care: A New Direction proposes the delivery of generalist services by the interdisciplinary primary care team and network described above. There will continue to be a need for specialist teams to meet certain population health needs. However the primary care team will be capable of meeting many of these needs as regards generalist services. Well established linkages and referral protocols to specialist services will need to be developed to ensure appropriate access to services to meet wider service user needs.

There is evidence to show that a model where health care professionals work as a team provides a more effective service to service users. The introduction of primary care teams is also associated with high levels of service user and carer satisfaction. The introduction of a multidisciplinary primary care team has been shown to enable people to be maintained at home in times of crisis, a reduction in emergency admissions and shorter lengths of hospital stay.

Primary care can lessen the current reliance on specialist services and the hospital system (particularly accident and emergency, out-patient services and diagnostic services) and, based on available evidence, has the potential to reduce the requirement for specialist services, reduce hospitalisation rates, promote more rational prescribing and improve efficiency and effectiveness.

The development of the primary care team model with its skill mix will ensure that many health professionals will have more time to engage in preventive activities, secure the input and support of colleagues and develop their knowledge and skills through continuous personal and professional development on an interdisciplinary basis. With the introduction of extended hours, working hours for many team members can become more flexible.

The basic structural unit of care in the community will be the practice population-based primary care team. Partnership between health professionals and service users is seen in the Primary Care Strategy as one of the key elements to the future success of primary health care. Real teamwork requires that team members serve a common population, use common service user care records and meet regularly to coordinate care.

The nursing and midwifery functions will include some or all of the following competencies: advanced nurse practitioner, clinical nurse specialist, public health nursing, midwifery, mental health, practice nurse and general nursing competencies, depending on the needs identified by the needs assessment process. Recruitment of Health and Social Care Professionals with the appropriate clinical competencies is essential – this may include clinical specialists as indicated by the needs assessment.

The number and ratio of team members is flexible and will be determined by local needs assessments, geographical location, population size etc. The carrying-out of a local needs assessment is an essential part of the process of establishing a primary care team. The lead role in managing this process will be taken by the statutory health agency responsible for the planning and delivery of services in the area.

Primary Care Networks covering the enrolled population of a number of primary care teams and serving natural catchment areas need to be developed as a key resource. Whilst it may take some time for the full complement of staff envisaged for such networks to be available on a widespread basis it will be important to establish relationships between staff assigned to Networks and the Primary Care Teams through robust processes and protocols. In addition the involvement of staff assigned to the network in needs assessment will be important. Strong systems of engagement with the wider health sector will also be necessary.

1.2. Access to the Primary Care Team

1.2.1 Key Principles

- Service users will be enabled to access the appropriate member of the primary care team directly.

- A triage arrangement should be put in place to facilitate linking service users to the member(s) of the team most appropriate to their needs. Triage may be organised at different levels – team, area, or regional.

- There must be arrangements in place to ensure that, whichever team member a service user chooses to access, his or her needs are effectively matched with the appropriate professional competencies required to meet them.

- The concept of access needs to include wider parameters such as access to information on services and health, participation, barriers to access and consequential health inequalities.

1.2.2 Discussion

The self-referral model of access to primary care, now a feature for many of the professions, will be reinforced in the new model of primary care, as appropriate. This will be a change where previously the general practitioner was the first point of contact for many needs, and if necessary referred service users to other primary care services.

The system for delivering primary care services will be oriented towards the needs of its users. It will also enable people to take control and responsibility for their own health. This approach to accessing the team empowers the users of the services, by enabling them to make their own choices about which primary care services they wish to use as the first point of access. This will require specific capacity building/empowerment initiatives for both service users and providers. Appropriate and effective use of resources will need to be monitored and evaluated.

It will free primary care professionals, particularly general practitioners, from dealing with issues and conditions which can be more effectively be handled by other members of the team. At the same time, service users who wish to access their general practitioner as the first point of contact may continue to do so.

Where a system of triage and referral at the point of access is used, this will ensure that people can be linked with the most appropriate professional for their needs. It may be felt that a triage arrangement is neither necessary nor appropriate for a particular team, particularly where services are not being delivered from one common physical location. Further development of this concept will be informed by the practical experience of the first implementation projects. In the future telephone triage arrangements will provide a number of organisational options including local, area or regional service provision.

Appropriate local team-working protocols should be put in place to ensure, inter alia, that service users are referred to other team members as appropriate and that care is provided by the team on a co-ordinated and interdisciplinary basis. Protocols for referral to services in the Network and specialist services will need to be established. Local team management/co-ordination structures will provide a forum for the development of such protocols.

The monitoring and evaluation arrangements for each team must be capable of establishing the extent to which direct access is in place, whether any practical difficulties are being experienced and the measures adopted to address these.

Primary Care Teams will need to establish proactive approaches to engage communities to address the wider access issues. Whilst establishing clear arrangements to facilitate access to team members, access to information on service availability, health information and participation in decision-making must also be provided for. Marginalised groups may need specific initiatives to ensure equity of access.

1.3. Equity

1.3.1 Key Principles

- All of the population served by the team should have access to the same range and quality of services, regardless of their eligibility status.
- The funding and service delivery arrangements, including the physical facilities, must be such as will ensure this.
- The system must respond to people's needs rather than have access dependent on geographic location or ability to pay.
- Fair and equitable access to health and social care must take cognisance of the person's ability to self refer, self-identify needs and also ability to access.
- Service provision should strive, in conjunction with other agencies and communities, to achieve equality of health outcomes, particularly having regard to the social and economic determinants of health.

1.3.2 Discussion

The Primary Care Strategy, in setting out the vision for future primary care service delivery, does not differentiate between holders of medical cards and other service users. It is a key principle, therefore, that people are enabled to access services on an equitable basis in all respects. For example, there should be common waiting areas and access times, as currently applies to the provision of general practitioner services. Those most likely to suffer deprivation and consequential ill health should be proactively engaged in consultation and service provision.

Equity means that

- health inequalities are targeted.
- people are treated according to need.

Improving equity of access has the potential to improve health by ensuring that people know what services they are entitled to and how to get those services and that there are no barriers, financial or otherwise, to receiving the services they need.

It is widely recognised that people from lower socio-economic groups experience a disproportionate burden of ill health. The equity principle recognises that social, environmental and economic factors including deprivation, education, housing and nutrition affect both an individual's health status and his or her ability to access services. The equity principle underpins the National Development Plan and the 1999 Report of the Chief Medical Officer highlighted the need to address health inequalities in more radical ways. The primary care model will help to address this. The provision of services should proactively target health inequalities.

Collaborative and partnership arrangements need to be established through cross-sector structures and engagement to adopt a more preventative approach to tackling health status inequalities. It will be essential that at local level primary care teams ensure a high level of engagement with the communities they serve and feed into more strategic and operational responses at network and Local Health Office level.

