COPE Galway
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What changes in models of care and in the way we deliver care are (a) most urgent, and (b) what implication will this have on capacity requirements?

COPE Galway is a local Galway charity that provides a range of services to some of the most vulnerable and isolated people in Galway. The services we provide are across three areas:

- Homeless Services
- Domestic Violence Services for women and children
- Services for Older People

Our vision is Improved Quality of Life in a Home of your own for people affected by Homelessness, Women and Children experiencing Domestic Violence and Older People.

COPE Galway Senior Support comprises of three different areas - Community Catering, Sonas Day Centre and Community Support. The growth in the number of people over 85 is at a rate of 4% with an expected quadrupling from 100,000 to 440,000 nationally by 2041(Galway City and County Age Friendly.2014). With the stated government policy and the preferred choice of the majority of older people to remain living independently there is a requirement for significant investment in community support for older people. CSO figures from 2015 highlight that 10.7% of people aged 65 and older are at risk of poverty with another 2.7% living in consistent poverty. COPE Galway's, Community Catering provides approximately 155 meals for older people every day. Whilst the majority of older people currently receive regular (unmodified) meals, a growing number of vulnerable older people (80+) require a home delivered meal modified to suit their medically related dietary requirements. Modified meals can be divided into two broad categories: firstly, those addressing medically related dietary requirements including diabetes, coeliac or renal conditions; secondly, those appropriate to older people who have dysphagia – a difficulty with the swallowing process. In recent years we have experienced an increase in the number of modified meals we are producing & delivering to older people. Currently approximately 30% of our meals fall into the modified category equating to 14,500 meals per annum. Both modified meal diets are challenging for an older person and/or their carers to manage. At a time when an older person needs high quality nutritional support, it is our experience that they are often unable to manage this. They often struggle to cook an appropriate nourishing meal that meets their needs and they make do with something basic. These modified meals allow the older people COPE Galway works with to continue to live in their own homes.

COPE Galway operates a range of services to people who are homeless or at risk of homelessness including Preventative Services for those at risk of homelessness, Emergency Accommodation for people who are homeless, Transitional Accommodation and Resettlement and Tenancy Support for those who are moving out of homelessness into independent living. It is well established that homeless peoples' physical health is worse than the general populations and they are more likely to suffer from mental health conditions (O'Reilly, F. Barror, S. Hannigan, A. Scriver, S. Ruane, L., MacFarlane, A. and O'Carroll, A. 2015. Pg. 9) with "the severity of their illness being higher due to a number of factors such as poverty, delays in attending the doctor, non-compliance with medication, cognitive impairment and the effects of homelessness"(O'Carrol, A. 2013. Pg. 11). Respondents to a Partnership for Health Equity survey

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highlighted that almost 50% felt their health as only fair or poor with almost all respondents reported having mental or physical health problems. Almost half of the respondents had experienced mental health issues as well as addiction problems (Dual Diagnosis) and over half the respondents had previously experienced suicidal thoughts with more than a third had attempted suicide (O'Reilly, F. Barror, S. Hannigan, A. Scriver, S. Ruane, L., MacFarlane, A. and O'Carroll, A. 2015. Pg. 47). A snapshot survey by the Simon Community also found respondents had high levels of physical and mental illness and problematic drug and/or alcohol use. Respondents frequently had complex and overlapping health conditions and problematic drug and alcohol use and these complex health conditions required a range of interventions. They found that many respondents present infrequently or in some cases not at all. They identified that having a medical card is key to accessing services and cost was the key barrier in accessing services. They found the chaotic nature of respondents' lives together with lack of medical card; negative experiences of the health service and the prioritisation over other needs such as shelter means health needs can be ignored and left undiagnosed. The findings of the Simon Community health snapshot suggest that health provision for those who are homeless, needs proactive and co-ordinated primary health care services which can also direct people to the most appropriate source of health support needs (Walsh, K. 2011.Pg 36).

