

The Health Service Executive GP out of hours Review Group on the future provision of GP out of hours services-

Northdoc Medical Services CLG - Submission. March 3rd 2017

DDoc - the north Dublin GP out of hours service.

Executive summary

The purpose of this submission is to give a brief insight into the current model of out of hours care in place in North Dublin and by doing so highlight the major strengths (and obvious weaknesses) of the current model. It is also to ensure that when reviewing an out of hours model that there is proper attention given to the extended benefits that accrue to all aspects of the primary (and secondary) care services, and to the local community.

There are important connections and valuable relationships in place that need to be preserved and promoted – between OOH services and primary and secondary care; between OOH and ED departments; Palliative care services; Mental health Services; Homelessness Services; Training and Retention of GPs in areas that include areas of social deprivation, and continuous medical education in General Practice.

In areas of social deprivation the OOH service is a lifeline to those parts of the community whose needs are particularly complex and aggravated by poor social conditions and difficult personal circumstances. The OOH setting provides continuity of the daytime GP care on which that these particularly vulnerable patients depend.

It would be a very costly mistake both in financial and social terms to assess the value of out of hours provision in isolation, simply by focusing on Call Centres, Numbers of patients seen by category; Clinical software and KPI's based on 'response times', and numbers of patients seen by hour or location. This approach would perilously ignore the benefits of a service embedded in the local health community and the people it serves.

There is a social value to GP led OOH provision and there is an economic value when its relationship to secondary care and social impact is considered.

Other factors that we will examine here are the levels of governance surrounding areas such as recruitment; patient safety; induction of GPs and training (specifically for the out of hours setting); third party independent patient safety and service delivery audits specific to OOH services; Patient satisfaction surveys; GP satisfaction surveys; collaboration with other Co-op's; ICGP and the quality improvement division of the HSE on antibiotic prescribing; and collaboration with the RCSI the HRB on patient complaints and safety.

Northdoc is an out of hours model is unique in two ways. Firstly, it is the first company in Ireland to have been awarded the prestigious "Social Enterprise" Mark. This is an international

accreditation recognising our services to the community, our work with GP groups involved in outreach services to the homeless community, street workers, and drug addiction services. Secondly, the Northdoc financial model is based on a “For Benefit” company structure whereby all funds, both public and private, are pooled inside the company and dedicated to improving the standard of care we deliver and to enable and support other GP services in the community especially in areas of social deprivation.

We are not suggesting that our model should be applied anywhere else. We are simply stating that the model that has evolved in North Dublin is best suited to the primary care needs of our patients. It has also ensured positive local GP engagement in providing this service to the general population and especially to vulnerable groups in the community.

We will address the weaknesses (Serious I.T. shortcomings; the inability of the HSE to respond in a timely and flexible manner to the needs of the service and population we serve; limited geographical coverage – (could be a city and county wide service); a more appropriate triage system; The fact that we have overall responsibility for the safe delivery of the service while having little or no way of managing the service - holding all of the responsibility and none of the control.

Our main recommendations will be that out of hours services be provided and managed by local GPs; that there is appropriate public educational programs in place around the use of both primary and secondary care services; restoration of distance coding for home visits; a more ‘can do, will do’ attitude from the HSE and Dept. of Health; more work using a proven partnership approach between HSE and local GPs to develop more services and improve the patient experience in out of hours primary care; and funding for GPs to manage all aspects of the service, especially in IT and governance.

It is generally recognised that the primary care share of the health budget as a percentage of overall health spending is low. At the same time there is also recognition that primary care is a critical part of health delivery and has potential to ‘do more’ so that services currently provided in the more expensive secondary care area might be provided in a more timely and cost effective fashion. The HSE needs to consider the value of transformational spending and be more flexible and less territorial in internal budget management. There must be a realisation that valuable changes in out of hours will require realistic funding.

The Model

The North Dublin OOH service provider consists of three distinct arms: Northdoc is responsible for providing the doctors and medical governance.

The HSE is responsible for providing nurses, call takers, drivers and supervisors and for making available five treatment centres to including drugs, medical equipment and mobile units.

The third arm is Caredoc, which is responsible for providing nurse triage for the co-op.

In Northdoc both private and public income are pooled and used within the company to provide GPs and to cover the administrative costs for the service provided.

Prior to the arrival of DDoc in November 2006, local GPs used deputising services. Transformative work has been done through Northdoc to promote the participation of local GPs. This has transformed a service based almost solely on locum services, to one provided by local GPs who are doing OOH sessions and thereby providing their expertise in their regular DDoc sessions for the benefit of patients in their local community.

