Irish College of General Practitioners

Submission of the Irish College of General Practitioners to the Oireachtas Joint Committee on Health in Relation to Primary Care Expansion

Building capacity in GP led primary care

Essential for health system transformation and sustainable health care

November 2017

The Irish College General Practitioners (ICGP) is the professional body for general practice in Ireland. The College's primary aim is to serve the patient and the general practitioner by encouraging and maintaining the highest standards of general medical practice. It is the representative organisation on education, training and standards in general practice.

The College is the recognised body for the accreditation of specialist training in general practice in Ireland and is recognised by the Medical Council as the representative academic body for the specialty of general practice.

There are 4,156 members and associates in the college, comprising over 85% of practising GPs in the Republic of Ireland. There are 205 members in Northern Ireland, the United Kingdom, Canada and other overseas locations, and 690 GP trainees.

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Section 1– Opening statement

Introduction

The ICGP would like to thank the chair and members of the Joint Oireachtas Health Committee for the invitation to reflect on the planned expansion of primary care.

The ICGP's representatives include:

- Dr Brendan O'Shea, Director of the Postgraduate Resource Centre
- Dr Mark Murphy, Chair of Communications and Board Member

General practitioners are at the heart of the Irish healthcare system. Every day, thousands of people all over the country get to see their family doctor without any waiting time, getting quality attention and care. To ensure we can continue to provide that cradle to grave service to an expanded population with more challenging conditions, and address our retention and manpower crisis, we urgently need to commit to greater resources and a new contract.

In this submission, we show you what expansion means, what the challenges are, and what our legislators need to do to ensure general practitioners can continue to be at the heart of a reformed health service.

It is the view of the ICGP that unless adequate capacity is built in GP led primary care, the remainder of primary care, the secondary care sector, and the broader health system will never function safely, efficiently or effectively. As a result of chronic underfunding of GP led primary care, there are separate intractable difficulties regarding how secondary care is delivered in the Irish health system, and it is not the task of primary care to fix these.

Protracted and grave difficulties relating to critical bottlenecks in emergency departments, in waiting times for most public hospital services, in sub optimal care health outcomes, in perceived and actual gross inequalities in access, and in well identified system risks arising from overcrowding and healthcare acquired infections, will all continue as the inevitable consequences of a hospital centric health system, where decades of systematic under resourcing of GP led primary care are clearly evident.

Specialist services ('consultant led') in a hospital centric model have been and will continue to remain unable to safely or effectively address the present volumes of clinical workload. Much of this workload is best addressed in the community setting, delivered by teams of GPs and practice nurses, working in a generalist service, based in practices adequately supported by administrative staff, and allied health professionals, with access to diagnostics (radiology and laboratory), so that more health care needs of most people can be addressed in the community, closest to where people live, and at the most appropriate levels of cost and complexity.

Strong international evidence exists in relation to developing a health system based on strong GP led primary care. Development of universal access to strong GP led primary care delivers substantial benefits to all citizens, and must now be considered as relatively inexpensive, in terms of whole system healthcare costs.

In this statement and accompanying briefing document, the position of the ICGP regarding the expansion of primary care is set out in detail.

Initial steps towards achieving a health system based on GP led primary care must be the immediate reversal of cuts introduced under the Financial Emergency Measures in the Public Interest (FEMPI) legislation, and the replacement of the present GMS contract with one that addresses the needs of people who attend GPs and their practice teams for ongoing medical care. These two issues (FEMPI and contract) are constantly to the fore in communications between our college and GPs who are ICGP members, and GP trainees.

It is the view of the ICGP that FEMPI legislation has destabilised general practice, particularly in rural and deprived communities.

Stronger primary care

Key features of stronger primary care in the context of the Irish health system are as follows:

Adequate numbers of GPs and practice nurses, extending from 3,700 GPs and 1,700 practice nurses in 2017, towards a minimum of 5,000 of each in the coming decade, capable of addressing the needs of an ageing population of 5 million citizens. The ICGP is committed to the expansion of training and educational capacity for general practice, and actively collaborates with the Irish Practice Nurses Association in developing multidisciplinary learning for GPs and practice nurses. These projections are based on data from health systems that function more effectively that ours, and where numbers of GPs are in the order of 90 per 100,000 pop.

