More to give?

The consultant in charge of the HSE's clinical programmes believes there is scope to improve services in the health system. Aine Carroll spoke to **Niall Hunter**

DR AINE Carroll, National Director of Clinical Strategy (*pictured right)*, has said that the Irish health service has the capacity and capability to improve services and care using existing resources.

The HSE's much vaunted Clinical Programmes, to which Dr Carroll was appointed Director last October, was established in 2010 to improve and standardise patient care throughout the health service by bringing together clinical disciplines, including GPs and enabling them to share innovative solutions to deliver greater benefits to patients.

Dr Carroll points to improvements in care across a wide range of disease areas covered by the 33 programmes, including stroke, severe lung disease, epilepsy, heart failure and acute medicine.

However, in spite of this, there are still major access problems in terms of lengthening waiting lists and continuing pressure in hospital emergency departments.

Asked about this, Dr Carroll, who is a consultant in rehabilitation medicine, said there had been an unusually large number of flu-like presentations in EDs through last winter and spring, putting extra pressure on the system. She said without the work done by the programmes, the pressure would have been worse.

Lack of real primary care input into the direction of the clinical programmes has been a major issue. Has this been dealt with?

"One of the reasons for the recent restructuring of the programme is to make sure that we have alignment on integration. Not just between programmes, but right across the different aspects of our health service. Obviously a patient journey doesn't begin in an acute hospital. We need to be planning from prevention right through to sustaining services in the community.

Dr Aine Carroll

"In terms of leadership it is a question of having the right person to lead the programmes, somebody who has got the right leadership skills regardless of whether they come from acute hospitals or a primary care background. In certain programmes, especially the chronic diseases, the joint lead approach has worked quite well and currently we have put out an expression of interest for a primary care lead, and we are developing a primary care programme specifically to look at the interface between primary and secondary care and making sure we pull together those different strands."

Asked if she thought it was a mistake to make the clinical programmes so hospital oriented at the beginning, Dr Carroll says the programmes have to map out the patient pathway and it all depends on where you start that patient pathway.

"Retrospection is always a great teacher of course, but I think with the restructuring of the programmes and the emphasis on working across primary, secondary and tertiary care, we can make sure that the patient journey is as streamlined and as easy as possible for the patient mainly but also for healthcare professionals," she said.

Dr Carroll feels there have been very tangible benefits accruing from the launch of the clinical programmes in 2010.

"There are now 33 programmes and I believe there have been tangible benefits from each and every one of them. If I had to pick out one example I would cite the acute medicine programme, which has led to a more streamlined approach to admissions and scheduled care pathway. Length of stay has been significantly reduced. With the stroke programme, in a very short timeframe, Ireland has gone from one of the worst thrombolysis rates to one of the best compared to other countries. We have also seen improvements in areas such as COPD with community outreach programmes, and improvements in epilepsy and heart failure and stroke services.

Challenged on the fact that in spite of these apparent improvements, there are still major problems with access to scheduled and unscheduled care, Dr Carroll says if you look at the issues with unscheduled care, internationally there is an issue with this.

"In Ireland, this year there has been an unseasonably large number of flu-like presentations in emergency departments over the winter period. There have been problems recently with pressures on the system and a larger number than anticipated admissions through EDs.

"If the acute medicine, emergency medicine and surgery programme hadn't done their work, looking at unscheduled care, then the pressure on our system recently would have been much higher than it actually was."

But are the clinical programmes going to get to the bottom of these basic access problems?

"I would say, yes they are. The role of the programmes is to identify the correct care pathways and to provide that strategic vision for how services should be provided, with the operational side of the system then implementing those changes. Is it going to be easy to achieve? Of course not. But it is important to acknowledge that other countries have taken 15 to 20 years to implement the types of changes that have been seen in this country over the last couple of years."

Will the target to reduce outpatient waiting lists to one-year maximum and treatment lists to eight months in 2013 be achieved?

