

**Irish College of
General Practitioners**



Primary Care Teams
A GP Perspective



Primary Care Teams – a GP Perspective

Review carried out by Irish College of General Practitioners – October 2011

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1.0 Introduction

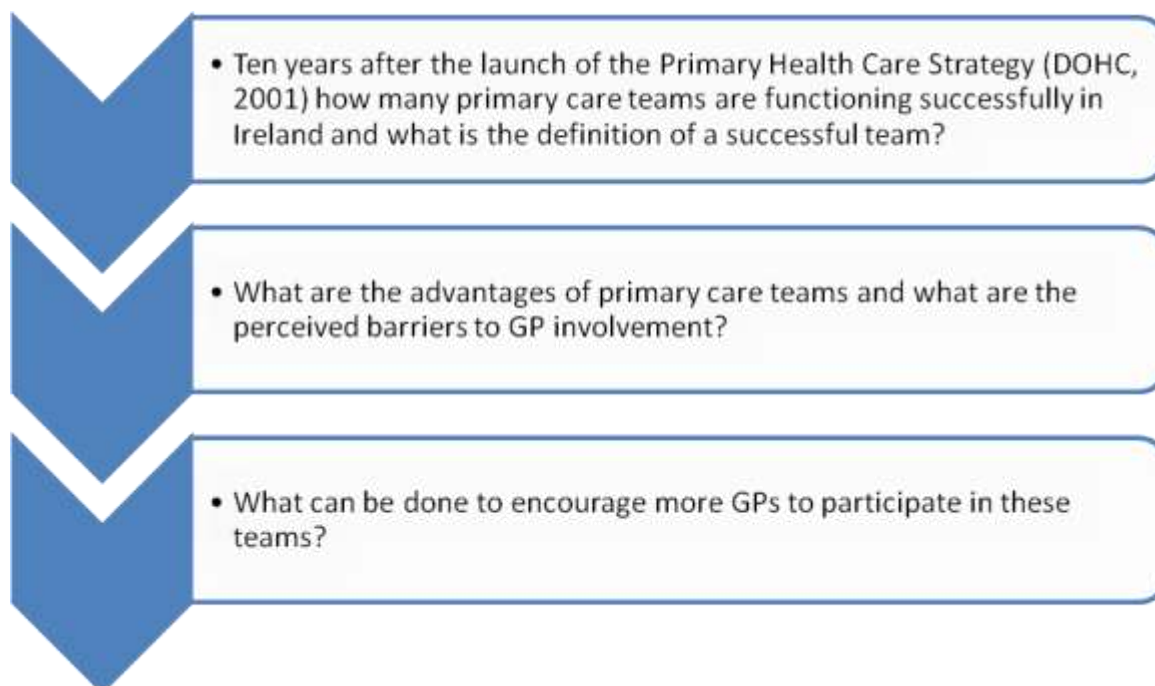
At the 2011 ICGP AGM in Galway, Minister Dr James Reilly TD said it was time to acknowledge primary care teams (PCTs) that were “real” in terms of their delivery of excellent care to patients. Minister Reilly was also very clear that he did not accept that there were 356 teams in operation (HSE figures); and the suggestion that even if a GP had expressed an interest in becoming part of a team this could subsequently be interpreted that a functioning team was in existence.¹

Subsequent to this, the ICGP met with Minister Roisin Shortall TD who also expressed concerns in relation to the development of PCTs. It is clear that there is a need to clarify objectively the current state of play in terms of effective primary care teams.

The ICGP has been supportive of the theoretical basis for PCTs as the optimum model for delivery of primary care services to patients. The ICGP believes that the GP and the Practice Nurse are the core members of the team. If this concept is not accepted as a starting point then team initiation and development cannot be effective.