Maintain and develop the independent contractor model of GP led primary care, known to be efficient and adaptive, developing stronger GP led teams, supported by adequate numbers of practice nurses, administrative staff, health assistants, and sessional allied health professionals, with access to diagnostics, supported by effective access to specialist services, utilising appropriate information technology, and supported by education and research.

Shift care of people with complex medical problems from secondary to primary care, strengthening levels of social care in the community, so that people who are frail and older can have most of their care in communities, with closer reference to their expressed preferences, up to and including their end of life care preferences. The recruitment of greater numbers of GPs and practice staff, together with the growing provision of social care, will enable more essential care to be delivered at home through general practice led primary care.

Build capacity in GP led teams, which more effectively support GPs and practice nurses in their clinical work. Terms and conditions relating to practice nurses must be addressed to make practice nursing a viable career for practice nurses. This must be addressed as a priority.

"She was with the practice for three years, having come from renal medicine nursing. We spent a fair bit of time and effort training her, the patients loved her, she was a fabulous team member, and I think she really enjoyed the work…

But she wanted to set up her own home, and have a family, and in the heel of the hunt, she left to go back to hospital nursing – much better terms and conditions. I think she was really sorry, the practice was a bit gutted, and we were back to scratch. I can understand entirely where she was coming from though..."

Action points identified by the ICGP

Action points regarding the expansion of primary care have been the subject of focused reflection by the ICGP Board, Council, standing committees, and faculties, in plenary sessions with College members and general practice team members, over the last 18 months.

The ICGP has informally reflected with GP representative organisations and the relevant State agencies.

Key conclusions have been communicated in detail, and are reflected in evidence based submissions by the ICGP to the Oireachtas Joint Committee on Health and on Future Healthcare, which are appended here for ease (p.10).

A summary of relevant action points relevant to the expansion of primary care are identified below and are in keeping with the ICGP strategy document 'Beyond 2020 – Statement of Strategy'.

ICGP action points for expansion of primary care:

1. Reverse cuts to general practice resourcing from FEMPI measures.
2. Effective contract for general practice, delivering adequate flexibility, resourcing and development.
3. Recruit and train adequate numbers of generalist practice staff, planning for a population of 5 million.
4. Make available adequate and accountable capacity in allied health disciplines in communities.
5. Active, ongoing, effective collaboration between the ICGP, GP representative organisations and the HSE.
6. Engagement of private health insurers with GP stakeholders and State agencies on multimorbidity.
7. Focused engagement of GP stakeholders and State agencies on care for people with multimorbidities.
8. Protected transformation funds for education and research relevant to general practice development.
9. Targeted funding for GP involvement in nursing home care and end of life care.
10. Targeted funding for GP diagnostics – radiology (including GP point of care ultrasound) and laboratory.
11. Targeted funding for clinical workloads (e.g. haemochromatosis, aural mircrosuction, minor injuries)
12. Expansion of GP training capacity towards an annual intake of 250 GP and PN training places.
13. Development of practice nurse education to include continuing medical education for practice nurses, as a collaborative undertaking between GPs (ICGP), practice nurses (Irish Practice Nurses Association and Schools of Nursing) and the HSE.
14. Extend the use of electronic medical records and administration beyond general practice throughout the remainder of the health system, particularly hospital based services
15. Urgently and aggressively implement key policies relevant to the expansion of primary care as a national strategic priority, in the interest of equity, clinical safety and improving medical care.

Section 2 – Briefing document

ICGP perspectives on the expansion of primary care

Primary care is first contact, personalised medical care, accessed by people when they have a medical or health related issue they are unable to resolve themselves. It is care provided in the community setting, best considered as accessible to all people in the community. Primary care is best delivered by health care professionals who practise medicine with generalist skills and a generalist mindset.