Section 2

Working as a Team

2.1 Team Management

2.1.1 Key Principles

- The development of the Team must be based on developing a responsive, integrated people centred service, promoting working together to increase effectiveness in meeting health and social care needs.

- Management arrangements must be put in place to facilitate and support the effective operation of the team. These arrangements will include meeting training and support needs.

- The team should agree on the assignment of a leadership role(s) within the team. The management functions of the team may be undertaken by any member of the professional staff of the team, for an agreed period of time, as agreed by the team.

- Team Management must have regard to, and link with, the overall Health Service management structure.

- Periodic reports on the team's activities will be required. The Team will prepare, implement and monitor an annual operational plan – linked to the wider network and Local Area service plan.

2.1.2 Discussion

2.1.2.1 Management of the Team as a whole

A primary care team is required to deliver a range of generalist health and personal social services to a defined population. Management is about facilitating and enabling the team efficiently and effectively to meet a range of identified and planned goals. The team concept is about real integration, not a group of individuals working in parallel. The future development of the primary care model should ideally see teams functioning with a considerable degree of autonomy, as the optimum structures to allow the model to flourish are developed within the Health Service Reform Programme. Within this context there will need to be clear accountability and responsibility for each team's activities and services as a whole, supported by robust management arrangements.

A clear written set of protocols and procedures should be established to ensure effective practice as a team and transparency in respect of individual roles and responsibilities. Primary Care Teams will link as appropriate with the management structure of the Local Health Office. This management framework will be developed by the Health Service Executive and will include arrangements for supporting and developing professional practice.

The wider management framework of the service should act as a support to the primary care team management structure and not assume the discrete management functions appropriate to and required of the team itself.

2.1.2.2 Management Functions

The management functions required of the team are likely to fall within several areas, which may include – Administrative, Team Management, Clinical Management, Service Planning and Resource Management. Each team member may have responsibilities in relation to each of these areas but it is the overarching aspects that will need a structured response, to ensure the effective functioning and collective accountability of the primary care team.

2.1.2.3 Administrative Support

Administrative support is needed to facilitate the effective operation of the team as a whole. Many administrative tasks can most appropriately and effectively be undertaken by Clerical/Administrative personnel. The Team Administrator should have day-to-day responsibility, on behalf of the team, for such matters as:

- Provision of general administrative arrangements for the team.
- ICT administrator, quality assurance of data.
- Supervise the administrative staff and systems within the team.
- Human Resources and personnel administration.
- Linkages with other health services providers, service users, non-health service agencies and health service management structure.
- Management of enrolment process.

2.1.2.4 Team Leadership

Leadership roles can be assigned to one or more team members. Key tasks for leaders will include managing the team, leading the team and providing support to other team members - to ensure that their respective roles are complementary and that the overall service as delivered by the team is maximised in terms of effectiveness and efficiency.

The manager role may facilitate developments and processes within the team which will improve the clinical contribution of those within the team and the team overall. For example, it may be considered appropriate to have regular meetings at which the cases of individual service users could be considered and plans agreed for the management of their care collaboratively and by the different members of the team.

As the team evolves a clinical leader role may be agreed, to lead the team on clinical issues. The functions of the team leader(s) may therefore include leading appropriate team members in:

- Development of protocols, guidelines, referral arrangements, care management packages and care planning.
- Implementation, updating and monitoring of guidelines and their application.
- Quality assurance programme to underpin guidelines and care planning.
- Clinical Risk Management and clinical governance.

As well as taking responsibility for their own performance individuals operating as part of a team must have regard to the team's responsibilities. Clinical Risk requirements will quite often span several, or all, team members. To operate effectively as a team, group responsibility and initiatives will need to be process; structure or systems-led rather than personality-led.

2.1.2.5 Service Planning and Resource Management

In line with the principles enunciated in the *Report of the Commission on Financial Management and Control Systems in the Health Service* regarding non-hospital expenditure the overall direction of national policy is, where appropriate, to devolve resource management out to the individual practitioners/service units. Primary care teams will need to be equipped to discharge this responsibility. Assigning resources to Team level requires a set of arrangements that can ensure individual and team requirements are met (within the available budget). Priorities will have to be established that are in line with national policy, national and regional service plans and be supported by appropriate operational plans at service level.

2.1.2.6 Management of Change

Change management support will be necessary for each team to provide for its formation and development. Learning from team formation in the existing Implementation Projects will inform this process.

All team members will be supported through appropriate and continuous training and development.

During initial set up stages support and training will be required to develop team identity, shared understanding and clarify roles, responsibilities and working practices.

2.2. Teamworking: unified approach to care management

2.2.1 Key Principles

- Multi-professional teamworking is a fundamental principle underpinning the new primary care model.
- Teamworking creates a system of primary care teams composed of different professions working in collaborative relationships and interdisciplinary settings.
- Complementary working with other professionals will reinforce individual professional roles.
- Teamworking must be provided for through specific arrangements defined and articulated in agreed protocols for the provision of care to the defined population, based on need.
- The clinical lead in the development of a given set of arrangements may be taken by any of the professionals within the team as appropriate.

2.2.2 Discussion

The vision of teamworking as set out in *Primary Care: A New Direction* is one of a system of planned, structured teamworking, where all team members are committed to the provision of services as a team to meet the needs of the same population.

Teamworking implies co-ordinated and structured arrangements to ensure that service users' health and social care requirements are identified and met by the team. This involves ensuring that each person's requirements are assessed and matched with the skills and competencies needed to address them. Some of the service requirements may be delivered by community based voluntary organisation providers.

Where the different members of the team have different contractual and employment status - with for example, general practitioners (and their employees), or therapists in private practice, in a contractual arrangement with the health agency, and the other members employed by the health agency – structured arrangements are needed in order for teamworking to take place on a mutually agreed basis.

Teamworking will enable more competencies to be made available for service users, thereby providing an enhanced range of services. These services will be delivered in a more co-ordinated, continuous manner than is often the case at present. This will lead to greater capacity in primary care which will allow more activity to take place within primary care and more accessible services to be delivered locally.

The objective should be to maximise the effectiveness of the team, such that the whole is greater than the sum of the individual parts. The benefit for primary care professionals will be that they can enjoy the support of a greater range and number of other professionals than is the case at present. This will allow each professional to focus on the competency which they provide best and to broaden its application into new fields, such as prevention and rehabilitation. Where competencies are shared within the team there will be need to be a process of agreement to determine who takes the lead.

Additionally, this will allow support to be given to inter-referral between primary care providers, which can also enhance the capacity of primary care.

Governance arrangements should ensure that formal arrangements for teamworking are in place in each team.