Strengths

Patient Safety:

As a GP led service we fully appreciate and understand the importance of an out of hours service being well organised and vigilant in the safe provision of care to patients. We have implemented a medical governance structure in our service which is overseen by a full-time medical director. Over time we have developed and published a comprehensive GP support Handbook specifically tailored for GPs working in the out of hours setting. The Medical Protection Society in the UK has completed an audit with specific emphasis on patient safety and have approved our system of governance and our handbook and web based GP support facility.

We have also implemented our own internal clinical notes audit system which ensures continual appraisal of the quality of clinical notes and therefore the quality of care and safe delivery of GP services to our patients. This is a unique form of audit practice in the Republic of Ireland. The introduction of this audit tool throughout the UK has measurably improved patient outcomes and both informs and improves GP performance. Northdoc also facilitate Clinical update courses for clinicians.

Patient satisfaction:

We undertake surveys of patient satisfaction on an annual basis. Questions are asked about every point along the patient's journey in the out of hours setting. We broke the questions down to cover the patient experience with the call takers, triage nurses, receptionists, nurses

in the centres, and broke the GP experience down to; rapport and history taking, thoroughness of examination, and satisfaction with the doctors' explanation of findings and treatment. Overall satisfaction rating the out of hours service is high at 95%. You can see the relevant survey in full by [clicking here](#).

What is not apparent in the survey, but is fed back both directly from service users and through GPs, is the high appreciation levels in nursing homes and palliative care settings. The avoidance of referrals to A & E for elderly and palliative care patients is considered one of the most significant benefits of having the GP out of hours service available to the community.

A Social Enterprise Company:

The structure of the company is different from most GP co-ops in Ireland, in that private fees are retained by the company and are not distributed to members. Instead, it is used solely for the promotion of the company's activities as a "for benefit" company. This allows us to be flexible in response to demand surges and flexible in response to our medical partners providing specific services to vulnerable groups such as the homeless.

The ethos of the company underpins our social engagement values. We implement this both directly through provision of GP services to patients regardless of means or GMS status. Our fundamental commitment is to ensure that at least primary GP care will be provided to these people in the out of hours setting regardless of their means.

Quality of GPs – Recruitment and Induction:

Northdoc is committed to recruiting as many local GPs as is possible to participating in the service. We have a robust recruitment process which has been approved by the MPS in the UK. When recruiting GPs we expect a minimum standard of qualifications which is based on the MICGP, MRCGP or equivalent EU qualification. Doctors must already have a minimum of three years full-time GP experience in Ireland and must have a good fluency in spoken English. As part of the recruitment and induction we have GP company director overseeing the recruitment process. Members and sessional GPs must complete basic life-saving courses every two years, engage in continuous medical education, and be familiar with the range of services that they will have to provide in an out of hours setting. These include; involuntary psychiatric admissions, catheterizations in the community, and for GPs to be familiar with our unique GP handbook which covers a range of medical presentations that are specifically challenging in the out of hours setting.

CPR courses for all Northdoc GPs

Every year we organise CPR courses for member and sessional (Locum) GPs who work in the D Doc service. As well as the obvious benefits of having done the course it also gives GPs a worthwhile opportunity to 'train together' in a positive and collegial setting.

GP registrar training and GP retention:

Northdoc are committed to facilitating training of new GPs and we work closely with the GP training colleges to ensure that trainees can actively participate in the out of hours service. They are able to meet their school requirements for doing 120 hours in GP OOH settings and at the same time, by their interaction with Northdoc, hopefully consider staying in the area as a career option.

Attracting GPs to areas of particular social deprivation is a known challenge to everyone involved in the provision of primary care. Through our connections with GP practices in these areas and by working with our partner organisations (Safetynet, Deep End) we seek to encourage young GPs to be familiar with and have a desire to work in those areas where the need is greatest and most challenging.

Research - Collaboration - Education

The Northdoc model, like other Co-op's, is in a sense like one very large GP primary care practice in that there is a high volume of patients and therefore a high volume of quality data. This has allowed us to collaborate with South Doc, the Irish College of General Practitioners and the Quality Improvement division in the HSE in the rollout of a significant antibiotic educational project. Using multimedia through TVs in the centres, our website, educational leaflets for patients, stickers for children, and helpful leaflets for GPs interacting with patients during consultations. The upshot of this will be a "before" and "after" study of the effects of the project which of course is to drive down the use of, and more importantly, the expectancy for the use of, antibiotics in the community.

We are currently working with The HRB Centre for Primary Care Research and the RCSI to explore the possibility of using an existing evidence-based coding system to code Northdoc complaints data focusing on quality improvement in patient safety.