Any capacity review must address the issues mentioned above in terms of both older people and homelessness as well as begin planning for the growth in an ageing population, rising levels of ill health and ongoing service deficits. The current approach to healthcare is based on problem oriented care, gives little consideration to the person's experience, preferences and knowledge and instead focuses on professional knowledge and interventions on behalf of the person (Age Action. 2016. Pg. 3). This 'deficit' approach is not effective as care is provided to those most in need such as those at risk and emergencies rather than taking preventative or early intervention measures. This 'deficit' approach is more costly and has implications for the sustainability of this current approach (Age Action. 2016. Pg. 6). Health Policy and Services need to move towards an asset based approach which strengthens and promotes factors that protect against poor health, supports good health and wellbeing as well as fostering communities and networks that sustain health. Early intervention and self-management are resourced and prioritised with care being delivered in the community therefore reducing pressure on hospitals (Age Action. 2016. Pg. 3). This approach is based on creating and sustaining support in the community, outside of the traditional boundaries of health and social care services and promotes good health and wellbeing and strong social connections (Realising the Value. 2015. Pg. 1).

COPE Galway feels that in terms of models of care and delivery of care that are most urgent for older people and those who are experiencing homelessness are:

- Develop comprehensive services in the community by moving away from high cost, reactive acute care services towards primary and social care services. These services should be preventative, proactive with integrated care that are close to peoples communities, focusing on managing chronic illness and maintaining health and well-being (Age Action. 2016. Pg. 6). These community services should be available for everyone in the community.

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- Ensure there is a statutory entitlement to homecare and make available comprehensive services to support independent living. Homecare can be difficult to access and the provision of these services is discretionary and is dependent on the available resources in a particular area at a particular time (Age Action. 2016. Pg. 8).

- Chronic disease management should be expanded to cover more conditions and these programmes should be made available in every Primary Care Centre making them available to everyone in the community.

- Examine the current skill mix within the health care system. While the greatest demand on services in the future will be to meet the needs of those with multi-morbidities that require health and social care (Age Action. 2016. Pg. 7). As the biggest growth will be in the need for hands-on, out of hospital and social care, additional training for less qualified staff such as health care workers needs to be provided in order to meet this need (Age Action. 2016. Pg. 7).

- Delayed discharges need to be addressed by providing care and support in the community. These community services should be available for everyone in the community.

- The Development of a Primary Health and Social Care Hubs where homeless people can attend for nursing and medical care from doctors, nurses, dentists, physiotherapists, chiropodists and occupational therapists as well as for social welfare, housing and key working services from social care providers, is an ideal approach to the delivery of a holistic framework of health service provision. It is suggested that these services be located within the one building and that all those who attend whether for medical, housing or social care needs would be encouraged to avail of the other services (O'Carrol, A. 2013. Pg. 3) These Primary Health and Social Care Hubs will support the role of Homeless Action Teams by ensuring better coordination and management of services meaning clients will not fall through 'gaps' in service provision and there will be no duplication of services. It will also improve outcomes for individuals with high or diverse support needs. Within this service there needs to be capacity to work on an outreach basis in order to engage with those no longer linking with services as well as to work with those who are now living in their own home. The Development of Intermediate Care Centres to be attached to the Primary Health and Social Care Hubs. A major gap in healthcare for those who are homeless lies in the recuperative phase of care that follows a medical intervention. Due to the shortages in beds, hospitals cannot keep such patients until completion of their, often long, recovery period; while nursing support at home is also impossible. This intermediary gap between hospital discharge and complete recovery indicates a need for a working model of 'intermediate care' facilities; this may offer a promising alternative to long-term hospital admission for vulnerable groups of patients (De Maio, G, Van den Bergh, R, Garelli, S. Maccagno, B. Raddi, F. Stefanizzi, A. Regazzo, C .Zachariah, R. 2014) .
- There needs to be greater collaboration between drug and alcohol services and general mental health services in order to improve health outcomes for people with dual diagnosis (Simon Communities in Ireland, 2016. Pg. 3).

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(b) What implications will this have on capacity requirements?