2.0 Review Objectives

This review aims to provide answers to the following questions from a GP perspective:



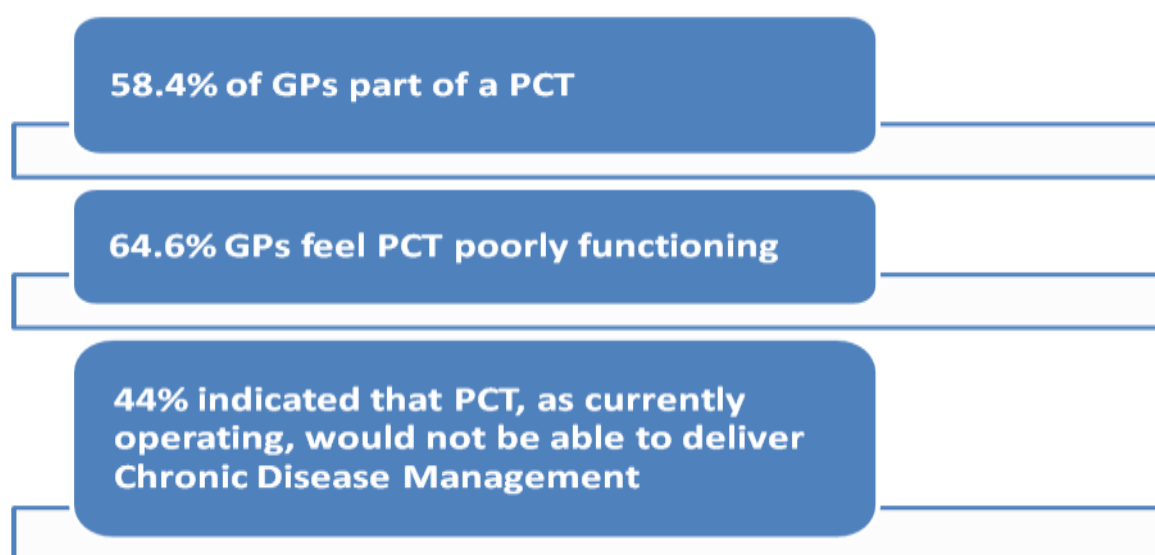
In an effort to answer these questions the ICGP has consulted with a wide variety of members from large and small, rural and urban practices throughout the country. This report is the product of that consultation.

3.0 How Many Primary Care Teams are Functioning Successfully in Ireland?

The 2001 Primary Health Care Strategy² proposed that multi-disciplinary teams would be introduced to deliver enhanced primary care services. The members of the team would include GPs, nurses, physiotherapists, occupational therapists, social workers, home helps and administrators. Each team would in turn be supported by a wider network of primary care professionals including speech and language therapists, dieticians, pharmacists, community welfare officers, chiropodists and psychologists.

In a recent ICGP Survey³ completed by 423 members (response rate circa 17%), 41.6% indicated that they were not part of a primary care team while 10.1% indicated they would be joining a PCT in the near future. These figures are disappointing but even worse of the 195 GPs who reported being part of a PCT, 64.6% reported that this was a poorly functioning PCT. The results of the survey are endorsed by a recent report from the Department of Public Health and Primary Care in Trinity College Dublin⁴ where only 36% of respondents indicated that their practice was functioning as a part of a primary care team. Furthermore, only 44% of respondents indicated that they believed PCTs would enhance their ability to deliver chronic disease management within their practice. At a time when the HSE is developing Clinical Care Programmes that seek to move the management of chronic disease into the community based on optimizing PCT involvement this does not bode well.

The Comptroller and Auditor General (CAG) report⁵ highlighted that the number of functioning teams (as described by the HSE) was over estimated as only 54% of PCTs reported regular GP representation at meetings. Even if GPs had ceased to attend teams were still reported as operating.



4.0 What is the Definition of a Successful Primary Care Team?

The HSE⁶ define the criteria for an effective PCT in terms of:

- Identification of PCT boundary,
- Mapping of current population, by identifying population sizes, location of proposed centres, road systems, public transport, GMS patterns, natural GP affiliations, availability of GPs, social cultural and service links etc.,
- PCT staff in place, including additional resources appointed,
- Establishment of Local Implementation Team meetings, where guidelines - protocols have

- been agreed and implemented,
- Referral process - inter referrals,
 - Meeting management – frequency,
 - Information sharing,
 - Enrolment process - criteria agreed,
 - Commencement of Clinical Meetings (attended by multi-disciplinary team members), where a patient's needs require two or more inputs from professionals.