We are exploring other innovations regarding education and communications, exploring ways in which the GP experiences can be shared throughout the GP community and the public. Our website promotes HSE public health communication (Under the Weather). See our [public advice messaging here](#). Our podcasts will explore and share the experiences of GPs, especially in challenging areas of social deprivation. You can sample our podcast [here](#).

We have also funded a project with Safetynet where we sponsored the project involving major two-day mobile x-ray facility for the homeless and prison population in North Dublin. Subsequent to this, the HSE having seen the value of it and has sponsored subsequent surveys with the x-ray unit.

Audit – Clinical and Service:

When it comes to patient safety and the efficiency of the delivery of care we provide an out of hours we believe that an audit our services from an impartial and professional body such as the Medical Protection Society in the UK is an essential part of ensuring patient safety and that the GPs and the service are properly resourced to do the best job they can. On the back of a successful audit in 2012 we have invited the MPS back to carry out a full service audit in

March of this year (2017). This will be a comprehensive review of all aspects of the service, from call taking, through triage, to GP consultations, and the nurse/medicines/drivers and home visit aspects of the service.

The last audit carried out by MPS identified “a drive for quality” within northdoc during its 2011 audit. Inviting them back this year shows the commitment of the leadership of Northdoc to continuous improvement. We learn useful lessons from these audits across a range of issues; complaints, patient safety incidents, satisfaction surveys and feedback from staff and local GPs.

Responsive complaints handling service:

GP Out of hours settings are an area of concern as indicated by the ever-increasing cost of indemnity insurance in this area. Costs in the UK are spiralling and GPs in the UK are looking to government to provide indemnity. The out of hours GP setting is one where the patient and doctor do not have the same relationship in terms of familiarity that they would have the daytime service. This can lead to misunderstandings and this in turn can lead to complaints. While the level of complaints remain low (1/1000) any one complaint might end up as significant.

We have developed a robust complaint handling system which has been commended by the MPS for its responsiveness (patients are usually contacted by a medical director with the specific responsibility of looking after complaints within 72 hours of making contact by any means - whether verbal, email, written or by leaving a message with the service. The fact that the GP is involved in the process seems to be very encouraging and reassuring for the complainants involved.

Most complaints are fully dealt with the patient satisfaction within 10 days. That is, fully completed. This compares very favourably, and in fact is far faster, and has better outcomes than any public pathways such as the HSE’s own ‘have your say system’. The benefits of a quick, comprehensive and caring response is good for the patients and helps avoid unnecessary escalation.

Compliments are now becoming more commonplace. Probably because the ease of access we provide patients via our website and the ease with which people can email from their mobiles soon after an event. We treat compliments under the same processes as complaints thus ensuring that everyone involved get the positive feedback as well the negative.

Low referral rates to A & E

Referral rates from GPs in out of hours setting is extremely low. Self-referral rates (Especially to Temple Street) are high. GP out of hours services are keeping people away from ED departments. Pressure on ED departments could be further reduced by promoting GP out of hours as a much quicker alternative to being seen in A & E.

Prevention of hospital admissions from Nursing homes.

Northdoc research carried out in 2016 showed that the vast majority of home visits out of hours to nursing homes were appropriate. It also found that this was a big factor in preventing direct referrals of elderly to A & E.

Filling the Gap

Between the hours of 6PM in the evening and 8 AM in the morning there is a deficit of services in terms of public health nursing, Social workers, and outreach support services. This exacerbates the health needs of patients and having GPs in place is another safety net in place. Apart from GP services, there is only the Gardaí, Ambulance and A & E during these times.

House calls to the Elderly

The elderly are the most vulnerable and often the least able to attend GP centres in the out of hours setting. Again, home visits to the elderly helps them avoid using the only alternative of self or family referral to A & E by ambulance.

Psychiatric patients – Reassurance and continuity of care.

The current out of hours setting is invaluable to daytime GPs when assessing acute psychiatric emergencies, (the acutely suicidal/ psychotic patient) both in providing reassurance to the patients of the continuity of the service, but also in preventing self-referral and indeed GP referral to the emergency department.

Continuity of Care – Special cases

The facility for daytime GPs to 'flag' patient's charts in D Doc avoids unnecessary stress for patients. A special note on a patients chart might be added in a palliative care case (Example 'do not refer to a & E' or can inform the on duty OOH GP of the range of care in place with the list of the prescribed medication already in play.

Local GP Involvement and Ownership.

The community's response to having a locally GP sourced and managed service is very positive. See patient survey results above (95%).

