Management of Primary Care Teams
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1. Introduction

There is considerable international evidence demonstrating that robust primary care systems are associated with improved healthcare outcomes in the community. The establishment of multi-disciplinary Primary Care Teams (PCTs) facilitates the provision of care as close as possible to peoples homes and the integration of primary, secondary and tertiary care services.

PCT’s provide an access point to local health and personal social care services such as general practice, physiotherapy, public health nursing, diagnostic services, occupational therapy, speech and language therapy, and support for chronic illnesses such as diabetes, asthma etc. PCT’s support people in their own homes and communities for as long as possible, decreasing hospital attendances by offering traditional hospital-based programmes in community settings as well as facilitating early hospital discharge and supported care at home.

More than 850,000 people now avail of ‘one-stop’ shop health and personal social care from PCT’s. The HSE is on target to have 530 local Teams in operation by the end of 2011 - everyone in the country should ultimately be able to access up to 95% of the care they need within their local community.

To date, there has been a focus and concentration on the initial establishment of PCT’s across the country. The transformation of multi-disciplinary community-based services into PCT’s has led to a number of teams pioneering new programmes and services for their local community.

The HSE is currently making significant organisational changes to enable it to deliver hospital and community services in an integrated manner. At national level, the HSE has commenced the structural changes needed to develop an integrated services model with the establishment of a single Directorate of Integrated Services and a Quality and Clinical Care Directorate. The four Regional Directors of Operations provide for the leadership of the Regional Teams in both

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service delivery and reconfiguration of services into Integrated Service Areas (ISAs). Integrated Service Areas are catchment areas for populations to receive an integrated service.

The overall aim is to enhance integration and to remove the need for people to navigate between unconnected services. The changes will result in a less hospital-oriented system and will see hospital resources being reallocated to expanding community based services. This focus on simplifying service delivery will be supported by the appropriate organisational and management arrangements.

2. HSE Service Delivery Model

The HSE service delivery model is based on all services, community and hospitals, being population focused and ensuring effective integrating arrangements at all levels. The approach is to have co-terminus services along four population centric levels within each region for the majority of services, integrated by nationally defined care pathways and protocols that will:

- Clearly define a catalogue of services to be delivered, including access mechanisms, care settings etc.
- Provide clinical protocols for assessment, referrals, treatment and maintenance of clients along the patient journey.
- Provide clarity in relation to transcending boundaries across the four levels.
Figure 1 below sets out the four population centric levels that will exist in each region in the provision of both preventive and interventive components of care, in accordance with national frameworks and protocols. The design intent is for the majority of services to be delivered within the first three levels.

- Level One – Primary Care Team Level.
- Level Two – Community Health & Social Care Networks.
- Level Three – Integrated Service Area Level.
- Level Four – *Regional Tertiary Services.

*Note – Some Tertiary Services may be provided on a multi regional basis and quartenary services will be provided nationally in designated centres.
The following is a brief outline of the components of the service delivery model.

3. Primary Care Team

A multidisciplinary PCT provides health and personal social services to a local population of approximately 7,000 – 10,000. The PCT provides the first point of contact for patients and clients in a local setting and ensures continuation and co-ordination of services. The PCT will almost always be responsible for initiating, arranging and communicating with all services in relation to the care of a patient/client.

Primary Care Teams will:

- Serve as the first point of contact when individuals need to access the health and personal social services system;
- Provide a defined set of community-based services, as well as additional programmes and services based on local population needs;
- Develop individual care plans for patients, particularly those with chronic illness or other complex needs;
- Liaise and collaborate with other community-based professionals such as mental health, specialist child protection and disability services, to ensure all of a patients health and social needs are provided;
- Liaise and collaborate with acute hospital services in order to deliver a seamless service for patients, reduce hospital admissions, facilitate early discharge and strengthen the delivery of chronic disease management programmes;
- Liaise with local statutory and non-statutory groups to develop interagency community health projects and ensure meaningful consultation with the local population;
- Support the shift in the balance of care from an acute to a community setting.
4. Health & Social Care Networks

The Health & Social Care Networks (HSCN) will be comprised of a small number of PCTs and will provide services for a population of 30,000 to 50,000. They will represent natural community groupings and take consideration of road and transport infrastructure. The map in Appendix I sets out the proposed HSCNs for the entire country.