While these criteria reflect the criteria for an effective PCT from a HSE perspective the ICGP was interested in looking at defining a successful PCT in terms of its impact on patient care and to that end we framed our review around the following;

ICGP Definition of a Functioning Primary Care Team

A functioning primary care team is where a patient receives a better standard of care from interacting with a team than they would receive from dealing with individual health professionals.

In essence teamwork leads to the sum being greater than the parts leading to improved quality of service for the patient.

5.0 Our Findings

Following our review with GPs around the country, we can summarise our findings as follows.

5.1 What are the Advantages of Primary Care Teams?

Advantages:

- Improved quality of service for patients – the sum is greater than the parts;
- Maximises the benefits derived from co-location of GPs and other primary care team members in the same building;
- Encourages inter referral between GPs at a local level promoting services at primary care level and reducing referrals to secondary care;
- All team members including GPs develop a better understanding of their roles thus ensuring appropriate referrals and better use of resources. GPs describe enhancement of clinical management and new approaches to patient care as a result of team participation. The role of the Home Help in particular is clearly valued by GPs and patients alike;
- Several members of the team make house calls which may reduce the number of visits that a GP has to undertake and enhance the service for the patient;
- Links with the mental health team have traditionally been poor in the community but the advent of PCTs has enhanced communications and understanding in some parts of the country. The role of the primary care Mental Health liaison Nurse, where they have been established, has been welcomed by GPs. A model for direct access by GPs to counselling services in the North East has been particularly successful in this regard. If Mental Health in

primary care is to be meaningful GPs will need direct access to staff with mental health training to support them in the delivery of care;

- Links with primary care social workers have been very positively received by the GPs – (as these social workers are distinct from the child protection social workers) they have protected time to meet the needs of patients in the community;
- Where teams have been successful a key person in this success has been the local primary care manager. GPs highly value managers who have been proactive, flexible, open communicators showing a willingness to engage in a positive manner with them and thus encourage participation and belief in the team concept. Naturally this has also led to improved GP - HSE communications on all aspects of local service delivery;
- There is a potential for a population based approach to prevention with all team members involved e.g. team members running a Well Man or Well Woman evening for patients, suicide prevention talks, school visits;
- A number of PCTs have tried to adapt and change their model of work to tailor for different patient groups e.g. single mothers with anxiety/depression in an area of deprivation⁷;
- Despite the appointment of additional staff, many services e.g. physiotherapy have unacceptable waiting times for services (partially offset by the fact that close working relationships enhances identification of patients requiring urgent care and all services can be mobilised quickly e.g. care of a terminal patient);
- Where direct access to diagnostics e.g. radiology is provided, it greatly enhances the ability to provide care for patients in the community and facilitates appropriate referral.

5.2 Perceived Barriers to GP Involvement in PCTs

5.2.1 Management

- Top down approach by HSE management- poor engagement with GPs at local level – when initial approach was not well managed subsequent attempts were rebuffed by GPs due to prior experience and perceptions. The CAG report⁵ highlights that only 15% of PCTs carried out a community needs assessment prior to first clinical meeting;
- Frustration has built up where a PCT is formed in an area involving a number of practices and neighbouring practices are excluded from involvement;
- GPs may be assigned to several different PCTs/meetings – as patients are assigned to teams based on their geographical location rather than general practice registration. This is a fundamental flaw in the methodology employed to define a PCT. The logical starting point would appear to be the patients registered with a given general practice and then add a number of practices together. The concept of catchment areas as has been a long established practice in community psychiatric services has always caused problems for patient access to services. A patient may be attending a GP in a health centre for example but may not be eligible to be seen by a physiotherapist working in the same centre due to their home address. Replicating this approach is not to be recommended;
- Goals/Aims of PCTs not clearly defined leading to lack of buy- in as to advantage of participation;
- Clinical Governance structures are not clear with lack of clarity with regard to final clinical responsibility for team decisions;
- Management of team members does not appear to be optimal – difficult to ascertain who is in charge with team members reporting to multiple managers. This silo effect where team members are reporting to largely hospital based discipline managers is not conducive to team cohesion and productivity;
- Clerical support is essential otherwise team members can spend up to 50% of their clinical time doing administration – appointments etc. rather than seeing patients;