The implementation of the new primary care model will require some changes to present arrangements and structures, to facilitate teamworking. Primary care professionals will be working in a structured multidisciplinary environment where there will be a need for strong horizontal working relationships among the team members and a reduced emphasis on vertical reporting relationship within professions.

To fully exploit and maximise the potential of the reorganised teams/networks attention will have to be given to the change management requirements of the revised arrangements and this will need to be resourced.

Where the configuration of population, geography and other factors facilitate delivery of services from a single site, this will assist the process of effective teamworking. However this is not a prerequisite in all cases and the teamworking model will be applied in a wide range of settings, including those where services will be delivered from more than one site.

2.3. Governance and Accountability

2.3.1 Key principles

- In order for primary care teams to function effectively and efficiently, appropriate governance arrangements will need to be in place.
- These need to be at the level of the team itself and within the organisational structures for the planning and delivery of services at local, regional and national level.
- Individual accountability and team accountability needs to be recognised and articulated formally.
- Staff will work within their profession's standards of practice, code of ethics and professional conduct.
- Formal Monitoring & Evaluation of services must be an integral part of the service.
- Risk Management, including Clinical Risk Management, will form part of the Governance arrangements.

2.3.2 Discussion

The relationships between primary care professionals within the new primary care model are not governed by hierarchy or primacy of any one profession over others, thereby requiring the development of systems to enable the team to function effectively with appropriate systems of governance and accountability.

In the primary care context, governance can be described as a system by which an organisation can be enabled to achieve its objectives and meet the necessary standards of accountability, probity and openness. Maintaining a sound system of governance is a key requirement for the successful operation of a primary care team. As matters stand, the different members of the team have different contractual and employment status, with general practitioners in a contractual arrangement with the health agency (and their employees in a contractual arrangement with them), and the other members generally in the direct employment of the public health service. This makes it all the more important to have agreed appropriate governance arrangements in place with all team participants.

A governance framework brings together requirements for systems, processes and arrangements to manage a variety of issues. It requires clear arrangements for the allocation of responsibilities. Good governance is - among other things - participatory, transparent, accountable and efficient.

The development of governance arrangements and a governance framework for primary care is a developmental process, aligned to both the overall implementation of primary care policy and to the structural reform of the health services. The governance framework should also include arrangements for the Primary Care Network and for area/region based services, to assure an integrated/sustainable response to assessed need.

The initial group of primary care teams provide a setting in which approaches to governance can be explored. The types of issue being addressed in this context include:

- Identification of team membership
- Range of services to be provided
- Agreed standing operating procedures dealing with such matters as:
    - team meetings
    - quorum for meetings
    - leadership arrangements
    - management of team
    - reporting structures
    - finance
    - decision-making process
    - management of service user self-referral
    - enrolment process
    - data management, protection
- Agreement on teamworking process inclusive of identification of team leader(s) and explicit acknowledgement of key worker concept.
- Role of team manager
- Roles and responsibilities of team members
- Continuing Medical Education (CME) and Personal Development
- Agreement on assessment process for all contacts with team
- Referral processes within the team and to external services
- Arrangements for community involvement
- Establishment of a Quality, Evaluation and Monitoring framework

The governance framework should, ultimately, aim to address and establish mechanisms for system wide quality improvement, monitoring and evaluation, performance indicators and value for money initiatives.

The National Primary Care Steering Group have developed a *"Framework for Quality Assurance in Primary Care"* and this provides a range of recommendations to provide direction on the development of appropriate quality assurance initiatives, drawing on examples and experience from other international systems.

One of the key proposals of the Health Service Reform Programme is the establishment of the Health Information and Quality Authority and in this context a formal accreditation system for primary care is likely to emerge.

Section 3

Linking the Team to the Population and Service Users

3.1. Population to be served

3.1.1 Key Principles

- Each primary care team must serve a defined population.
- The enrolled population should be within a defined geographical catchment area.
- The dominant approach will be to assign all staff resources to the enrolled population list. Harmonising the existing service user lists and the geographical "patch" system into a single unified approach is a priority.
- The team must establish a clear understanding of the size, demographic and socio-economic profile of the population served.

3.1.2 Discussion

By planning and delivering primary care services to an identified population, the range and nature of the services, and the arrangements for their delivery, can be tailored to the needs of the population. The coverage, composition and number of primary care teams will be established on the basis of needs assessments, consistent with a population health approach. Needs assessments can also specifically identify special needs or areas of disadvantage to ensure that teams' resources can be tailored to meet those needs.

The provision of services to a common population provides clarity for the teams as to the specific population being served and facilitates population-based health interventions such as screening and health promotion programmes. Continuity of care will allow complex health and social problems to be dealt with through a detailed knowledge of service users and their families. It also allows the development of closer working relationships between team members.

In order to facilitate the delivery of primary care services by the primary care team to a common population, it is necessary to develop approaches to agreeing this catchment population. The team should have the capacity to deliver a comprehensive, effective service to the enrolled population and not "over-reach" in respect of coverage – both in terms of total numbers enrolled and the geographical area covered.

Currently, services are delivered by (a) general practitioners and their staff (b) other primary care professionals in the community, the latter generally being employees of the public health system. General practice populations tend not to align with the community care catchment populations, as their service user lists are determined by which service users choose to register with each general practitioner under the General Medical Services Scheme, or who choose to attend them as private service users. On the other hand, services delivered by the Health Boards (in the future the Health Service Executive) tend to be organised on geographical lines, typically by District Electoral Divisions (DED's) within Community Care Areas – usually county-based.

While the ideal organisation model is of an integrated team serving a whole (fully registered) population there is potential, pending the achievement of that goal, for greater health service coverage in having certain members of the primary care team serve the population enrolled with the team, while other staff may also have a geographic remit. In this way they could serve both the enrolled population of the team and meet the needs of service users not registered with a primary care team, including assisting them, where appropriate, in registering with a team of

their choice. This will assist in ensuring universal access to primary care services for the population as a whole, inclusive of transient and socially excluded groups of society. Gradually, as more teams are established, there can be less reliance on such a dual arrangement and service delivery will be primarily through the Primary Care Teams.

The Strategy envisaged that each primary care team would serve a population group of between 3,000 and 7,000 people, depending on whether a region is rural or urban. Among other factors, the number and ratio of team members will depend on needs assessment, location and population size. Initial experience with the establishment of the first implementation projects suggests that some teams will serve somewhat larger populations and this can be accommodated within the model described in the Strategy.

3.2. Enrolment

3.2.1 Key Principles

- Where a primary care team is being established, arrangements should be made to create a population-based register on the basis of a voluntary enrolment arrangement.
- Service users are free to enrol with the primary care team of their choice operating in their catchment area.
- People should be encouraged to enrol with a particular General Practitioner within the primary team.
- They should be made aware of the purpose for which personal information is collected and the way in which it will be used to enable the appropriate service to be delivered by the primary care team.
- Enrolment by individuals from the defined population should be facilitated by the relevant team.