Specialist community based services will be organised at this level and will include Mental Health, Child Protection, Disability Intervention Teams etc.

Services will generally fall into three types:

**Specialist Assessment and Advice** - The Primary Care Team retains responsibility and care delivery with the specialist service providing diagnosis/assessment, advice and support;

**Shared Care** - The specialist service shares responsibility for the care of the patient/client either continuously or on a crisis intervention basis to support the PCT;

**Case Management** - The specialist service assumes responsibility for the care of the patient/client, liaising with the patient’s PCT as necessary to ensure continuity of care (usually time limited).

All specialist community based teams will be organised on a HSCN basis so that all PCT’s will only have to liaise with one specialist service from each domain.

5. Integrated Service Areas

PCT’s and related secondary care acute hospitals will have co-terminus population catchment areas. This is the basic building block for clear and delay free pathways for service users from their PCTs to acute secondary care services and for specialist teams from the tertiary centre to outreach into communities. A shared responsibility for these populations is the basis for the development of integrated services across traditional settings. Nationally defined care pathways will define the appropriate location of specific aspects of service provision.
The geographical area will be known as an Integrated Service Area (ISA) and will facilitate the integration of secondary care, primary care and continuing care services, with all personnel and settings providing integrated services for a shared population. The ISA will contain a hospital or a number of hospitals that provide for all of the secondary care acute hospital needs for that community (not including specialist tertiary acute hospital services). Some hospitals may operate as both tertiary and local hospitals and cognisance will be taken of this issue in the mapping out of catchment areas particularly in the Dublin region.

Purpose of Integrated Service Areas

The purpose of having defined Integrated Service Areas is to:

- Improve integration of acute, primary and continuing care services;
- Provide clarity for primary care providers on access to secondary care;
- Ensure that patients who require more complex or critical care will have access to a designated acute centre with the relevant clinical expertise;
- Support clinical governance across a group of hospitals;
- Provide a population health focus for the broad range of health needs of a community;
- Enable integration with other public services.

6. Tertiary Services

More complex medical conditions need to be managed in regional hospitals where the clinical expertise can be provided. While each region will be broadly self sufficient in this regard some services will be provided on a multi-regional or national basis. This will be based on current hospital reconfiguration programmes and programmes of care.

7. Programmes of Care

A programmatic approach with clear care pathways is being developed to improve patient access and to manage patient care in an integrated manner across service settings. The overall objective is to deliver integrated and responsive care which achieves best health outcomes and ensures
most effective use of resources. This approach will also enhance clinical decision making and support the shift towards prevention and community based care.

The specific diseases/services selected for the initial clinical care programmes are:

- Stroke
- Heart failure
- Acute coronary syndrome
- Diabetes
- COPD/ Asthma
- Epilepsy
- Obstetrics
- Mental Health
- Care for the Elderly

8. Approach to Primary Care

The goal of Primary Care Services is to improve the health of the population by providing local access to multi-disciplinary Primary Care and collaborating with specialist services to provide responsive and integrated care.

This will be achieved by:

- Health and personal social care personnel working collaboratively in a multidisciplinary environment;
- Working collaboratively with local communities;
- Identifying and addressing local needs based on local needs assessment;
- Identifying and working towards removing health inequalities;
- Improving access to services;
- Improving performance through national care standards and development of good quality information systems.
- Implementation of the Clinical Care Pathways.
Multidisciplinary working and a population approach are key features in organising and delivering primary care services.

Working in an integrated way enables staff to focus on the totality of needs of the patient and client in an organisational arrangement which facilitates effective working relationships within and across teams. PCT’s are central to the new service delivery model and will act as a linking bridge across community specialist services and acute services as well as being the principal point of interface between the HSE and patients/clients/service users.

Hence the basic building block of services will be the PCT, a multidisciplinary group of health and social care professionals who will manage and deliver services to a defined population of approximately 7,000 to 10,000. To facilitate the development of PCTs, the appropriate HSE staff will be reconfigured into (a) PCTs or (b) specialist community based multidisciplinary teams.

Historically the organisational arrangements positioned and managed staff in professional silos which inhibited collaboration and the provision of integrated services.

Organisational and management arrangements must facilitate interdisciplinary collaboration and team work if an integrated service is to be provided to a local population.