- According to the CAG report⁵ “There has not yet been a change at the level of control and management that would put PCTs at the centre of primary care delivery”.

5.2.2 Meeting Structures

- GPs express frustration that having a meeting is portrayed as having a successful team;
- GPs have to travel to meetings and do not receive expenses to do so while other team members are paid to attend and receive time in lieu if it is held out of hours or during lunchtime. Furthermore, when travel time is taken into account, a meeting may take up to two hours out of a busy day. Doctors who have patients in four or five primary teams cannot be expected to devote 16 to 20 hours each month to meetings;
- Timing of meetings – meetings often held during busy working hours making it impossible for GPs to attend;
- Frequency of meetings may be perceived as excessive and should be determined on need at local level by team members;
- Many GPs do not see the point of listening to other doctors’ patients being discussed and would like to attend only when their patients are listed for discussion. However this is not universal – some GPs find input from colleagues very helpful in this regard.
- Multiplicity of meetings in relation to PCTs is another problem – clinical meetings, business meetings, local implementation group meetings, regional implementation group meetings etc.

5.2.3 Disintegration of Services

In the case of successful teams, the services they currently provide are starting to disintegrate due to:

- Waiting list for access to services in the community
- Jobs embargo

Disintegration of services discourages GPs from joining PCTs as they perceive no benefit for their patients and a lack of true commitment on behalf of the HSE/DOHC to primary care development.

5.2.4 Confidentiality

- Many GPs have expressed concerns in relation to confidentiality especially sharing patient records;
- Concern re consent and informed consent from patients to discuss their medical information at team meetings is an important issue for many GPs;
- Concerns re presence of non health professionals at team meetings especially in rural areas where patients’ relatives may be present.
- Feedback to the patient of the outcome from the meeting may also be an issue.

5.2.5 Access and Eligibility

- Access for GPs to PCTs seems to vary from area to area. There is a wide variation in access to ancillary services both within and outside PCTs which can be frustrating for GPs and hinders quality of patient care.
- Access to diagnostics and secondary care services varies with area- this should be a top priority for development in health service that seeks to be primary care led and mindful of resources;
- In some cases, no private patients are seen by PCTs– in other areas a quota system seems to be in operation where a limited number can be seen per year;
- Nursing home patients in most instances are not eligible for PCT care – this is a particular source of frustration for GPs as it seems to be based on the premise that nursing home

patients are private patients at a time when large numbers are only eligible through the Fair Deal scheme and clearly cannot afford services such as private physiotherapy;

- Where waiting lists exist for PCTs, patients may repeatedly not attend for appointments - a system for managing this as per hospital OPD approach may be necessary;
- GPs are the only professionals available out of hours thereby limiting the availability of other team members particularly when urgent situations arise. The CAG⁵ reports that 11% of team members have extended their working hours since establishment of the PCTs with 3% working at weekends.

5.2.6 Information Technology and Communication

- The majority of GPs use computerised medical records. Other PCT members in general have limited access to IT support and use paper records;
- The lack of a Unique Patient Identifier hinders registration with general practice and PCTs and inhibits service provision and development;
- Secure email is not available for PCT members and sending patient identifiable clinical information by normal email breaches data protection law;
- The CAG report⁵ highlights the lack of IT infrastructure as a major block to team communications;
- There is little communication between established PCTs – potential opportunities to learn from each other are lost;
- More could be done to establish directories of local services for use by PCT members.

