

**Oral Submission to the Oireachtas Committee
on the Future of Healthcare**

Opening Statement 21/9/2016

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CARLOW-KILKENNY

Executive Summary

As active clinicians we support this Oireachtas project to provide political stability and direction to the health service with a 10 year plan, agreed by all stakeholders to change the direction of healthcare, towards more care in the community delivered by GP-led Primary Care (PC).

Our hospital-centric health system can't survive the confluence of increasing demand, reduced capacity and the burden of chronic disease, multi-morbidity and an ageing population. Our hospitals and GPs must be supported through the transition process to deliver this new model of care.

A radical realignment of healthcare is needed towards GP-led primary care. More resources are required for general practice to lead community-based, team-care which is more preventive, predictive and anticipatory. Person-centred care must align with population health management.

This can be delivered by general practitioners working through Primary Care Teams (PCTs), with additional practice nurses, ancillary staff and an enhanced PC network that is supported by Secondary Care (SC).

Funding for general practice must reach levels similar to other OECD countries. General practice currently receives less than 3% of the State spend on health compared to 10% in the UK.

The alignment of Information and Communications Technology (ICT) between GPs and hospitals with a shared Electronic Health Record (EHR) is critical.

This will require GP leadership and a change within general practice to enable its traditional person-centred care to also become more population focused.

A new relationship between Primary Care (PC) and Secondary Care (SC) is required as equal partners in shared care.

Integrated thinking and care models should be supported by the state and health insurers.

Ambulatory Care using an Acute Floor model should be standardised at all Acute Hospitals, with direct GP STREAMING into Acute Medical Assessment Units (AMAU) and Acute Surgical Assessment Units (ASAU).etc.

Scheduled care in hospitals needs urgent re-thinking. New referral pathways for timely consultant advice are required. Use of ICT and Virtual Clinics should be optimised.

Access to diagnostics in PC should become independent of hospitals.

Primary Care Resource Centres (PCRC) and Primary Care Centres (PCC) should be opened to all patients and GPs in a catchment area, and should act as service and diagnostic hubs.

Local clinician/management engagement should be supported through ICGP-sponsored Local Integrated Care Committees (LICCs) and should be funded and developed nationally.

Transitional Funding for Health Transformation is required. Efficiencies will return costs to state. When the final Care and Treatment Model is agreed a suitable funding mechanism can be agreed.

Early projects should focus on high users of health care, medicines management and End of Life Care Packages.

All of the above is predicated on a new GP contract, agreed by all stakeholders, which addresses chronic disease management in the community through resourced GP-led PC.

Introduction:

Thank you to the Committee for inviting us today.

We are two front-line clinicians based in Carlow-Kilkenny (CK). We're not academics, nor health economists, but we've learned what works. We've also seen what's possible when GPs and hospitals work together.

We're not representing any organisation in this submission today but reflecting our own learnings and experience gained over three decades of local engagement.

We support the Committees vision to transform the health service by a 10-year plan that is agreed by stakeholders and the State. We believe that the Digital Age for Healthcare requires new thinking, new care pathways and new relationships between PC and SC. Mostly it requires joined-up thinking and activity in health.

Background:

All across the country our hospitals, community services and GPs are struggling with increasing demand, finite resources, reduced capacity, fragmented care, an ageing population and the growing burden of chronic disease and multi-morbidity. Our manpower crisis compounds this and there has been an absence of confidence and direction in our disconnected system. Relationships between PC and SC are strained in most areas.

The FEMPI cuts which took 38% of State funding away from practices over five years were applied disproportionately to general practice leaving it currently unable to take on new commitments without new resources. While hospital budget cuts were less severe the combination of bed closures, manpower and service cuts have left our hospitals also unable to cope with increasing demand. It's a perfect storm for the health service and for patient care. We can't continue as we are. New thinking is needed.

The Carlow-Kilkenny Model:

We come from Carlow-Kilkenny where we're used to "new thinking". There has been a 20 year history of engagement between GPs and the Hospital – much involving the ICGP-St Luke's Liaison Committee. This led to integrated thinking and improved patient flow in CK. We call it a "hospital without walls" as GPs have strong relationships with the hospital and are involved in all levels of service development and governance.

Over recent years given all the challenges we recognised the need to work more closely. We formalised and then structured this engagement by scheduling monthly business meetings between GPs, consultants, hospital management, CHO partners, Mental Health, Public Health and pharmacy colleagues. These meetings attract 20-30 doctors monthly. It's a forum that builds relationships, encourages ideas and agrees change. It works through contact, respect, trust and innovation. Everyone may attend and everyone is equal.