The more subtle and unseen advantages lie in the local GPs relationships with local hospitals, palliative care centres, mental health services, and their innate knowledge of the needs of the local community. This cannot be overstated.

For GPs to buy into the system they have to have a sense that they are driving it. Any organisation providing the out of hours service must be able to respond quickly and effectively to evolving health needs in the community in the out of hours setting.

Only a GP led model can ensure this. Unless the GPs themselves are both owning and driving the service they will inevitably distance themselves from it. Given the benefits of having them involved as discussed almost everywhere in this document, it is obvious that to control it they must also own it. To ensure that they feel they are a relevant part of it they need to be involved in the management and resourcing of its provision.

Local GPs throughout the country are very proud service that they provide. This is aside from the frustration they feel in terms of resources. Nevertheless that pride has to be harnessed and for it to be harnessed in a useful way it has to be properly funded. The level of spending on primary care generally is accepted as being too low. It goes without saying that to provide an out of hours service across the country, assuming it's considered to be desirable, will simply have to be funded properly.

Weaknesses

All of the responsibility and little control:

GPs provide medical governance and oversight for the safe delivery of out of hours service to patients. In simple terms they have all of the responsibility where patients care is concerned. While Co-op's vary in model type, Northdoc and one or two others are in the unenviable position whereby they have all of the medical governance responsibility and for patient care and yet they have no control or significant or tangible say in the delivery of the operation.

The HSE insist on holding control over assets such as the IT infrastructure. This means that any innovations and improvements are doomed to a slow and tortuous path where change is concerned.

A number of Co-op's look after their own IT and are funded for this by the HSE. This puts these co-ops in a position to modify their IT, improve it, and get more useful data. This in turn helps inform management and improve patient care outcomes. As private companies they can change their minds quickly, respond quickly to the availability of new innovations in IT.

Northdoc's work in research, system management, and patient care is compromised by not having the same facilities as other co-ops when it comes to IT. This is one area where the attitude of "Can't do /won't do" is most evident. Control of delivery underpins the quality of service delivered.

It is simply unreasonable to expect the GPs to take ultimate responsibility for patient care while not allowing them to manage the delivery of that care except in the areas of clinical governance.

MPS (Medical Protection Society) pointed out in the last audit of D Doc that they thought it was unusual that the management (HSE) of the service were simply not rostered when the service was in operation. Northdoc, apart from the obvious provision of GPs on the roster, also roster Northdoc management throughout the out of hours when it's in operation. During busy surges in demand Northdoc effectively manage the entire system through communications directly with the clinical teams, triage service and call centre.

Service does not cover all of Dublin

The D-Doc service does not cover all of Dublin. Given the high level of patient care, standards of medical governance, existing relationships with other parts of the primary care service already mentioned, and indeed the secondary care services, already developed by Northdoc, it seems that it might make sense to replicate this high standard of service throughout the city and county.

Throughout this document we have underlined the importance of local GP involvement and buy-in for the quality of care that has been developed. Therefore it is essential that any involvement by way of expansion of the existing service must be underpinned *by the voluntary involvement of any GPs in other areas of the city. Unless GPs feel that it will provide a better level of care to their patients, is also workable, and that they have control over the*

delivery of the service it would be unlikely to succeed. Therefore any expansion of the service in Dublin needs to get the GPs on board first, as it is the cooperation of local GPs who will facilitate any positive outcome.

No incentive to switch to video consultations or Dr Advice

Video consultations and phone consultations by GPs have been trialled in many rural parts of the UK and some parts of Ireland with apparent success. Those Co-op's that we have spoken to in the UK have told us that the system works very well for patients and GPs alike and is probably the best way forward in providing GP services especially in remote inaccessible rural areas. This should be developed and the only way to progress this is to provide funding. A model of remuneration for video and phone consultations needs to be explored.

Inadequate data collection and monitoring:

Taking the analogy that Co-op's are like one single large practice in terms of the potential for data collection then the ability to collect that data is entirely dependent on the IT infrastructure in place.

Our experience of the current IT system is very poor in terms of data collection. Direct access to the existing IT provider (and management of the system) may improve this. However, direct management of our IT infrastructure will allow us to look at alternative systems that may be better equipped in terms of data collection and monitoring.

Challenges

Keeping GPs in the game:

The first challenge is maintaining GP interest in providing GP out of hours services. We have discussed earlier the advantages of local GP involvement, both in the community and with other primary care services and hospitals.

GPs are dealing with ever increasing demands on their daytime practices and ways must be found of attracting them to managing and providing GP services in the out of hours setting.

