IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Submission to the Department of Health on Draft Policies to Enhance Roles for Nurses and Midwives

Development of a Community Nursing and Midwifery Response to an Integrated Model of Care
Developing a Policy for Graduate, Specialist and Advanced Nursing & Midwifery Practice

May 2017

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
Tel: (01) 6767 273
Fax: (01) 6612 758
Email: vhetherington@imo.ie
Website: www.imo.ie

The Irish Medical Organisation (IMO) welcomes the opportunity to comment on two new policies proposed by the Department of Health to enhance nursing and midwifery roles and career pathways in community care:

- Development of a Community Nursing and Midwifery Response to an Integrated Model of Care
- Developing a Policy for Graduate, Specialist and Advanced Nursing & Midwifery Practice

While the IMO recognises the important role of nurses and midwives in the provision of nursing care to patients in Ireland and that there is an opportunity to enhance their roles in the community, the IMO has grave concerns that the proposed Community Nurse and Midwifery Model of Integrated Care runs contrary to the evidence supporting General Practice and care in the community.

In response to increasing demands on the healthcare system, the draft policies for consultation by the Department of Health propose an enhanced role for nurses and midwives. In addition to their public health nurse roles including child health and school visits, visits and care of elderly persons and care on discharge from hospital, the draft policy on the *Development of a Community Nursing and Midwifery Response to an Integrated Model of Care* suggests an expanded role for nurses and midwives into roles that are traditionally within the remit of Specialists in General Practice and their teams. Those roles include first point of contact for patients accessing the health system, coordination of care, patient referrals, and continuity of care in the management of complex and chronic illness.

To support enhanced roles for community health nurses and midwives, the Draft *Policy for Graduate, Specialist and Advanced Nursing & Midwifery Practice* suggests that on completion of two-year postgraduate training nurses will be equipped with the skills allowing them to carry out the roles of a GP who has undergone five years of medicine and four years of specialist post-graduate training. While the performance of advanced nurse practitioners will be measured on the basis of process rather than patient outcomes.

While the draft policy suggests that clinics led by advanced nurse practitioners have been established in a number of jurisdictions, the development of non-physician-led healthcare services shows a profound lack of understanding by policymakers and allied healthcare professionals alike of the key role played by General Practice and community care in modern healthcare systems. In an era of scarce resources it is important that new models of care are supported by evidence.

Evidence Supporting GP Care and care in the community

Since the WHO Alma Ata Declaration of 1978[1] many countries have recognised the need to re-orientate healthcare towards General Practice and care in the community. While the draft document *Development of a Community Nursing and Midwifery Response to an Integrated Model of Care* recognises this international shift towards Primary Care, it ignores the extensive body of evidence in relation to Primary Care which shows that continuity of care and the patient-centred, rather than

[1] WHO, Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

disease focused, approach that is specific to General Practice is associated with better health outcomes, equity of access, reduced inequalities in health, more appropriate utilisation of services and long-term cost effectiveness[2] [3] [4]. In a landmark study in *The Milbank Quarterly*, Starfield, Shi, and Mackino drew on a significant body of existing research to demonstrate that general practice with a strong supply of physicians, a strong patient relationship with general practitioners, and patient receipt of important features of general practice, were all associated with improved health outcomes, reduced disparities in health and lower total health costs.[5]

Continuity of care or having a general practitioner as a regular source of care plays a crucial role in improving patient outcomes. A seventeen year study of over 1,700 older patients found that continuity of care, attending the same general practitioner, was associated with low mortality, as those with poor continuity of care showed significantly greater mortality than those in the maximum continuity of care category.[6] Findings of this kind are evident throughout research and acknowledge a strong link between continuity of care and improved patient mortality, across all-causes.[7] Continuity of care in general practice has also been linked to reduced probability of patient hospitalisation,[8] an uptake in screening programs and immunisation,[9] improved medicine use and adherence,[10] and lower healthcare costs.[11] Elements of high quality general practice, encompassing robust continuity of care, have been identified as: greater first contact access and use, more person-focused care over time, greater range of services available to patients when needed, and coordination of care.[12] The presence of these elements is strongly linked with superior patient outcomes and lower healthcare costs.