3.2.2 Discussion

The population to be served by each primary care team will be primarily determined by a process of voluntary service user enrolment. Individuals will be actively encouraged to enrol with one primary care team, and with a particular general practitioner within the team. A key purpose of enrolment will be to facilitate a long-term relationship between the service user, the team and the wider network of providers. It will also enable population-based health interventions to be targeted at specific population groups, to address identified needs.

The Strategy nonetheless intends that the system of enrolment will be flexible, so that individuals will be free to change teams easily should they so wish.

The arrangements for the operation of the enrolment system will need to be considered and addressed locally in each case where a team is being established. There is room for local initiative and innovation as regards how the enrolment process should be conducted.

People should be encouraged to enrol with a particular general practitioner within the primary team. General Practitioners' General Medical Services lists may therefore provide a starting point for the registration process. The enrolment process may be undertaken, for example, by raising the issue with service users as they attend for consultations, by reviewing and validating practices' existing service user lists or through a separate communication process with the target population.

Principles which should inform teams' approach to enrolment are:

- People should be enrolled with only one primary care team at any one time.
- People should be informed of the implications and benefits of enrolment so that they can make an informed decision as to whether or not they wish to be enrolled.

- People should be asked to provide (or to verify, where such information is already held by the team) in written form the required set of information necessary to enable them to be enrolled.

- People should be informed about the purpose for which personal information is collected, how it may be used by the team and the basis on which certain information may be accessed by more than one team member to facilitate the delivery of an integrated service.

- Parents, guardians or legal representatives can enrol minors or dependants with the team.

- Service users must be free to un-enrol from the team at any time and if they so request, they should be removed from the team's enrolled list.

- In the case of enrolled service users who do not avail of any team services or otherwise communicate with the team over a particular period, there should be an arrangement in place to verify their status and whether they wish to remain enrolled with the team. This does not alter or affect existing or future arrangements in relation to the verification of service users' continued GMS eligibility.

- To ensure continuity of care, clear protocols should be established for the transfer of data from the team to another team, as a person transfers to the care of another team.

The way in which enrolment arrangements are implemented and the level of success of the approach adopted should be the subject of regular evaluation.

In the longer term, the planned development of a national electronic health care record and a system of unique personal identifier will facilitate the operation of service user enrolment with the primary care team.

3.3. Service user choice

3.3.1 Key Principles

- Choice, of team and of General Practitioner, must be a central feature of the provision of primary health care.

- Service Users must be enabled to see whichever member of the primary care team or network they choose.

3.3.2 Discussion

Choice is currently a feature of the General Medical Services and of care provided for private service users. Any new model of care will preserve this and will seek to strengthen it by increasing the range of services from which people can choose and by allowing people to change service providers where they wish to do so.

People will be free to choose which team they register with. Different members of a family will be able to enrol with different teams or with different General Practitioners within the team. The system will also allow people to change their nominated team or General Practitioner. This preserves a key strength of the General Medical Services system.

Increasing the number and type of staff/providers within primary care gives people choices which they did not previously have. Similarly, the planned expansion or development of telephone access to triage and other services will introduce a choice that is not there at present.

As part of the process of widening the implementation of the principles contained in the primary care strategy, health boards have been asked to consider approaches to the process of reorganising primary care and community services, to give wider effect to the teamworking concept. The principles of choice must be maintained in the service delivery structures that may emerge from this process.

The process of establishing further primary care teams should be underpinned by the provision of appropriate material for the local population as to the choices they can make and the information they may need in order to make those choices.

3.4. Community Involvement

3.4.1 Key Principles

- Primary care teams should ensure user participation, including involving local community and voluntary groups in service planning, delivery, monitoring and evaluation.
- Communities must have an input to local needs assessments initiated by the statutory health agency.
- The ability and capacity of communities to determine the services they require needs to be acknowledged.
- Community Involvement should be seen as an ongoing process.

3.4.2 Discussion

The strategy *Primary Care: A New Direction* states that community participation in primary care will be strengthened by encouraging and facilitating the involvement of local community and voluntary groups in the planning and delivery of primary care services.

Appropriate mechanisms and arrangements need to be developed to give effect to the above principles in a way that meets the needs of individuals, communities and service providers.

The National Health Strategy '*Quality and Fairness - A Health System for You'* has as one of its guiding principles "people-centredness". In the context of primary care:

- services must be organised, located and accessed in a way that takes greater account of the needs and preferences of the community they serve.
- health and social systems must be able to accommodate differences in service user preference and encourage shared decision-making.
- communities should be supported in taking greater control, but also greater responsibility, for their own health.
- communities need access to high-quality information on health to fully benefit from health and social systems and to participate in decisions relating to their health. Readily available information stimulates self-help and informed choice.
- there must be increased involvement of service users as partners in planning and evaluation as an important component in promoting openness and accountability.

The objective is to have a process by which communities are enabled to become actively and genuinely involved in defining the issues of concern to them, in contributing to the decision-making in respect of the planning, development and delivery of services and in the monitoring and evaluation arrangements.

At local level, primary care teams should ensure user participation in service planning and delivery. Service users should also have an input to needs assessments initiated by individual health agencies. It is essential is that there should be meaningful dialogue which allows the views of communities to be heard and taken into account.

The initial implementation projects are exploring various models of community participation, including direct membership of the team decision making processes. The experience of these arrangements will inform the development of national guidelines.

In November 2002 the Health Boards Executive produced a guidelines document intended to assist health boards in developing their plans to engage with communities. Work is also underway in the National Primary Care Steering Group to develop appropriate practical guidance for health boards, service providers, primary care teams and community interests on how the commitment to community involvement may be given effect. Other resources available include existing Health Board policy documents on consultation and advocacy (e.g. the Eastern Regional Health Authority Advocacy Framework Document – 2004)

Where a primary care team is to be established, the process of communication and engagement between providers and the community should commence at the planning stage, so that there can be clear communication and consultation about what is intended. This will enable clear communication of the rationale for the delivery of services by the team and the changes it will mean as regards service delivery, and to enable the community to contribute in a meaningful way to the establishment of the team, the definition of the services it should provide and the ways in which the community's needs can best be met.

It is appropriate, given that community involvement has not heretofore been an integral element of the way in which our health and social services are planned and delivered, that the way in which this occurs should be monitored and evaluated so that effective and meaningful arrangements result.

Section 4

Linkages and Supporting Structures

4.1. Adherence to national frameworks and guidelines

4.1.1 Key Principles

- A quality outlook must underpin the planning, management and delivery of services within the health system so that quality can then be measured and demonstrated in an objective way.

- The delivery of services by a primary care team must be in compliance with any relevant national guidelines, frameworks or protocols.