5.2.7 Infrastructure

- 8% of PCTs are currently fully co-located. If current projects are completed on time it is estimated that this figure will rise to 29% by the end of 2011⁵;
- The preferred option for further development by the HSE is for leasing arrangements with the private sector. However the CAG⁵ has criticised the appraisal methodology employed to reach this conclusion;
- The uncertainty surrounding support for development of practice premises linked to universal reduction in GP practice income is hindering the ability of GPs to be more proactive in infrastructure development;
- Again one size does not fit all and a flexible approach to the ideal infrastructural developments – taking cognisance of what is already in existence is needed. The Case Studies included in Appendix 1 reflect the variety of models of successful teams in terms of team composition and infrastructure.

5.3 What Can Be Done to Encourage More GPs to Participate in These Teams?

Successful PCTs need to be encouraged to share their experiences with others. GPs in particular should be more vocal in terms of the advantages where they perceive improved quality of care for their patients.

5.3.1 Management

- Accept that one size does not fit all (reflected in variety of case studies Appendix 1);
- Develop a variety of PCT models based on successful teams to date – promote innovation and flexibility in approach;
- Focus on meeting the needs of the community and PCT members including GPs at a local level;
- Define clear goals and aims for individual teams;

- Provide direct access to diagnostics for GPs;
- The role of GPs and practice nurses in the context of health service reform need to be clarified, resourced and developed;
- Develop clear lines of management for team members in a unified manner. The CAG report⁵ outlines the absence of a single manager for PCT members. The HSE plans to introduce one manager for three to five PCTs – the number and role of these managers needs careful consideration;
- Role of administrator is crucial for success as clearly described recently by Spellman⁸ ----- Administrative support to the Nursing and Allied Health Professionals on the Team and local network including booking clinic rooms, booking appointments, recording referrals, maintaining databases, record keeping, typing, organising and taking minutes at PCT meetings. This facilitates health professionals to see more patients.

5.3.2 Meetings

- Teleconference facilities could be provided to reduce time commitment for GPs;
- Alternate meeting venue to minimise travel for individuals;
- Flexibility in setting meeting times e.g. alternate early morning and lunchtimes;
- GP could attend or participate by teleconference if their own patients are being discussed;
- Continuing professional development points can be claimed for meeting participation;
- The resource implications for GPs attending meetings should be acknowledged and supported.

5.3.3 Disintegration of Services

- If PCTs are regarded as the lynch pin to develop primary care services then they should be prioritised for development and maintenance of staff levels;
- Waiting lists for PCT services should be kept to an absolute minimum;
- If PCTs are truly seen as the centre of primary health care provision then resources must be ring fenced for both primary care and general practice.

5.3.4 Confidentiality

- Issues such as sharing of records and consent need to be addressed by guidelines at national level and sharing the practical experience of implementing them on the ground could be used to encourage more GPs to participate in PCTs. Although HSE Information Sharing Guidelines⁹ were produced in the initial stages of establishing teams they do not appear to be in use. Rather than “reinventing the wheel” these guidelines could be revised and implemented.

5.3.5 Access and Eligibility

- Access and eligibility issues need to be addressed through national guidelines and implemented uniformly throughout the country;
- Out of hours health professional availability needs to be addressed.

5.3.6 Information Technology and Communications

- Secure email for PCTs would be a major step forward;
- Communication via a local (not HSE) intranet has also been used to enhance communication between team members;
- Local directories of services need to be developed, disseminated and maintained;
- Sharing of good practice between PCTs should be encouraged.

5.3.7 Infrastructure

- A variety of approaches to infrastructure development should be available related to local health service needs;
- Clarity in terms of primary care development and the role of general practice is needed to encourage GPs to participate in infrastructural development
- Innovative approaches to funding and resourcing infrastructure need to be considered.

6.0 Conclusion and Recommendations

The Primary Care Strategy² promoted the concept of primary care being delivered through PCTs. The implementation of this strategy has been piecemeal at best. There are examples of PCTs that work effectively in delivering improved quality of care to patients. These teams need to be supported and their experience shared. Perceived barriers to participation need to be addressed in order to encourage further participation by GPs.