The general practitioner (GP) has historically been viewed as central to this important strand of healthcare. During the last decade, general practice nurses (PNs) in Ireland have become increasingly important in both Irish, and similar health systems internationally. PNs occupy an increasingly important part of GP led primary care.

Overall however, this same decade in Ireland has seen the fundamental destabilisation of the general practice business model. As many as 1 in 5 newly trained GPs leave the system, shortly on completion of their training. Marginalised practices (particularly rural and deprived urban) are closing, with practice lists amalgamating, and increasing difficulties experienced by people requiring primary care, and by GPs, in terms of workload, and taking necessary leave from their work (e.g. sick leave, holidays, study leave, etc).

In addition to provision by practitioners with a generalist mindset (GPs, PNs and community pharmacists), continuity of care is known to be an important characteristic in the delivery of effective primary care. Continuity is considered valuable by people who use the service. It is important to those seeking care that their care is at least partly provided and co-ordinated by a health care professional who knows them in a personal way, through sustained relationships developed over years. Separately, there is an evidence base which indicates that continuity of care is associated with reduction in healthcare costs.

It is the view of the ICGP that expansion of primary care now urgently requires building capacity in general practice teams, with particular reference to GPs, PNs, practice administrative staff, and community pharmacy. These categories all operate with a generalist perspective.

The ICGP supports College members working in salaried positions, employed by the State or by corporate primary care chains, but it is nonetheless of the view that the efficiencies, professional autonomy and complex adaptivity inherent in the independent contractor GP practice model, are particularly effective and valuable both to the State and its citizens, and to the broader health system.

When adequately supported, the independent contractor model delivers stability and continuity which are important for both the practitioners and the people who rely on the service. It is the view of the ICGP at the present, in 2017, that GP led primary care, delivered predominantly through the independent contractor model should be promoted and supported as the cornerstone of primary care, while recognising that there may be a marginal place for salaried GP positions in particular circumstances.

Primary care teams and general practice teams

Primary care teams (PCTs) at present can only be viewed as a failed initiative conducted by the HSE in a well intentioned effort to improve care. Research conducted by the ICGP (O'Riordan 2015) on this important aspect of primary care demonstrates that while over 70% of GPs positively view the concept, less than 16% reported favourably on their experience with PCTs.

Outside of the GP led element, members of the primary care teams are not IT enabled (frankly astonishing in a highly IT literate society in 2017), PCT meetings for the most part are not run efficiently, GPs are debarred from participating as rotating chairs, and the process appears more concerned with administrative form than service delivery to most GPs. GPs do not have the protected resource time to attend such activities.

> *"I used to go, but I don't anymore. Its twenty minutes each way to get to it… when I sit down, I report into it, they write everything down, and then I go. That doesn't seem like a team meeting to me, and besides, I can get everything I need by filling out forms in the office… going to these meetings serves no earthly purpose as far as I can see, which is a pity… and of course when I get back late to the office, the place is absolutely heaving…"*

There is no mental health discipline represented in most PCTs. During a decade where surviving general practices have increased in size (O'Dowd 2015), many GPs are of the view that it should be possible that where appropriate and practical, that PCT services can and should be delivered from general practices. The ICGP believes that the PCT process should be re-examined and the root causes of previous failure addressed. Further, while there is good use of electronic medical records in general practice, further investment in IT and broadband is necessary in order to derive the further benefits of a population based approach towards better health in our communities.

Irrespective of whether PCTs are to be dropped or developed, ICGP policy now places a major emphasis on building stronger general practice teams, both in terms of team size, capacity, and a broader and deeper skill mix, with sessional inputs from allied health professionals.

Primary care centres

Primary care centres (PCCs) are viewed unfavourably by a majority of GPs, who value the independence of working in a service in which they are effective stakeholders, and in which they can adapt and develop in accordance with the needs of the local community they serve, and with their own professional needs, as community based doctors.