[2] Starfield B. Shi L and Macinko J, Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502)
[3] Atun R, What are the Advantages and Disadvantages of Restructuring a Health System to be More Focused on Primary Care Services? Copenhagen, WHO Regional Office for Europe, Health Evidence Network report ; January 2004
[4] Kringos DS et al, The Strength of Primary Care in Europe, NIVEL 2012
[5] B. Starfield, L. Shi, and J. Mackino, Opcit
[6] O.R. Maarsingh *et al.*, 'Continuity of care in primary care and association with survival in older people: a 17-year prospective cohort study', *British Journal of General Practice*, Vol. 66, No. 649, August 2016, e531-539.
[7] D.W. Shin *et al.*, 'Impact of continuity of care on mortality and health care costs: a nationwide cohort study in Korea', *Annals of Family Medicine*, Vol. 12, No. 6, November 2014, pp. 534-541; R. Baker et al., 'Population characteristics, mechanisms of primary care and premature mortality in England: a cross-sectional study', *BMJ Open*, Vol. 6, No. 2, February 2016, e009981.
[8] V.H. Menec *et al.*, 'Does continuity of care with a family physician reduce hospitalizations among older adults?', *Journal of Health Services Research and Policy*, Vol. 11, No. 4, pp. 196-201; J.M. Gill and A.G. Mainous III, *Archives of Family Medicine*, Vol. 7, No. 4, July 1998, pp. 352-357.
[9] S.A. Flocke, K.C. Stange, S.J. Zyzanski, 'The association of attributes of primary care with the delivery of clinical preventive services', *Medical Care*, Vol. 36, No. 8, August 1998, pp. 21-30.
[10] C.C. Chen, C.H. Tseng, and S.H. Cheng, 'Continuity of care, medication adherence, and health care outcomes among patients with newly diagnosed type 2 diabetes: a longitudinal analysis', *Medical Care*, Vol. 51, No. 3, March 2013, pp. 231-237; M.A. Brookhart *et al.*, 'Physician follow-up and provider continuity are associated with long-term medication adherence: a study of the dynamics of statin use', Archives of Internal Medicine, Vol. 167, No. 8, April 2007, pp. 847-852.
[11] M.J. Hollander, 'Financial Implications of the Continuity of Primary Care', *The Permanente Journal*, Vol. 19, No. 1, Winter 2015, pp. 4-10.
[12] B. Starfield, 'Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012', *Gaceta Sanitaria*, Vol. 26, No. 1, March 2012, pp. 20-26.

International research into Primary Care from Starfield et al[13] to Kringos et al[14], firmly relates to the unique role of the General Practitioner in terms of continuity and coordination of care and the resources provided to support GP care. In Europe, Kringos et al[15] found that countries which are considered to have a strong Primary Care system exhibit the following traits:

- Universal access to GP care with little to no out-of-pocket payments;
- Provide appropriate economic conditions and distribute resources equitably based on medical need;
- Have strong governance arrangements in place including compulsory registration with a GP and a GP gatekeeping role;
- Provide a comprehensive range of services in General Practice and the community;
- invest in the development of the workforce.

Evidence supporting nurse-led care in the community

Contrary to the evidence supporting GP care, there is currently insufficient evidence to support nurse-led care in the community. Arguments in favour of nurse-led services centre around perceived quality of care and patient satisfaction and propose a solution to the imminent shortage of GPs, however, there is no evidence to suggest that patient outcomes are improved or that care is more cost effective. A recent systematic review of evidence relating to autonomous advanced nurse practitioners found no evidence that health status, quality of life, hospitalisations or mortality are improved and that there was no evidence to justify the position that independent advanced nurse practitioners provide the same quality of care as medical doctors.[16] The evidence review carried out by the Veterans Administration also found that a great deal of the literature supporting roles for advanced nurse practitioners referred to non-autonomous, physician supervised, team models of care and protocol-driven care for patients with specific conditions.[17] Other research in this area reveals that nurse-led care is significantly less efficient in the performance of tasks that are usually within the remit of the general practitioner. In primary care, nurse-led services have been found to order far more diagnostic imaging and testing for their patients than general practitioners,[18] spend twice as long on consultations with patients as general practitioners,[19] and use more health resources generally than general practitioners as a result of consultations.[20] By contrast, general practitioners are more focused on gathering information directly relevant to diagnosing and treating the immediate presenting complaint than non-physician health professionals, who are likely to

[13] Ibid
[14] Kringos DS et al, The Strength of Primary Care in Europe, NIVEL 2012
[15] Ibid
[16] McCleery E, Christensen V, Peterson K, Humphrey L, Helfand M. Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses, VA-ESP Project #09-199; 2014.
[17] Ibid
[18] D.R. Hughes *et al.*, 'A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits', *JAMA Internal Medicine*, Vol. 175, No. 1, pp. 101-107; K. Rosenberg, 'NPs and Physician Assistants Order more Imaging Tests than Primary Care Physicians', *American Journal of Nursing*, Vol. 115, No. 3, March 2015, p. 63.
[19] C. Seale, E. Anderson, and P. Kinnersley,, 'Comparison of GP and nurse practitioner consultations: an observational study', *British Journal of General Practice*, Vol. 55, No. 521, December 2005, pp. 938-943.
[20] A. Hemani *et al.*, 'A Comparison of Resource Utilization in Nurse Practitioners and Physicians', *Effective Clinical Practice*, Vol. 2, No. 6, November 1999, pp. 258-265.