4.1.2 Discussion

The National Health Strategy places a strong emphasis on ensuring that Ireland has a high-performing health system. It recognises that improving system performance requires development of standardised quality systems to support best practice care and that quality and continuous improvement must be embedded in daily practice to ensure consistently high standards.

The Strategy states that national standards and protocols for quality care, service user safety and risk management will be drawn up for all health and personal social services. While driven centrally, these standards will be developed on a partnership basis with relevant stakeholders and will be updated regularly.

The Health Information and Quality Authority will have a key role in the development of an appropriate quality assurance framework for the health service including primary care. This will also be informed by work carried out in the National Primary Care Steering Group on quality and integration issues.

Quality assurance mechanisms will be introduced as a means of improving performance and preventing problems using a structured set of planned and systematic activities such as documentation, training and review. This approach will allow the quality of services to be benchmarked as well as improving consistency, increasing accountability and ensuring that good practices are spread throughout the system.

Where national frameworks, guidelines or protocols have been drawn up and issued in relation to the delivery of primary care services, or the interface between primary and secondary care services, primary care teams, networks and statutory health agencies must ensure that they comply with these.

The primary care strategy envisages that the interface between primary and secondary care will be advanced through a number of initiatives, designed to improve integration. It is envisaged that integration initiatives will include:

- referral guidelines and protocols for consultant care and diagnostic services.
- discharge plans agreed between the hospital and a key primary care worker/service.
- integrated care pathways and referral guidelines facilitated by key workers.
- individual care plans, appropriate to identified need.
- shared care arrangements for specific health conditions.

It is also envisaged that national standards will be developed to support the planning and delivery of services by primary care teams. These will lay down key principles, while at the same time allowing scope for the development of more specific local protocols which will facilitate and underpin the concept of teamworking which is central to the Primary Care Strategy.

The implementation of this approach in the delivery of primary care services will ensure that there are agreed national principles and standards of service which must be complied with by primary care teams and networks.

It is in the interest of all team and network members that they be able to demonstrate compliance with agreed standards as a means of improving performance and preventing problems.

Regular review of quality standards supports and encourages a culture of continuous improvement. This is an essential component in a sector where new technology and social and demographic trends require the system to be flexible and responsive to changing needs and priorities.

The Report of the Commission on Financial Management and Control Systems in the Health Service in respect of performance management/accountability is a significant component of the Health Service Reform Programme. It is expected that this will involve the development and implementation of standardised activity/budgeting arrangements within formalised service planning processes. Such arrangements can be anticipated to apply to individual providers, teams and networks.

4.2. Information and Communications Technology (ICT)

4.2.1 Key Principles

- Primary care services will be characterised by their utilisation of modern ICT technologies and information systems facilitating integrated team working/collaboration across distributed service delivery settings.

- Primary care teams will require appropriate electronic communications and electronic record systems, with provision for appropriate linkages to the primary care network and community care services.

- Systems should provide for the generation of an electronic health record for each service user, to which team members should have role-based access.

- Appropriate protocols will be necessary to ensure that issues including confidentiality and the need for service users' informed consent are addressed.

- Systems must facilitate collection and provision of appropriate data on a standardised basis for epidemiological and service planning purposes.

- Systems should also have the capability to link to those of other health care agencies and providers, secondary care services such as laboratory, radiology, outpatients' department and admissions/discharges facilities thus facilitating seamless integration of up to date data and improved service user interface.

- ICT developments should be in line with national initiatives in this area.

- Systems must have the ability to disaggregate data to support evaluation and planning e.g. socio-economic group analysis, targeted services planning, ethnicity.

- Systems must support the financial management requirements of the service.

4.2.2 Discussion

The National Health Strategy recognises that modern Information and Communications Technology (ICT) has the potential to improve radically the range and type of services, as well as the method of delivery, for professionals and the public.

The future direction of information and communications technology for the healthcare system is set out in the National Health Information Strategy.

ICT can provide rapid access to clinical and administrative records as well as a range of knowledge to assist with decision-making. Data collected at this stage will be a key source of information for planning and performance measurement. The phased introduction of a system of electronic service user records will support the clinical process and offer great potential to enhance the quality and safety of care. In particular, the linkage of electronic records to create an electronic health record (EHR) will provide new opportunities for supporting shared care.

The use of a unique personal identifier for the public services is of critical importance in achieving

the highest quality of care and in the delivery of person-centred health and social services. It is also proposed to introduce health information legislation to address concerns and ensure that health information can be utilised for the benefit of all.

The exploitation of the full potential of information and communications technology will be central to the implementation of the Primary Care Strategy.

Plans for the provision of services by the primary care team must ensure that appropriate electronic communications and electronic record systems will be put in place for the team across the multiple service delivery settings, with provision for appropriate linkages to the primary care network. Such systems should provide for the generation of an electronic health record for each service user, to which team members should have role-based access, i.e. they would be enabled to access those parts of the record relevant to the requirements of their role as a member of the primary care team. Appropriate protocols will be necessary to ensure that issues including confidentiality and the need for service users' informed consent are addressed.

It is envisaged that among the types of data and activity required of a software package are:

- The collection of a standard core set of service user data in respect of each service user of the team, to include general and clinical information;
- The recording of service users' encounters with the primary care team;
- Medication history;
- Integrated systems for appointment;
- Information to enable the provision of the best possible health and social care interventions through assistance from clinical data and best practice knowledge.
- General and clinical management tools for preventative care management, preventive screening, immunisation routines etc.
- Ability to communicate with other aspects of Community and Hospital based services.
- Ability to support finance aspects of Team activities e.g. Budgets, Billing.
- Database analysis to assist in service planning, evaluation, audit, performance.

The systems must also facilitate collection and provision of appropriate data on a standardised basis for epidemiological and service planning/budgeting purposes including needs assessments. Other requirements include tools to support the most effective use and targeting of resources, information about health and primary care services for service users and the public, including specific health information and advice.

A key element of the model described in the strategy is the achievement of integration between service providers at primary care level, and between primary and secondary care services. It is envisaged that the systems used should also have the capability to link to other health care agencies and providers, and hospital departments such as laboratory, radiology, outpatient department and admissions/discharges. The agreement and utilisation of a unique identifier is critical to achieving this level of integration.

At present there is no "off the shelf" software which meets all of the needs of an integrated primary care team and supports its functioning in the manner described in the strategy. The Department of Health and Children intends to explore at national level how best the development of appropriate software can be informed and promoted, as a support to the implementation of the multidisciplinary primary care model. The ICT requirements of the new primary care model will also be addressed in the context of the national, enterprise systems, approach to be taken in the development of ICT as a key enabler of the provision of an integrated and information-driven health system nationally.