Further, it is the view of the ICGP that the HSE has in many instances unfortunately utilised the development of PCCs to enable the more rapid development of corporate primary care chains in selected locations in a manner which has unfortunately compromised the continuity and quality of care, and shifted the balance of autonomy and franchise of GPs and their patients, living in a particular community, away from that community, and towards vested external business interests.

At this point, while recognising the well documented shortcomings and challenges arising as a result of the corporatisation of primary care, the ICGP is committed to working with all relevant stakeholders to manage this risk, given what has been done, while continuing to promote the value of responsible and community focused GP led primary care, operating predominantly in the

independent contractor model.

GP diagnostics

While policy consensus regarding the importance of access to diagnostics has been achieved, the fact of the matter is that GP access to diagnostics in 2017 is most unsatisfactory. Despite demonstrator projects undertaken by the HSE, the reality faced by most people attending their GP is that unless they can fund private diagnostics themselves, waiting times for most standard clinical investigations are unsafe, grossly excessive and operate far outside EU norms, even in far less affluent countries than Ireland. Likewise, GP access to laboratory services is at best patchy and non-standardised.

These are pressing issues that need to be resolved urgently as part of the expansion of primary care. This, together with a shortage of GPs is at the heart of the public waiting list scandal, which, at the time of writing is in excess of 650,000 patients.

> *'In my practice, the (HSE) courier calls at 11am, four days a week to collect blood samples for the lab.*
>
> *That gives a window of just 8 hours in the week to get bloods done.*
>
> *Outside of this time, you are just messing about, asking people to take in their own bloods to the lab, or bringing them in yourself… and of course the lab doesn't like to get them after 3pm…'*
>
> *'No, we don't have BNP levels available in our county for GPs… this is a real problem in managing our patients with heart failure… the SHOs and interns in the hospital have it but we don't!'*

Approach towards complex medical needs and long term illnesses

The expansion of primary care to deliver a good standard of care to people with chronic multiple illnesses in the community is an important and fully agreed policy objective.

In 2016, the ICGP re-aligned itself with the expressed position of the Integrated Care Committee of the HSE in this regard, to focus on cardiovascular disease, asthma, COPD and type 2 diabetes in education, training and research.

Training, guideline development and clinical expertise are not the problem here, but rather capacity in GP led primary care. The need to train and retain adequate numbers of GPs and PNs is the single most important issue to address in this context. It is stated policy at the ICGP to support general practice teams to engage fully and effectively with HSE policy in terms of shifting care for people with multimorbidity from secondary to primary care.

It is further the view of the ICGP that while there are clear shortfalls in human resource terms within general practice, absolutely no other of the main care disciplines has any prospect of addressing the burden of multimorbidity, in terms of necessary skills, expertise or capacity.

While there is already some provision in the current GP contract in relation to asthma and diabetes, this clearly needs to be expanded. Separately, it is a formal concern of the ICGP that private health insurers do not reflect chronic disease management or recognise the needs of people with multimorbidity in their care plans. This needs to be addressed.

Strategic focus on building nursing home care and social care

The ICGP is of the view that a strategic focus on building social care and nursing home care in communities is key to reducing the present impossible burden on the secondary care system, caused by the inappropriate presentation of primary care workload in the hospital setting.

The ICGP supports the concept of GPs being enabled to work more closely with nursing home care teams to enable the improved care of residents, to enable nursing home beds (est. 26,000) to be used for step down care from the acute hospital sector, and to enable direct community admissions for low complexity medical admissions by GPs to nursing homes where there is an augmented input by appropriately supported GP colleagues. Focused improvements in end of life care and end of life care planning will also appropriately reduce the level of unscheduled and inappropriate acute hospital admissions.

Building capacity in social care relates to expanding the Fair Deal Scheme to enable more care packages delivered by community nursing and care assistants so that older people may remain in their own homes at end of life, and reduce the probability of unnecessary transitions into residential care and unscheduled admissions into secondary care.