recommend a larger number of treatments than general practitioners.[21] Accordingly, there is no evidence to suggest replacing general practice with a non-physician led health care service is cost effective, and it may even be more costly.[22]

The unpublished evidence review carried out on behalf of the Department of Health found no single overarching model of nursing and midwifery practice in the community that had been scientifically evaluated had emerged.[23] The review also found that there was insufficient evidence to inform the cost effectiveness of integrated models of nurse led care in the community and that further research was needed to underpin the development of future services. [24] Despite this, the Department of Health is proposing a vague model of nurse-led community health services that, rather than complementing GP care, will offer an alternative model of care that undermines continuity of care in general practice and risks further fragmentation and duplication of care.

Investment in General Practice and Care in the Community

After decades of under investment, services across General Practice and the community are under-resourced and providing a more integrated approach to care remains a significant challenge. Currently in Ireland 24 million consultations are undertaken in General Practice each year and 90% of these presentations are treated in General Practice without referral to secondary care. However the development of General Practice in Ireland has been restricted by a 30 year old GMS contract and funding cuts of 38% under FEMPI legislation. The skills of 2800 GPs and their practice staff, including 1800 practice nurses, are underutilised awaiting negotiation of a new GP contract. There is a shortage of GPs and many newly qualified GPs are choosing to emigrate. While in the community there are difficulties accessing diagnostics and waiting lists apply across the country for access to allied community health and social care services.

In the IMO's recent submission to the Oireachtas Committee on the Future of Healthcare, the IMO is calling on the Department of Health and the HSE to agree a strategy with the IMO for the development of General Practice in Ireland over the coming decade which includes:

a) A commitment to preserving the following positive traits of General Practice including the role of the GP as gatekeeper to the health system and coordinator of care which ensures more appropriate use of scarce healthcare resources.
b) A manpower action plan to address the growing shortage of GPs and practice staff
c) In order to halt the exodus of GP trainees, priority must be given to negotiating a new GP contract with the IMO that is properly resourced and fit for purpose for a 21st Century Health Service with a focus on:

[21] C. Seale, E. Anderson, and P. Kinnersley, 'Treatment advice in primary care: a comparative study of nurse practitioners and general practitioners', *Journal of Advanced Nursing*, Vol. 54, No. 5, June 2006, pp. 534-541.
[22] S. Hollinghurst *et al.*, 'Comparing the cost of nurse practitioners and GPs in primary care: modelling economic data from randomised trials', British Journal of General Practice, Vol. 56, No. 528, July 2006, pp. 530-535.
[23] DOH, Development of a Community Nursing and Midwifery Response to an Integrated Model of Care, Consultation Document March 2017. pp9
[24] Ibid pp27

- Terms and conditions that ensure both existing and newly qualified GPs are attracted to a career in the health service. Investment in evidence-based Chronic Disease Management Programmes for which GPs are already trained
- Allowances for the employment of practice staff (including medical, nursing and practice support staff)
- Additional supports that address the real and specific needs of patients in both rural and deprived areas
- Appropriate adoption of new work practices such as telemedicine that are based on international best practice and assure continuity of care

d) Incentives must be provided for the development of infrastructure including premises, medical equipment, diagnostic equipment, IT
e) Access to diagnostics and allied health and social care professionals in the community (see integrated care)
f) The expansion of GP care that is free at the point of access on a phased basis taking into account income and medical need and that ensures there is sufficient capacity to cope with increased demand.

In order to ensure patient safety, quality and continuity of care any transfer of care from GPs to nurses should be made in agreement with GPs under a new GMS contract and take place ideally within the practice team ie. to practice nurses. Any expansion of nursing services within the community should equally be aligned with services provided under a new GP contract.

Community Nursing and Midwifery Services

While Ireland currently has one of the highest number of nurses in the OECD/EU, there is a need to expand the community nurse workforce to meet the needs of the population in the future with the skill mix to meet the vast range of requirements for support including extended care in the community, community psychiatric nursing and child health services.

In recent years there has been significant investment in Community Intervention Teams where nurse- led teams provide acute nursing care at home or in residential settings in order to prevent hospital admissions or to facilitate early discharge. While the relationship between these teams and General Practice has yet to be defined, teams accept patients on referral from hospital or their GP. The draft policy provides no detail on expanding the availability of these teams out of hours. There is no mention either of expanding the provision of community psychiatric nurse services.