4.3. Needs assessment

4.3.1 Key Principles

- As part of the putting in place of a new primary care team a detailed local needs assessment must be carried out, using an approved method.
- Local communities must be involved in the needs assessment.
- Local needs assessment should include data sets in line with regional and national assessment templates.

4.3.2 Discussion

Needs assessment is a tool that can be used to identify priority areas for service development and to aid service planning. It is a systematic study of demographic, epidemiological, and other factors to describe gaps or discrepancies (in terms of capital infrastructure, human resources, equipping and information and communications technology etc.) that exist between the system of primary care as it exists now and what will be required to meet current and future needs. Needs assessment over time can provide valuable information on health and social gain.

The Primary Care Strategy identified health needs assessment as central to effective primary care. The coverage, composition and number of primary care teams will be established on the basis of needs assessment consistent with a population health approach. They will take into account demographic factors, epidemiological factors, geographical considerations and existing health and social service provision. Needs assessments should specifically identify special needs or areas of disadvantage to ensure that primary care teams can be targeted to meet those needs.

There are two principal components to the task required so as to inform the planning and development of primary care services, both nationally and at local level. The first component is to identify in global (macro) terms what will be required in each region, in a way that will enable the products of this work support planning at regional and national levels, particularly in the area of future human resource needs of the system.

The second component is to identify a methodology for carrying out a more detailed and more local needs assessment in conjunction with the development of any new primary care team. This will include addressing how local communities can become involved in the process and thereby have an influence over the definition of local priorities and the services that will be provided in response. The services provided by the team should reflect local measured need.

At the request of the Department of Health and Children the Health Board Chief Executive Officers established a group at national level to co-ordinate the carrying out of a national needs assessment and to agree on definitions, standards, and the process for the task.

An agreed set of templates and relevant definitions was developed by the group for use in each health board to gather information on a regional basis. Some topics, e.g. community participation and equipment requirements were considered more suited to be addressed at a later stage by a subsequent Local Needs Assessment.

Further work will be undertaken to agree approaches to the local needs assessment process based on the work of the national group and the experience of needs assessment for the initial implementation sites.

Key resource input and expertise already exists within the Health Services and indeed other agencies including the statutory and community sectors. Departments of Public Health in the health sector will have already undertaken research and analysis on a range of issues both disease specific and general needs assessments. The Chief Medical Officer's Annual Reports have highlighted a number of issues. National strategies have identified issues on topics such as Cardiovascular Disease, Cancer, Health Promotion, Women's Health, and Travellers' Health.

In the wider State sector data and information is available to support needs assessments e.g. FÁS, Department of Social & Family Affairs, Local Authorities, education sector, City & County Development Boards.

A considerable range of research and needs assessments have been undertaken by the Community & Voluntary sector, which provides important sources of key indicators and evidence of needs. Existing information relevant to needs assessment should also be sourced from professional bodies.

Organisations supporting and advocating for the needs of various groups have an important role to play in identifying the needs of a given population – strategies and research in areas such as Physical & Sensory Disability, Travellers' health needs, Mental health needs, Services for older people, etc have issued a range of research and position papers on the needs of their particular areas of interest which should inform needs assessment and analysis.

4.4 Intersectoral actions

4.4.1 Key Principles

- In order for primary care teams to maximise their impact on factors that influence health and social wellbeing at a local level, they must work with other sectors to address such factors.

- The process of interaction with the local community should provide a significant input into the identification of relevant issues and the possible means of addressing them through intersectoral collaborations.

- Governance arrangements should ensure that intersectoral action takes place at the level of the team.

- Co-operation and participation, as appropriate, with the Intersectoral agenda of the wider Health Service and State Agencies will be essential.

4.4.2 Discussion

The multi-factorial nature of the determinants of health and social wellbeing has been recognised for over half a century. The control of many of these factors lies outside the areas of activity which can be addressed by traditional health and social services and, therefore, intersectoral collaboration is important if they are to be addressed. The need for and value of this approach is well recognised at both national and international levels but, despite this recognition, the required links and conjoint actions have been slow to develop.

The National Health Strategy sets out a plan which has the capacity to address factors which influence health and social well being at all levels in society. Intersectoral actions are at the centre of this. There is considerable scope for intersectoral action within local communities, between the primary care team and other sectors such as local authorities, schools and the social welfare system. If primary care teams are to maximise their impact on factors which influence health at a local level, they will need to engage with these other sectors.

One of the key reasons for involvement of the local community as set out in the primary care strategy was to enhance the advocacy role of primary care teams in ensuring that local and national, social and environmental health issues, which influence health, are identified and addressed.

Each primary care team should put in place a plan to develop some initial intersectoral action designed to reflect local needs. One team member should be given lead responsibility for ensuring that this happens. Some examples of this kind of intersectoral action can be seen in the RAPID programmes (Revitalising Areas by Planning, Investment and Development), community development programmes and the piloting of health action zones in some parts of the country. Formal representation within the Primary Care Team management structure could be considered, as this can be a significant enabler to this proposed approach.

County Development Board structures bring together representatives from a range of sectors – education, industry, state, community and the social partners. Engagement at this level is more likely to occur at area or network level however through these structures concerted joint action can bring local benefits. In addition the County Development Boards and their constituent

members have considerable data available on local needs.

It will be necessary for teams to engage in action of this type but the precise programmes or areas of activity will depend on local needs and other factors. The process of interaction with the local community should provide a significant input into the identification of relevant issues and the possible means of addressing them. Guidance will be developed based on the experiences of intersectoral action in individual projects.

Primary Care teams should ensure that they link in with the wider health service structure where formal arrangements exist to foster joint action by the State agencies with other relevant parties to deliver service responses to identified need. Similarly, each Network will need to make appropriate linkages both with the associated primary care teams and the wider structures outlined above.

4.5. Interface between team, network, community based specialist teams and secondary care services

4.5.1 Key Principles

- The effective operation of the primary care team will require effective linkages between the team, the primary care network, community-based specialist teams and secondary care services.

- Linkages to Community & Voluntary Sector Providers need to be developed, and other non-statutory providers supported by appropriate formal service agreements and referral protocols.

4.5.2 Discussion

Among the major factors on which the effective operation of the multidisciplinary primary care team will depend is the establishment of effective linkages between the team, the primary care network, community-based specialist teams and secondary care services.

Primary care will play a significant role in the future configuration of health services including the changes recommended for the acute hospital system in the Report of the National Task Force on Medical Staffing (June 2003).

The primary care network will be a wider network of health and social care professionals who will work with a number of primary care teams. The strategy identifies the need for formal communications processes between the core primary care team and the wider network of professionals. It also indicates that named members of the primary care network will be designated to work with specific primary care teams. This concept should similarly apply to the membership of the Network.