If it can be clearly demonstrated that Irish patients receive better care and health outcomes from PCT participation this would be the best way of encouraging GPs to take an active part in team activity. The focus on holding meetings is not the right approach and does not equate to a functioning team. One size does not fit all and national approaches that do not take cognisance of local needs are doomed to fail.

In order to support GPs to maximise their potential to improve the quality of service to patients and optimise the overall use of health service funding the following actions need to be taken as a matter of urgency:

1. If PCTs are truly seen as the lynch pin to support the health service then resources must be ring fenced for both primary care and general practice development.
2. As there are finite resources available for the health service ring fenced resources need to move from secondary to primary care and specifically to general practice if chronic disease management is to be optimised.
3. Research and monitoring to demonstrate concrete outcomes and measures of success for PCTs needs to be undertaken.
4. Issues related to patient consent and confidentiality should be clearly addressed and safeguards agreed.
5. Access to diagnostics for GPs will enhance services for patients, save money for the health service and support appropriate hospital referrals.
6. Engagement at local level in planning and developing services needs to be undertaken and it must be acknowledged that one size does not fit all.
7. PCTs should be practice population based rather than geographical.
8. Access and eligibility issues for PCTs need to be addressed.
9. Investment in ICT and in particular the creation of a Unique Patient Identifier coupled with secure email should be a priority for the health services.
10. Clarity around support for infrastructural developments needs to be provided.

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Appendix 1: Examples of the Variety of Successful PCTs in Terms of Infrastructure and Team Composition

CASE STUDY 1

A successful “virtual” (i.e. not co-located) PCT composition from the West of Ireland****

3 single handed GPs in separate practice premises

3 Practice Nurses

3 Public Health Nurses and 1 Community Nurse

Physiotherapist

Occupational Therapist

Social Worker

Clerical Officer

Community Welfare Officer

Home help co-ordinator

**** *Linked to Occupational therapy and Speech therapist in a local Network of PCTs*

CASE STUDY 2

A structure that works but does not currently strictly fit into PCT model (North West Town)

“We have 4 GP practices within 3 miles of the town. We have a 29 bed community hospital and 2 hospice suites. All the GPs attend regularly. We also have a day centre. Another GP 10 miles away also has admission rights to the hospital. . We operate a very active admission, treat and discharge policy. Based in the hospital are a physiotherapy unit with two physiotherapists and a visiting paediatric physiotherapist, an x ray dept open two days weekly (usually), two Public Health Nurses with a further three in surrounding practices, a dentist for children, social worker for the elderly, visiting speech therapist, visiting occupational therapist, a palliative care nurse and a community psychiatric nurse .All of these services are readily available to the GP on the phone and regular contact is made during visits to the hospital. There are visiting Surgical, Paediatric and Obstetrics and Gynaecology Out Patient clinics. The social work service is based in a separate building two miles away and usually responds readily to a phone call. Next door to the community hospital is a small community in- patient psychiatric unit with a visiting psychiatrist and a Cognitive Behavioural Therapist. There is a regular psychiatric outpatient clinic.”

CASE STUDY 3

Primary Health Care Centre from the South

- 3 Group GP Practices co-located in the same premises
- Primary Care Team
 - Primary Care Nursing Service
 - Physiotherapy
 - Occupational Therapy
 - Child Health Services
 - Psychology
 - Podiatry
 - Speech and Language Therapy
 - Dietetic Service
 - Administration

CASE STUDY 4

Primary Health Care Centre in Dublin

2 GP Practices co-located in the same premises with

- **Primary Care Team**
 - Primary Care Nursing Service
 - Physiotherapy
 - Occupational Therapy
 - Social Work
 - Administration
- **Primary Care Team Network**
 - Dietetic Service
 - Mental Health
 - Audiology
 - Dentist
 - Community Welfare
 - Podiatry