Outcomes of Integrated activity in CK:

This GP-hosp-community engagement has led to many local initiatives that scaled:

1. Caredoc, one of the earliest GP out-of-hours co-ops, 1999

2. The first acute medical assessment unit (AMAU) with direct access to GPs (we call this streaming), 2000
3. The first acute paediatric assessment unit (APAU) with direct access to GPs, 2002
4. The first acute gynae assessment unit (AGAU) with direct access to GPs, 2005
5. The first GP-led community intervention team (CIT) which brings hospitals into the home. 2009
6. A new Acute Surgical Assessment Unit with direct GP access, 2014.
7. Other recent service developments include new services in Heart Failure (2014), Acute Arthritis (2015) and a GP led Gynae Clinic led by local GP Dr Eluned Lawlor.(2016)
8. The first purpose-built Integrated Ambulatory Care Centre in Ireland using an Acute Floor was opened fully in 2016 – again with direct GP access. The concept of an Acute Floor with GP Streaming is a proven mechanism that reduces admissions, shortens length of stay, and helps keep patients at home and not in ED departments or on OPD waiting lists.

The Scaling of the CK Model:

The CK model has now been adapted as a Local Integrated Care Committee (LICC) by:

1. The Irish College of General Practitioners (ICGP)
2. The Ireland East Hospital Group (IEHG) and
3. The Primary Care Division (PCD) of the HSE

- as a mechanism in other areas for local engagement and integration between primary and secondary care. The LICC is a bottom up approach that is supported from the top. This roll out is now being supported nationally by the PCD HSE.

There are a number of LICCs now active in the IEHG region, including Loughlinstown, Mullingar and Wexford. The IEHG have been hugely supportive of this integration with PC and consider alignment with GPs and CHOs as a key strategic priority.

The IEHG recognises that an important role of effective LICCs in a new health system will be to incrementally help shift chronic care from hospitals to primary care in an agreed manner with the correct resources to deliver benefits for patients. This can also ease the burden on hospitals and reduce costs for the State by supporting GP-led PC.

There are five steps to success in the journey towards GP-led primary care in Ireland:

1. We need a culture change towards more engagement between GPs and Hospitals who need to work together locally in real partnership with management (Hospital and Community) as equals in care. This engagement process (LICC) should be costed and funded by the State.
2. We need to move more care out of hospitals and into the community in an agreed and funded manner: The Primary Care Surgical Association is one successful example. GP-led PC, working through enhanced PCTs, and supported by SC can provide further models of community based care.
3. We need to resource and strengthen the infrastructure of General Practice by increasing the numbers of GPs, practice nurses and other healthcare staff to deliver these new packages of care. An End of Life Care Package should be the first. A new GP Contract that deals with Chronic Disease is also critical.
4. We need better flow for patients through the health system: Ambulatory Care using an Acute Floor with GP streaming is the future for acute hospital medicine. Scheduled Care including OPD and Day Care needs a 21st Century model using a shared EHR, ICT, Virtual Clinics and new care pathways. GPs are central to these developments.
5. We need the political and legislative certainty of ring-fenced funding to allow transformation of healthcare over an agreed time frame. Clinician leadership and innovation should be supported locally and allowed to scale where there is success. There will be benefits to the State from efficiencies, savings, confidence and a healthier population and workforce. The transitional funding for development of GP led PC shouldn't come from Hospital budgets. The eventual funding model for the new State health system should be determined only when we have the correct Care and Treatment service plan agreed by all the stakeholders and we are clear on work load and costs.

Why supporting GP led PC matters:

Regardless of the funding model we believe general practice needs to be at the heart of the new health system. We believe that general practice and GP-led PC can deliver comprehensive, co-ordinated, quality care that is accessible to patients and close to their homes. In an age of multi

morbidity and medical complexity, only the “generalist” GP can deliver appropriate care to this cohort in a cost efficient manner.

Standardise the role of the generalist GP:

We suggest the Committee advocates the Farmleigh Principles of GP-led PC which clarifies this role. These principles were developed by Prof Tom O’Dowd (Trinity College Dublin) in consensus with all stakeholders in 2015, using the TCD Chatham House Group – now known as Tomorrow’s Health. The Principles articulate clearly what work is done in general practice, and who is accountable. It should be central to any new GP contract and a foundation stone for integrated care with our hospital partners.

Role of hospitals in the new system:

We believe that the role of our hospitals is to support PC. Not the reverse. Our current hospital-centric system delivers excellent specialist care but can’t deliver cost-effective care for the tsunami of chronic disease and multi-morbidity that is strangling our health service. 530,000 on waiting lists to see a specialist and up to 500 a day on trolleys shows the scale of the misalignment between demand and capacity.

Clearly capacity in our hospitals needs urgent attention.

New thinking on OPD access is also needed including better use of ICT and Virtual Clinics in chronic disease (like the Heart Failure Virtual Clinic run by Prof Ken McDonald which shows an 80% reduction in hospital referrals).

We need to work with the Clinical Programmes which are excellent examples of collaborative care pathways already developed between HSE, the Royal Colleges and GPs.

Manpower:

We believe our national manpower status is perilous both in general practice and hospitals. Many of our young graduates are leaving. In SC we are reliant on non-national junior doctors to run our hospitals. Without them the system would collapse. There is also a shortage of consultants. In General Practice some 28% of GPs are over 60 and face retirement. We train only 176 GPs a year yet require 250 just to stay still given emigration and retirements. We need to increase GP training numbers by 100 and work on retention of graduates. 90% of GP trainees are now

female, and most do not want full time positions or practice responsibility until their families are older.