It is also essential that clear lines of responsibility and accountability are developed to ensure robust management and governance. Service delivery and outcomes for the population that the PCT serves is ultimately how each PCT will be measured. The PCT will be the focal point for the provision and co-ordination of the vast majority of general services in the community. Effective management of the team is an essential requirement to ensure the PCT has a clear accountability for the achievement of better health outcomes for the population and individual users. According to the Commission Report on Patient Safety, a clear system of accountability should connect the holder of responsibility at each organisational level through to the top management team. This key objective has clear implications for the governance of PCTs, which are now becoming the key unit of delivery for all community services. Consequently the current organisational management structures need to be reviewed and redesigned.
9. Reconfiguration

A comprehensive review of all community based services is required in order to identify all services which will be reorganised into PCT’s. All remaining services which by their nature will be specialist to some degree or other, will be managed at ISA level but will be assigned to HSCN’s. In the case of Older Persons, for example, the vast majority, if not all services, should be delivered and managed at PCT/HSCN level whereas child protection services should be managed at ISA level and delivered at HSCN level.

The programme of care pathways will define services currently delivered within the acute setting which should more appropriately be delivered in community/primary care.

6. Governance of PCT’s

Clear lines of responsibility and accountability are central to effective management of PCT’s and are a critical building block for the delivery of safe, high quality and cost effective care for individuals and the wider community. Governance goes beyond what is purely ‘clinical’ and is inclusive of all aspects of care treatment and health service delivery to patients, including audit, risk management, whole system approaches to quality improvement, financial accountability and professional responsibilities. As the HSE rolls out multidisciplinary PCT’s across the entire HSE, it is critical that appropriate governance arrangements support the reconfiguration of service delivery and are linked appropriately to the evolving management structures at sub-regional level.

Currently, HSE professionals working within PCT’s receive clinical and administrative supervision through existing professional structures i.e. line managers. In relation to operational day to day matters, members of the team nominate a team leader or chairperson. The team leader takes responsibility for ensuring effective decision making and functioning of the team. He/she acts as chairperson for clinical team meetings and advises on the development of agreed protocols, guidelines, and care planning. In practice, HODs/ GPs tend to perform this role. The role of the HSE Development Officer has been to facilitate team development and processes which improve the clinical contribution of individuals within the team and the teams overall performance. Effective team working does just happen it needs to be fostered via good design
and effective processes. Currently such protocols and management processes are a work in progress with in the Primary Care Programme and in some areas HOD’s are working on developing relevant team policies eg Manual handing etc and other protocols and care planning tools.

The aim must be to establish a strong cohesive management arrangement to reflect the multidisciplinary approach to service delivery within the PCTs and ensure effective clinical and service leadership. It is critical therefore that there is clear service leadership and clinical governance arrangements to support PCT’s.

11. Management approach to PCT’s within a Health & Social Care Network

The objective is to develop fit for purpose organisational and management arrangements for PCTs that will:

− Facilitate the multidisciplinary team based approach to service delivery;
− Ensure compliance with the Quality and Risk Framework;
− Allow for flexible and appropriate deployment of resources across system
− Have clear spine of accountability to next level of management
− Deliver excellent outcomes for the designated population
− Support integration between acute and community/primary care services.

12. Proposed Model

An examination of the current PCT setting, through the lens of the HSE’s Quality, Safety and Risk Framework suggests significant risk in the absence of a service manager being responsible and accountable for the overall services provided by the PCT(s).

The proposed model represents a fundamental shift in service architecture from a unidisciplinary structure to a multi-disciplinary approach

In this context two key roles emerge:

− A Service Manager for a group of PCTs i.e. A Health and Social Care Network Manager;
- A Professional Discipline Lead (Physiotherapy, Occupational Therapy, Nursing etc.).

In this arrangement the primary care professionals work together for the local population, reporting on a day to day basis to a (HSCN) Service Manager, with an assurance relationship with an appropriate Discipline Lead.

The model would see many of existing heads of discipline and community based managers fulfilling either a Service Manager role for a Health and Social Care Network or the role of Professional Discipline Lead:

- The Services Manager will have responsibility for the delivery of direct and contracted services provided by a group of PCT’s. (HSCN).
- The Professional Discipline Lead will provide an assurance function regarding professional standards and development and may encompass responsibility across acute and community secondary care services.