Further development of GP co-operatives

Since their establishment from circa 2000, GP co-operatives have now evolved into substantial regional agencies, and are well placed to facilitate expansion of primary care.

While the 16 co-operatives do vary somewhat in operational detail and configuration, they do share the attributes of agencies with a close regional focus, tailored to the needs of the population they serve, and with effective clinical governance provided by local GPs who have standing and accountability in relation to the communities served by the co-operative.

Non GP led elements of primary care

Close consideration needs to be given to non GP led elements of primary care. The role of non-retail or community pharmacists has been proposed in 'A Future Together – Building a Better GP and Primary Care Service' (HSE 2017), and the ICGP is open to actively exploring this as being relevant to improved medicines management.

The failure of the extended (i.e. non GP led) elements of the primary care team (retail pharmacy excepted) to engage in electronic and digital communication and administration creates grave uncertainties regarding the non GP led parts of primary care. Sustained failure to use appropriate information technology creates uncertainty and major inefficiencies in terms of care integration, accountability and contactability. While recognising the increase in capacity in areas such as community physiotherapy, occupational therapy, public health nursing and community psychology services, this needs to be further developed in terms of capacity and governance, guided by real time data analysis, as an essential adjunct to the generalist medical services provided by general practice teams.

The ICGP is of the view that plans to increase numbers of advanced nurse practitioners in the community setting is of limited value. Introduced appropriately, and in modest numbers, tasked with a focus on education, care co-ordination and communication across the primary secondary care interface, ANPs may be useful, and initial experiences with the use of ANPs in the Heartbeat

Model of Care for Heart Failure bears this out.

ANPs will not, however, in the view of the ICGP, be helpful in the context of large numbers of older people with multiple long term illnesses, and who require very complex polypharmacy for their care.

The ICGP is of the view that sessional involvement, in general practices, by psychologists, counsellors, physiotherapists and selected medical specialists should be actively and urgently explored as part of the expansion of primary care.

Secondary care factors in relation to the expansion of primary care

Secondary care factors in relation to the expansion of primary care need to be considered strategically.

Firstly, major risks in secondary care that need to be managed include the following:

- Continued failure of secondary care to have a consultant led delivery model.
- Continued failure of secondary care to engage in electronic records and digital administration.
- Protracted and unsafe waiting times throughout the public hospital system.
- Risks relating to healthcare acquired infections.

These major risks need to be considered in terms of adding uncertainty in relation to primary care, and more positively, in terms of how building capacity in primary care and primary care expansion can assist in reducing these risks for people attending hospitals.

Secondly, it is the view of the ICGP that given adequate numbers of GPs and practice nurses, GPs could become involved in aspects of secondary care reconfiguration. Examples of this include the following:

- Involvement of GPs in running minor injury units (co-ops) in reconfigured Level 1 and 2 hospitals.
- Development of formal structures to train and support GPs with special interests.
- Sessional involvement of GPs in specialty interests, e.g. sessions in EDs, in selected OPDs etc.

Conclusion

Within the discipline of Irish general practice, the ICGP is certain of the following:

- The reversal of cuts under FEMPI legislation and a new contract for general practice are essential and urgent.
- The urgent expansion of GP led primary care is essential for the Irish health system.
- It can be achieved in a cost effective and highly transparent manner.
- The ICGP has an important role in terms of training GPs, and indeed other GP team members.
- The priority for the expansion of primary care must be the establishment of a minimum of 5,000 GPs and 5,000 PNs.
- All health insurers must be required to recognise primary care if they are to operate in the Irish economy.
- The failure of secondary care to embrace digital healthcare.

List of appended documents

1. ICGP submission to the Joint Oireachtas Committee on Health: Manpower and General Practice (2017)

2. ICGP submission to the Oireachtas Committee on the Future of Healthcare: General Practice is Key to Sustainable Healthcare (2016)

3. ICGP 'Beyond 2020 – Statement of Strategy 2016–2021 (2015)