Conclusion:

The Committee's plan for a 10 year consensus in health and a decisive shift towards primary care is welcome. There are specific challenges to be overcome. Building effective business relationships between SC and PC will be the key to success.

In Carlow-Kilkenny we have a tradition of engagement between GPs, hospital consultants and management: it's one based on dialogue, respect, trust and innovation and builds an integrated health system that works on solutions. We believe this model can scale with PCD and State support.

We believe that the emerging LICC process can improve the interface between PC and SC and should be extended nationally.

Ambulatory Care should be supported through an Acute Floor that integrates horizontally with services in the hospital, and vertically with GPs and the community.

GP-led PC working in partnership with hospitals and community is the best future of our health system. By working together we are stronger and patient care is enhanced. This is integrated care. This is the CK Model.

Thank you.

Dr Ronan Fawsitt, Chair, ICGP-St Luke's LICC
Prof Garry Courtney, Clinical Director, St Luke's Hospital, Carlow-Kilkenny.

APPENDIX 1

CARLOW-KILKENNY MODEL FOR ICGP-HOSPITAL-COMMUNITY LIAISON AND INTEGRATION OF PRIMARY AND SECONDARY CARE 2015

1. ICGP-St Luke's Liaison Committee (LC) 2010-2015

2. A Model for integrated care between primary and secondary care, formalising local GP-Hospital and Community liaison to improve care and services for patients.

Reasons: Poor connectivity between hospitals and GPs, health cuts, reduced manpower, and low staff morale increase risk. Working together we improve care for patients and develop solutions that can work elsewhere.

Methods:

- Build trust, respect, and collegiality
- Involve all clinicians/management and community partners
- Structure business meetings between GPs, consultants, management and community

Outcomes:

1. Improved standards and quality of patient care
2. Solved local care problems
3. Innovative service developments

CK LC began 1990 through local ICGP Faculty and Consultants at St Luke's as *ad hoc* structure.

Evolved over 25 years by local connectivity and innovation.

This tradition of connectivity led to:

1. First Acute Medical Assessment Unit in Ireland
2. Caredoc – among the first GP out of hours coops
3. Home Care Team (HCT) for palliative care in the home
4. First GP-led CIT (GP-led Community Intervention Team)

3. PATIENT CARE INITIATIVES

2010–2015

Principles: *Create an inclusive business structure and always put patients first.*

LC meetings formalised by agreement with local ICGP Faculties and Medical Board.

Scheduled monthly business meetings from Sept to May.

Attendance opened to all GPs, consultants, management, public health and UCD-IEHG partners.

Agendas - Minutes kept - circulated to all GPs, consultants, management and community partners.

Terms of Reference agreed.

CHO representatives involved from 2015

Professional, transparent, accessible and accountable process.

Whole-community thinking and responses to health-care problems.

GPs and Hospital are equal partners in single health community with shared patients and resources.

Participation, ideas, and innovation valued.

Solutions, not problems became the focus.

Every Hospital Department attended: (Medicine, Surgery, ED, Paeds, Obs-Gynae, Radiology, Pharmacy, Oncology and Psychiatry). Mental health services, especially Deliberate Self Harm became a priority.

Brought new services to patients with whole community support

Built partnerships with IEHG-UCD partners to improve/scale services for patients

Assisted other Faculties to strengthen their own LC

4. CHALLENGES AND SUPPORTS:

Despite austerity, health cuts and falling budgets, the LC formalised its structure.

Support from local ICGP Faculties, the Clinical Director, consultants and Manager at SLCK.

Used existing structures. LC meetings held before the monthly Clinical Society meeting at neutral venue which attracted high attendances for educational sessions with CPD points/Study Leave.

5. BENEFITS AND OUTCOMES:

LC is now a cohesive, functional healthcare conduit between PC and SC:

- A forum to solve local problems and innovate
- A method of agreed incremental improvement
- A track-record of change
- A mechanism to increase faculty relevance and participation

Some 2015 LC Projects delivered:

Monthly Heart Failure Clinic with online Virtual Clinics.

Monthly Acute Arthritis Clinic.

New safer Hospital Discharge Prescription Process.

Acute Surgical Assessment Unit (ASAU) – reduced ED waits, improved flow, enhanced patient safety.

Trolley Crisis Initiative:

GP Initiative for Emergency Referrals: GPs “reduce/hold/delay” referrals to ED/AMAU during periods of increased clinical activity at SLCK. Safe process now established with Bed Manager/GPs (Fax/text/email) - improved patient flow/safety.

Diabetes Care enhanced: More PUMPS in the community. Integrated model of care: no waiting lists for diabetes clinic.

Ante-Natal Visits Schedule; Agreed local pathways for shared care – reduced unnecessary visits

Learnings:

The key to progress is participation.

Robust meetings are an asset.

Disagreement can be a starting point for change.

LC works:

- Patient-focus brings better outcomes.
- Builds new services by agreement
- Reduces admissions during times of clinical surge
- Improves morale for clinicians/management and community partners
- Strengthens ICGP Faculty relevance and participation

TAKE HOME MESSAGE: THIS WORKS THIS SCALES THIS DELIVERS FOR PATIENTS