The requirement for integration between the primary care team and the specialist community teams, for example child care, disability and palliative care teams should also be addressed. Continuity of care is the primary objective to be achieved. Working arrangements with teams who have traditionally delivered both specialist and generalist services, for example, mental health and services to older people will require particular consideration as to the most appropriate alignment of the respective generalist and specialist service in line with the primary care model.

In some service areas a significant level of service provision is provided by the non-statutory sector. It will be important to formalise linkages between the primary care team and networks and such providers. Such arrangements may already be provided for through formal service agreements. More localised referral pathways may need to be developed. Primary care teams and networks should ensure they operate to agreed arrangements established at a more macro level with such agencies.

In establishing or mapping out new team formation, consideration needs to be given to the alignment of community based specialist teams with the team or network to ensure optimum linkages and working arrangements achievable from serving a common population.

The interface between primary and secondary care will be advanced through a number of initiatives, designed to improve integration. Services will be organised to provide the most appropriate response to initial needs and thereafter may reduce pressure on hospital services. Integration initiatives, aimed at enhancing communication and exchange between primary and secondary care should be locally agreed but within a national service framework.

It is envisaged that these will include:

- Referral guidelines and protocols for consultant care and diagnostic services.
- Discharge plans agreed between the secondary care and a key primary care worker.
- Integrated care pathways facilitated by key workers.
- Individual care plans for certain people, appropriate to their needs.
- Shared care arrangements for specific health conditions.
- Consultant Outreach services.
- Out of Hours collaboration.

The strategy seeks to ensure that service users requiring primary care services receive appropriate care in the appropriate setting. At present, for example, many of those who attend hospital Accident and Emergency Departments do so without having first accessed a general practitioner or other primary care provider. With the appropriate development of primary care services, a significant proportion of these service users should be capable of having their needs responded to in a primary care setting. Appropriately structured and resourced, a primary care service should be capable of meeting up to 90-95% of service user care needs.

The establishment of appropriate linkages and relationships between primary and secondary care services should make it possible to offer service users a much more seamless service, whereby they can avail of services at either primary or secondary care level, as appropriate, and move easily between the two as necessary.

The integration and interface of ICT systems outlined in section 4.2 need to be considered in conjunction with this section.

The change management aspect of achieving effective integration and interface between services is significant and will require ongoing support and leadership in the implementation process of primary care policy and in the restructuring process of health service reforms. Education and training programmes for all health and social care professionals must also include integration and interface principles and best practice elements.

4.6. Physical Infrastructure

4.6.1 Key Principles

- Services should be delivered from high quality, well-equipped, accessible premises.
- Team services will ideally operate from a central service point from which most services will be delivered.
- Where a widely dispersed population is being served the provision of services from more than one location, on an outreach basis, may meet needs more appropriately.
- The opportunity for developing facilities in conjunction with other public service providers and community interests will be explored.
- Funding mechanisms from the Private Sector will be explored.
- The benefits from the existing infrastructure will be maximised.

4.6.2 Discussion

The Strategy recognises that the provision of modern, well-equipped, accessible premises will be central to the effective functioning of the primary care team. Therefore one of the Government's key objectives is to facilitate and encourage the development, where appropriate, of modern, well-equipped, user-friendly buildings in which the broad range of primary care services, including general practice, can be delivered.

A key objective is the development of locally accessible primary care centres that allow many primary care services to be delivered via a single point of access for the user and which also facilitate closer co-ordination between providers. The concept of delivering all services from a single location is considered appropriate for many settings, especially in urban areas. It is also recognised that, where populations are widely dispersed, it may be preferable to have the team deliver services from more than one location, so that primary care services are easily accessible to those who use them.

The existing network of community health centres and general practice premises is not adequate to meet the needs of primary care teams. The Department of Health and Children recognises that in order, over time, to ensure that appropriate facilities are developed on the required scale, resources other than those of the Exchequer will be required. This is of course, in keeping with the historical situation, whereby there has been a mixture of private and public provision of facilities from which services of those professionals who will be members of the primary care team and network are provided.

The strategy emphasises the need to gain full benefit from existing buildings and to fully exploit any opportunities for public-private partnerships in implementing the development programme. These possibilities will be explored in the course of the implementation phase, with a view to reducing the burden on public funding. While the State may contribute towards developments in some instances, because of the scale of what will be required it is necessary to explore a range of different approaches to the financing and provision of these facilities.

The Department of Health and Children therefore wishes to encourage innovative approaches which have the potential to result in the provision of appropriate facilities to support the development and operation of primary care teams on a widespread basis.

Such approaches may, for example, involve groups of health professionals or independent developers, possibly in partnership with the statutory health agencies, developing facilities for the delivery of integrated primary care services. The success of such ventures will depend on a willingness by the parties involved, be they service providers, statutory health agencies or other parties who are in a position to provide finance and perhaps other supports, working in partnership to agree on mutually acceptable arrangements.

The potential for developing the required infrastructure in conjunction with other agencies such as Local Authorities, community developments such as Family Resource Centres, Community Day Centres etc. may offer the opportunity to combine resources to achieve more cost-effective outcomes.

The Department will continue to examine ways in which the process of engagement between the different interests might best be structured; this does not preclude direct engagement between parties at a more local level to consider in practical ways how such arrangements could be developed.

The design of facilities should have regard to the needs of the various stakeholders – both service provider and service users and should be such as to facilitate service integration and teamworking. Whilst a certain level of standard structural provision will meet the needs of a number of professions the needs of some professions will indicate particular, less standard, responses. Consultation on design should include input from the various professions.

Section 5

Future direction of primary care policy

5.1 Health Service Reform Programme

The Health Service Reform Programme represents a very significant process of change for the health system.

The principles underlying the reforms are:

- A new national focus on service delivery and executive management of the system.
- A major reduction in fragmentation within the system.
- The development of a single, standardised health and social services delivery system.
- Clear accountability throughout the system.
- Improved budgetary and service planning.

The implementation of national policy will be the clear responsibility of the new Health Service Executive, which will have as one of its three elements a Directorate dealing with the service delivery functions in primary, community and continuing care. These services will be organised on a regional and local basis – at regional level through four Regional Health Offices (RHOs) and at local level through Local Health Offices (LHOs) based on existing community care areas. The National Hospitals Office (NHO), fully incorporated into the HSE, will have responsibility for the delivery of acute hospital services.

A third element will be a National Shared Services Centre, which will provide shared services to the whole system in areas such as payroll, accounts, recruitment and perhaps other functions. It provides the opportunity to look afresh at how we organise and provide a range of support services common to the entire health system.

The Department of Health and Children will be reorganised to ensure an improved focus on policy development and oversight. There will be a clear separation between the executive and non-executive functions of the Department. Key to its revised role will be holding the Health Service Executive to account for its performance.