There is also a significant gap in the draft policy on the *Development of a Community Nursing and Midwifery Response to an Integrated Model of Care* on how child health services are to be delivered. The document misrepresents current school health services as only 'opportunistic' because there is insufficient time and school nurses to deliver them. The reality is however, that child health has been neglected as programmes are set aside for more 'urgent' care which has been increasing exponentially. The new model must describe how appropriately qualified nurses are going to deliver the full child health package, including school health. This is an expanding package of care, with a new emphasis in the Healthy Childhood Programme that cannot be delivered when a lull in urgent

care allows. Consideration should be given to the UK's Health Visitor model to ensure that children in Ireland have a good start in life.
The Draft *Policy for Graduate, Specialist and Advanced Nursing & Midwifery Practice* aims for 700 advanced nurse practitioners (RANP/RAMP) to be trained by 2021 from the existing cohort of patients. With shortages of nurses across the system there is a risk that nursing resources will be prioritised for acute care and long-term care facilities, leaving community care under-resourced. Integrated workforce planning should include an assessment of the number of community nurses and the skill mix needed to meet the needs of the future population including extended care in the community, community psychiatric nursing, child health services.

Supporting Integrated Care

The proposed model also draws attention to the need for a more integrated approach to the delivery of care. An integrated healthcare system can enhance quality of care and patient outcomes and has the potential to improve patient experience and lower costs in particular for patients with chronic disease who may require services from a wide variety of healthcare professionals across GP, community and acute hospital settings. Interdisciplinary team working should not be interpreted as one healthcare professional carrying out the tasks of all team members. The unique skills and strengths of each discipline must be recognised, respected and maintained. Interdisciplinary team working should be physician-led as physicians bear the responsibility and are accountable for diagnosis and therapeutic decisions.

The draft policy identifies some key enablers of identifies key enablers of integrated care including technology and leadership, but also mentions incentives to support integrated care. Again in line with the IMO submission to the Oireachtas Committee on the Future of Healthcare the IMO recommends that integrated care and interdisciplinary team working can be supported with

- Ring fence funding for the roll-out of a new system of electronic healthcare records
- Development and resourcing of clinical guidelines that define key roles and responsibilities of healthcare professionals operating within their particular domain of competence
- Integrated health and social care services requires integrated manpower and capacity planning and the provision of appropriate capital and operational resources. It is impossible to integrate services that are not appropriately provided in the first place.
- As above chronic disease management should be GP-led with appropriate resources provided under a new GP contract.

Summary of Recommendations

1. **The IMO recommends that the Department of Health examines the extensive evidence in relation to the key role of General Practice within modern health service – in particular the key GP roles of continuity of care and gatekeeper within the healthcare system.**

2. **In line with the IMO's recommendations to the Oireachtas Committee on the Future of Healthcare the IMO is calling on the Department of Health and the HSE to agree with the IMO a strategy for the development of General Practice over the next ten years to include:**

   a) **A commitment to preserving the following positive traits of General Practice including the role of the GP as gatekeeper to the health system and coordinator of care which ensures more appropriate use of scarce healthcare resources.**
   b) **A manpower action plan to address the growing shortage of GPs and practice staff**
   c) **In order to halt the exodus of GP trainees, priority must be given to negotiating a new GP contract with the IMO that is properly resourced and fit for purpose for a 21st Century Health Service with a focus on:**
      - **Terms and conditions that ensure both existing and newly qualified GPs are attracted to a career in the health service. Investment in evidence-based Chronic Disease Management Programmes for which GPs are already trained**
      - **Allowances for the employment of practice staff (including medical, nursing and practice support staff)**
      - **Additional supports that address the real and specific needs of patients in both rural and deprived areas**
      - **Appropriate adoption of new work practices such as telemedicine that are based on international best practice and assure continuity of care**
   d) **Incentives must be provided for the development of infrastructure including premises, medical equipment, diagnostic equipment, IT**
   e) **Access to diagnostics and allied health and social care professionals in the community (see integrated care)**
   f) **The expansion of GP care that is free at the point of access on a phased basis taking into account income and medical need and that ensures there is sufficient capacity to cope with increased demand.**

3. **In order to ensure patient safety, quality and continuity of care any transfer of care from GPs to nurses should be made in agreement with GPs under a new GMS contract and take place ideally within the practice team ie. to practice nurses. Any expansion of nursing services within the community should equally be aligned with services provided under a new GP contract.**

4. **Integrated workforce planning should include an assessment of the number of community nurses and the skill mix needed to meet the needs of the future population including extended care in the community, community psychiatric nursing, child health services.**

5. **Support integrated care and multidisciplinary team working with:**
    - **Ring fence funding for the roll-out of a new system of electronic healthcare records**
    - **Development and resourcing of clinical guidelines that define key roles and responsibilities of healthcare professionals operating within their particular domain of competence**
    - **Integrated health and social care services requires integrated manpower and capacity planning and the provision of appropriate capital and operational resources**
    - **As above, chronic disease management should be GP-led with appropriate resources provided under a new GP contract.**