(It should be noted that the competencies and recruitment mechanism for these posts will need to be developed.)

13. HSCN Service Manager

The HSCN Service Manager will manage a number of PCTs and other front line community care services in accordance with national policy, legislative and service delivery frameworks. This will include service, team performance management, financial and human resource management.

The HSCN Manager has executive responsibility for HSE staff and supports GPs as independent contractors.

The HSCN Senior Manager will have responsibility and accountability for the services provided by three/four Primary Care Teams i.e. HSCN.

The key responsibilities will include:

- Direct management of all HSE staff within the Network*;
- Support GP practices and be responsible for GP/HSE collaboration;
- Ensure appropriate collaborative relationships with acute hospital services and community specialist services and other agencies;
• Implementation of service protocols/care pathways;
• Development of population health needs assessment;
• Budget holder for the HSCN Network.
• Customer service and community participation

* Please note – Staff will be assigned in accordance with the memorandum of understanding set out in appendix I.

14. Professional Discipline Lead

The Professional Discipline Lead will provide a clinical assurance function to support high quality clinical performance of practitioners across a number of HSCN’s.

The key responsibilities will include:

- To be a key member of ISA clinical governance structure and work closely with the primary care clinical director providing input into the planning, budget setting and management of primary care services.
- To provide clinical leadership and assist in the implementation of clinical pathways.
- Implementation of clinical supervision structures, including peer supervision, mentoring, self-directed learning etc;
- Auditing of individual clinical performance
- Where required, direct clinical supervision of nominated individuals that will facilitate reflection on clinical practice, encourage professional growth and providing advice/direction on clinical practice
- Assisting in the implementation of the HSE quality and risk framework.
- Engaging actively in risk management and supporting standards of care and professional practice to ensure strong clinical governance.
- Implementation of a clinical audit programme to ensure staff are working within their scope of practice and within agreed standards clinical audit;
- Advising and supporting appropriate skill mix/staff rotation in consultation with HSCN service managers;
- Ongoing provision of advice and support to HSCN service managers in relation to particular clinical issues for the discipline;
- Identification of overall professional development needs, including core skills and making provisions for specialist competencies;
- Capacity Management: Monitoring and evaluation of activity across areas of responsibility from the perspective of standards of service delivery e.g. waiting lists, equity of resource distribution of population need etc;
- Working with the Primary Care Clinical Director to develop specialist competencies, including advanced scope and clinical specialist therapists in order to expand and develop services based on assessed need.
- Providing clinical guidance in cases where patients are referred only to a specific discipline.
- Managing and controlling agreed budgets within responsibility – eg CPD/training
- Provision of advice and support to HSCN Service Managers in relation to service and individual discipline issues;
- Collaboration with other professional discipline leads to develop interdisciplinary care pathways.

The Professional Discipline Lead will in some cases work across a number of settings such as PCTs, specialist services and secondary acute services. For example a Therapy Manager may manage a small unit in a hospital and provide the Professional Discipline Lead role to the therapists across a range of PCTs.

This post will be deployed, so as to ensure that no role confusion arises regarding the executive responsibility of the HSCN Service Manager.

15. Primary Care Clinical Director

In addition to the recently developed posts of Executive Clinical Director for Mental Health, and Executive Clinical Director for Acute and Continuing Care it is proposed to create Primary Care Clinical Director Posts in each ISA.

It is envisaged that this role will be filled by a GP initially but will be open to all professions after the primary care reconfiguration programme has been completed. This is predicated on the need
for strong medical leadership to ensure successful implementation of the patient pathways that will be defined by the programmes of care.

The Primary Care Clinical Director will be a key member of the ISA Management Team and will have authority in both the planning, budget setting and management of primary care services. Their specific responsibilities will include:

- Clinical leadership and direction for general practice and primary care services;
- Ensuring successful implementation of the pathways and protocols, developed by the national programmes of care;
- Implementation of the primary care strategy and ensuring an integrated service for patients and clients with other specialist services;
- Ensuring compliance with statutory requirements and ensuring patient satisfaction and patient advocacy in primary care;
- Leading clinical practice development and overseeing research activity in primary care;
- Developing effective relationships across all services.