"It's important to put targets into context. We all need goals to move toward. Yes, we hope to achieve them; however, it is all about how you change-manage things that have been in place for a long time. I hope we do achieve the targets and the work of the programmes may help to facilitate the achievement of the targets, providing the pathways that might help that to become a reality. For example, on outpatient lists the lists are being validated and once that is completed there will be a lot of numbers that can be removed from the lists," she explained.

Dr Carroll says as a result of the work of the acute medicine programme, there have been in excess of 50,000 bed day savings last year.

So, presumably the idea is to free up beds more quickly for people who need them. But they are still getting clogged up in spite of these efforts is that related to the fact that the system is not really fixed yet?

"Absolutely. If you look at healthcare internationally, there is an increasing demographic. We are surviving longer with multiple conditions. So the likelihood is that there is going to be increased demand on our health services. In terms of planning these services we have got to take that into account. Unfortunately, nowhere in the world has managed to come up with a definitive answer."

Regarding improving access to care, Dr Carroll believes the solution to this lies in implementing the clinical programmes. "We want services to be timely, efficient, effective. We want them to be equitable, patient-centred and the number one thing, safe."

But can the system be improved against a backdrop of massive cuts?

"The financial situation is certainly a challenge, but we also have the challenge of an ageing population, of people surviving with more complex conditions and increasing expectations about what our health systems can provide. We have to have adaptability and flexibility in our services to take all those things into account. Equitable access as well as efficiency and effectiveness is also very important. I believe we can improve the quality of our services even in constrained financial times, and we are doing that."

Dr Carroll agrees that there will always be a concern on whether you can make so many cuts without compromising safety.

"The World Health Organization has made recommendations about what types of cuts can be sustained within a healthcare system without impacting on services. The impression I would have is that we haven't reached that point yet. We have certainly got the capacity and the capability within our system to improve things with the resources we have."

Does Dr Carroll think there has been enough progress in efficiently moving a good deal of hospital care to primary care?

"I don't think things ever happen as quickly as people would like, but from linking in with the International Institute of Healthcare Improvement, I have been quite reassured about our rate of progress, because in talking to the experts there, they say that their journey has been one of about 20 years.

"This type of radical change takes time. If you think that in America, their journey towards reform has been one of 20 years, I am very reassured about what we have managed to achieve in a very short period of time in terms of the programmes- around two and a half to three years," she said.

Dr Carroll says a framework is needed for how we are going to manage long term conditions and that will be a challenge, given our ageing population and the large number of people with more than one disease at a time.

"The other major role of the programmes is prevention, so we need to work with the Department of Health on the prevention of chronic diseases, and we now have a chronic diseases programme up and running. And another important focus is end of life, making sure each programme is thinking about end of life and palliative care issues," she added.

But are the resources there to allow primary care to take on the care of more patients within this new framework?

"I want to make sure we develop a framework for the management of long-term conditions. We have some excellent examples of how care can be provided for some particular diagnostic groups but the challenge always is how do you pull those different pathways together if you have an individual who may have a number of conditions.

"Potentially you could have a GP or hospital doctor with eight or nine care bundles sitting in front of them, so we really need to have a framework for how we are going to manage long-term conditions and that is going to be a challenge, looking at our ageing population and the large number of people with more than one disease at a time."

But the bottom line surely is that the Department doesn't have any extra money to allocate to primary care to resource them to take on extra patient workloads.

"Well, that needs to happen. But I do think there is plenty we can be doing in terms of setting out how care can be provided in the community and looking at how far away from the ideal we are and what we can be doing in the meantime. That's why I am really looking forward to the primary care lead being appointed shortly so that we can really start to look at that," she said.

Is the ultimate key to achieving equity in the system sorting out eligibility in terms of universal health insurance?

"I think it is important that whatever we do, we ensure that our citizens have access to quality services, regardless of how we fund it. We need to make sure we are keeping an eye on what's happening elsewhere in the world, so that we don't make the same mistakes that have been made in other countries. As a society and as citizens within that society, if we value our health services, we need to be prepared to pay for them.

"I am NHS 'born and raised' and I think it is extremely important that all individuals have access to the services they require when they need it and not based on ability to pay. I don't believe in a two-tier health system. It shouldn't be a case of 'public' or 'private' services, it should simply be 'our health services'."