HSE and GPs should look to the experience of corporatizing the services in the UK in 2004. 'For profit' private enterprises piled in thinking there was an opportunity to make money. They did not stay long. The result was the decimation of GP services in out of hours to the community.

The UK government are now going to great lengths to incentivise local GPs to get back in the game of providing the service. So far, more than 50% of GP out of hours cover in the UK has been reinstated by the involvement of local GPs and the UK government are keen to get this figure as high as possible – the reason? – Where local GPs are involved the service is simply better and safer and more effective.

Managing Patient Expectations:

GP out of hours services are set up for the “urgent” provision of GP care. With changes in people’s lifestyles and the increasing demographic of both parents being at work, there is a tendency to look at GP out of hours as they would at any other service – available on demand 24/7.

There is a role for public education in terms of managing what may be realistically expected for ‘urgent’ health need. There are simply not enough GPs in the country to provide an on demand service 24/7. That message needs careful management, but it does need to get out there. The public should be encouraged to see their own GP, and the benefits of having a holistic approach where the GP knows the patient’s full health picture, must be emphasised as being both good for the patient, both adults and children.

Loss of distance coding on home visits:

The simple fact is that it is not financially viable to provide home visits over distance with the current level of remuneration. A model of remuneration needs to be agreed for this service to continue. Obviously this affects rural GPs more than those in centres of high density population.

Inadequate use of the strengths of the local co-ops

Refer to the strengths at the beginning of this document: the Co-ops have a wealth of experience and health data. They are ideally placed as a communications network for GPs and for the greater primary care environment. They could and should work more closely with their colleagues in secondary care where shared experiences and ideas could lead to improved service delivery.

The wider HSE organisation (not just those directly connecting with the co-ops) should have a proper knowledge and awareness of the services that the co-ops provide and link with them if they think the co-ops can help in their (HSE) own specific area of health delivery.

GMS Prescribing in out of hours:

GMS prescription services in out of hours is an antiquated, unnecessarily cumbersome, and needlessly expensive administratively. In an age where there are apps to order taxis, where money can be transferred by mobile phone, and even GP consultations can take place over virtual networks it is simply incredible that prescription forms are issued in hard copy, in triplicate, distributed nationwide and still filled in by hand or tractor feed printers that sit along clinical software programs that could easily replace all the paper, the cost of producing it, and the cost of manual administration all along the chain.

Solutions

Funding:

Funding and improving a service that is already working well seems like common sense. However, the HSE, Department of Health, government and all politicians have to decide that if they want to keep this well used, well valued, element of primary care they will have to fund it.

Restoration of distance coding on home visits:

See funding.

Patient Education:

The proper management of patient expectations is a key element in managing limited resources. The HSE have a number of very successful campaigns around public health. They need to consider adding a piece on the proper use of urgent health services.

Clear lines need to be drawn between what should be expected for emergencies, for urgent primary care issues, and for general personal health management.

The most positive message is always the most successful one. HSE should consider a promotion on the appropriate use of daytime GP care as the being the best possible way to look after adults personal health and that of children.

Consider extending the DDoc model:

We have demonstrated above that the provision of GP and out of hours is just one part of the benefits both to the community, the GPs, and primary care generally, and that there are considerable benefits other than basic care : Patient safety, good governance, quality GPs, GP training, GP retention, social Enterprise, palliative care, Mental Health, Research data, patient education, GP referral rates to A & E, relationships with other primary care providers, responsive complaints handling, GP ownership of the delivery of care with proper funding. All these things might make it attractive for other areas to combine efforts across the city and county. The governance and GP provision infrastructure is already in place. However, only persuasion, genuine positive engagement, recognition of the existing GP workload, and proper funding, can bring this into being.

GMS Prescribing in out of hours:

Clinical software programs that could easily replace all the paper and the cost of producing it.

The existing clinical software programs across the out of hours service should be used immediately to issue prescriptions, both private and GMS and reporting, accountability and payments should be automated. (See under challenges).

More services – using existing facilities

Consider engaging with GP OOH set up to provide additional services – Sexual Health clinics, community services.

Budgets, Resources, Demands.

It is generally recognised that the share of the health budget as a percentage of overall health spending is low. At the same time there is also recognition that primary care is a critical part of health delivery and has potential to 'do more' so that services currently provided in the more expensive secondary care area might be provided in a more timely and cost effective fashion. The HSE needs to consider the value of transformational spending and be more flexible and less territorial in internal budget management. There must be a realisation that valuable changes in out of hours will require realistic funding.

END.

Submitted on behalf of the Board of Directors of Northdoc Medical Services CLG

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