16. Quality and Risk Group

Given the objectives of achieving a multi-disciplinary approach ensuring clinical leadership and having in place effective organisational and performance management systems, a PCT Quality and Risk Group is required in each Integrated Services Area. This Quality and Risk group may be a sub set of the ISA Clinical Governance Group.

Primary Care Teams will operate within the overall Health Care Governance arrangements being developed by the HSE. At a national level direction will be given by the new Quality & Clinical Care Directorate. The PCT Quality and Risk and support group will be responsible for the introduction of national frameworks/protocols within the local areas and will link to appropriate clinical governance arrangements at Regional level/Sub-regional level.

The Quality and Risk group will be comprised of appropriate representation from the HSCN Managers/Discipline Managers and General Practitioners (ideally GPs involved with PCTs or Primary Care Support Doctors, presently known as GP unit doctors). The role of the group will
be to ensure integrity and rigor to service delivery within PCTs and to put in place measures and governance checks to review methods of service delivery. This will ensure that the operational service is adhering to best practice, minimizing risk and engaging in best practice. The group which will seek to combine interdisciplinary expertise to improve clinical and service standards, working relationships, communications and liaison across PCTs, service users and others. This group will be supported and guided by the Clinical Director for the ISA.

The roles set out below are some initial examples of how this governance group can make a tangible difference to service quality and rigor:

- Collate, evaluate and prioritise needs of sub-region and submit recommendations to the General Manager.
- Oversee implementation of national policies, legislation, service frameworks and protocols, performance framework and performance management.
- To develop and implement PCT clinical audit programme, including multidisciplinary approach to same.
- To develop quality improvement plan for PCTs in sub-region.
- To coordinate implementation of new care pathways throughout the service delivery system.
- To coordinate new service introductions through learning sites.
- To carry out trend analysis on learning from incidents and significant event audits in PCTs.
- To ensure TBPM is in place.

A potential option re the operating of this Quality and Risk group is a rotating chair, supported by a risk facilitator. (These posts will be identified during reconfiguration). The chair of the Quality and Risk Group will participate on the ISA Clinical Governance Group(s) as appropriate.

17. Summary

The proposed model sets out a framework to facilitate reconfiguration of existing management resources to support the PCT service architecture. This will see many of the existing professional
managers fulfilling either a service management role for HSCNs or the role of a Professional Discipline Lead. Clearly the competencies, job descriptions, recruitment processes etc for these posts will need to be developed.

This reconfiguration will involve many change management challenges and will require effective stakeholders/partnership consultation. A number of frameworks will be required to enable managers to carry out the roles required and these include:

- A Quality and Risk Framework for PCTs.
- A Performance Management Framework for PCT personnel.
- A Clinical Audit Framework.
- An Education and Training Programme.
- National Care pathways/service processes for each discipline to promote consistency/facilitate management
Appendix I

Memorandum of understanding re staff allocation to PCTs.

Principles to apply to memorandum of understanding re staff allocation to PCTs for each LHO area:

- Allocation of staff to all PCTs must be based on needs of population and competencies of staff, including travel and eligibility issues.

- The allocation of staff will facilitate an equitable service across teams within the LHO but must facilitate staff release.
  
  o For planned interventions across HSCNs that facilitate agreed care pathways within a discipline;
  
  o For professionals who have a specialist knowledge to support and act as consultant to discipline colleagues working across other Primary Care Teams and HSCNs;
  
  o For planned clinical audit programmes and professional supervision.

- Short term cover for sick leave/annual leave should be managed within the Health and Social Care Network by the HSCN Service Manager.

- In the event of longer term unplanned vacancies or unforeseen pressure points the HSCN Manager will request the professional lead to review the memorandum of understanding, where collaboration sharing of resources cannot be agreed by HSCN Managers.

- Final discussion regarding overall resource allocation will be made by the Primary Care Specialist Service Manager.

The initial memorandum for each Discipline be drafted by the appropriate Professional Discipline lead and signed off by the Primary Care and Specialist Service Manager, following discussion with the HSCN Service managers and overview with the Quality and Risk group.
Appendix II

Primary Care Teams and Health and Social Care Networks

Networks are outlined in black

Data Sources
Health Service Executive
Ordnance Survey Ireland
Central Statistics Office

Map Produced By:
Projects Office, PCCC
Health Service Executive
Holland Rd
Plassey
Limerick
APPENDIX III

Working and Consultative Groups

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