It is clear that, in order to support the development and implementation of the Primary Care Strategy, the system needs to change to reflect a configuration which favours primary care over the trend towards treatment in more specialised services. Primary care needs to be at the core of the health service delivery structures in order to provide its services in an effective manner. This will become one of the key considerations in the implementation of the Health Service Reform Programme in the coming months and years.

5.2 Primary Care and the Report on the Audit of Structures and Functions in the Health System ("Prospectus Report")

The Prospectus report states that sustaining or modifying the current structure of primary care is inconsistent with the level of effort required to reorganise and reform the acute sector on a national scale and prepare for the implementation of the Primary Care Strategy. It identifies the Primary Care Strategy as an important building block in the drive to shift the balance from care to prevention and states that this objective will require sustained support.

The report identifies a need for standardisation and coordination across the system from national down to local area level, with the objective of achieving consistent and comprehensive implementation of national policy. It identifies the principal challenge in the non-acute sector as the requirement to build the Primary Care Teams and Networks.

5.3 Primary Care and the Report of the Commission on Financial Management and Control Systems in the Health Service ("Brennan Report")

Of considerable importance for the implementation of the primary care strategy is the recommendation in this report that accountability for resource use and delivery of outcomes/performance should be at the level of the clinical decision-maker. By implication, this concept is readily extendable to the level of the primary care team that brings together a number of GPs and other professionals.

Furthermore, some significant changes are proposed to the service planning process which would enable responsibility to be devolved to General Managers in the executive health system for particular units of management.

The report also recommends the renegotiation of the GMS contract, with practice budgets to be established and significant changes to the arrangements for reimbursing community pharmacists under the medical card scheme and the Drugs Payment Scheme.

5.4 Primary Care and the Report of the National Task Force on Medical Staffing ("Hanly Report")

This report, published in October 2003, sets out how to implement the European Working Time Directive in hospitals and provide safe, high quality patient care by reducing the working hours of junior doctors (NCHDs), employing more consultants and reforming medical education and training. It concludes that a national reorganisation of acute hospital services is necessary.

The Report proposes that each acute hospital will in future function as part of a regional network with the full range of specialist services. Service users should only travel further for care which is best provided at "Supra-Regional" or "National" level. It recommends that Local Hospitals be reconfigured so that they provide the large majority of hospital care, outpatients care and diagnostic services for local populations.

The report proposes development of services in the community, ambulance services and appropriate minor injury and illness services in Local Hospitals.

It also highlights the need for hospitals to develop closer linkages with general practitioners and multidisciplinary primary care teams in line with the Primary Care Strategy.

The report recognises that the planning provision of acute hospital care cannot take place in isolation from the range of health services provided outside the hospital setting and that a very high proportion of service users' needs can and should be met within a further developed system of primary care. It emphasises that acute hospitals must work in close partnership with the primary care sector. It adds that the goal should be to establish close links between hospital services, particularly those at local level, and primary care teams, so that the right balance can be achieved between services provided in the community and in hospitals.

5.5 Direction of Future Department Policy

In progressing the implementation of the primary care strategy, the Department of Health and Children will continue to develop policy in primary care in a way which reflects the requirements of the Health Service Reform Programme; which builds on the experience in implementation to date and in the future; and which also facilitates the implementation of the strategy in the most effective manner.

While ongoing consideration, consultation and discussion will be needed in relation to the detailed implementation of the Primary Care Strategy, some general statements can be made about the direction in which the Department would wish to see its implementation progressing, particularly having regard to the Health Service Reform Programme announced by the Government in June 2003.

5.5.1 New ways of working – professional roles that reflect the primary care model

The contractual status of primary care professionals will need to be such as to support the new model. This will require new roles and responsibilities to be defined which reflect the generalist nature and content of work within the primary care team and which place a significant emphasis on interdisciplinary working. Contracts, job descriptions and conditions of service which reflect roles and responsibilities most appropriate to primary care will have to be developed.

The existing model of professional management, in which management arrangements are often largely hierarchical in nature, does not align well with the model of teamworking that is set out in the Primary Care Strategy. The primary care model requires horizontal working and reporting across disciplines. It is recognised that for training education and other professional development purposes, it may be necessary to retain professional linkages within individual professional strands.

5.5.2 The General Medical Services Contract (GMS)

The majority of general practitioners hold contracts for the provision of services to service users under the General Medical Services Scheme. The formation of primary care teams and networks may raise a number of issues regarding the GMS. In the longer term, the system may need to be configured differently so as to facilitate service delivery in accordance with the Primary Care Strategy.

The future approach, for example, to doctors' contractual arrangements for the provision of public general practitioner services will need to reflect the interdisciplinary nature of primary care services and be flexible enough to enable a much stronger emphasis on such areas as disease prevention and rehabilitation than exists at present.

5.5.3 Developing Primary Care Teams as separate functional entities

Parallel to the restructured and re-configured delivery system as outlined in the primary care strategy, consideration will be given to enabling the establishment of primary care teams as individual functional entities, with appropriate legal and contractual provisions. Currently any teams being established involve combining health board-delivered services and personnel with

those of independent contractors, principally general practitioners. Enabling primary care teams to be established in a number of structural formats would provide a variety of means to deliver on the strategy in a way that would support and facilitate the creation of cohesive and integrated primary care teams.

This would have a number of potential advantages:

- It would enable devolution of decision-making and management closer to the point of service delivery. Teams would, therefore, provide a local and flexible administrative infrastructure for the health services.

- It could enable primary care teams to function with a greater degree of autonomy than may be possible within present structures, while at the same time requiring appropriate arrangements for both financial and systems accountability.

- It would provide a rational administrative structure to enable implementation of the Brennan Commission's proposal to require more financial control and accountability for individual GPs. Budgets, together with corresponding financial accountability, could be assigned to primary care teams which would, in effect, be small groups of GPs and other health professionals.

- It could enable Local Health Offices to commission the provision of primary care services set out in a service plan within an overall regional or national primary care service planning framework.

5.5.4 Primary Care and the Hospital System

The thrust of policy will be to build up the capacity of primary care to link effectively with the acute hospital system and to deliver care which is most effectively and appropriately provided in the primary care rather than the hospital setting. This will include services in the team provided by health care assistants, home helps and basic nursing services. Integrated, team delivered services have the potential to reduce demand and inappropriate use of acute hospital services and to streamline access to a range of support services inclusive of day, respite and continuing care services.

Areas where potential for integration between primary and secondary care will be pursued include:

- Shared care.
- Referral and discharge arrangements.
- Integrated care pathways, case management and care planning.
- The identification of opportunities for development of primary care which might include, for example, the provision of minor injury units, non-acute hospital facilities and appropriate community-based diagnostic services.
- Conjoint/ Collaborative resource management in areas such as drugs/ medicines prescribing, pathology and radiology investigations and waiting list management.