In order to ensure access to healthcare for all, Universal Healthcare needs to be implemented, as the Sláintecare Report highlights "In Ireland, access to health and social care is not just determined by eligibility. It is also dependent on the type, volume and geographic location of services. Guaranteeing eligibility or even an entitlement to care does not ensure access, unless treatment can be provided within a reasonable timeframe" (2017. Pg. 16). The report goes on to emphasize that "Access to universal healthcare brings significant outcomes in terms of improving access to care, better health status and life expectancy, lowering financial hardship and improved equality"(2017. Pg. 16). In order to implement Universal Healthcare there needs to be a move towards an integrated model of care. Integrated Care can enhance quality of care and patient outcomes and has the potential to improve patient experience and lower costs (Irish Medical Organisation. 2016. Pg. 16). This model would involve the vast majority of healthcare being provided in the community and would involve the expansion of the entitlement to primary and social care services. The capacity of primary care, general practice and public hospital care to deliver better access would need to be expanded (Slaintecare. 2017. Pg. 56). There would be several implications on capacity requirements. There would need to be investment in Primary Care and Social Care in order to meet demand nationwide. The reforms to healthcare would have staffing implications and staffing numbers would need to be increased in order to have sufficient numbers of the range of disciplines including GPs, health care assistants, home helps, nurses/midwives, occupational therapists, physiotherapists, speech and language therapists, social workers and administrators and receptionists to provide adequate care in the community. In order for this to be fully implemented

- Inpatient charges for public hospital care would be removed, while prescription charges for medical card holders would need to be reduced.
- Community diagnostics would be required to expand and treatment services moved into the community.
- Counselling services being provided by private providers through GP and Primary Care referrals would be extended.
- Public Psychology services in primary care need to be developed. Access to Universal GP and Primary Care needs to be provided for.
- Palliative care needs to be provided for.
- Homecare provision needs to be increased. Additional services for people with disabilities need to be provided for.
- Funding needs to be increased for Child and Adolescent Mental Health Teams, Adult Community Mental Health Teams, Old Age Psychiatry, Child and Adolescent Liaison and Intellectual Disability Mental Health Services as well as for those with dual diagnosis in order to ensure timely access to these services.

2. How can Current Capacity be effectively used.

Current Capacity could be affectively used by developing comprehensive Primary Care as well as increasing funding and resources for General Practice. Primary care is where the vast majority of healthcare needs can be addressed at the most appropriate level of complexity and at least cost. It is, however, fragmented

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and insufficiently developed to meet increasing needs in an equitable manner (Department of Health. 2016. Pg. 5).

General Practice should have a central, enhanced role in Integrated Care Programs and Clinical Care Programs as a complete community-based chronic disease management programme, including the management of patients with two or more chronic medical conditions (multi-morbidity), will reduce healthcare costs and improve patient outcomes(Irish College of General Practitioners. 2016. Pg. 4). This will decrease the number of visits to Emergency Departments and allows hospitals to focus on secondary care and facilitate the necessary capacity for the creation of a single-tier universal healthcare system (Irish College of General Practitioners. 2016. Pg. 4). Implementing universal healthcare coverage for primary care will improve access, when less than half of the population has free access to primary care. By developing patient-centred programmes at primary care level will strengthen disease management. The continued support of the development of multi-disciplinary primary care teams (OECD. 2016) will strengthen primary care; this will reduce avoidable hospital admissions for those cases that could be treated in a primary care setting (OECD. 2016).

Despite the prevalence of mental health problems and their often chronic and debilitating nature, Irish public health policy has repeatedly failed to allocate the required resources to tackling these problems. Despite an increase in expenditure on mental health services it equates to only 6% of the overall health budget, a reduction in mental health funding as a proportion of the overall health budget in recent years (Mental Health Reform. 2017. Pg . 4) and is still below the 8.24% level recommended in "A Vision for Change" (2006. Pg. 178). Poor mental health costs the State an estimated €3 billion a year (Pringle, T. 2016) and the proportion of overall ill health caused by mental ill health is estimated at 20–25% (2006. Pg. 74). As *A Vision for Change* highlights "it is evident that the progressively declining percentage of total health funding devoted to mental health is inequitable" (2006 Pg. 178).

COPE Galway and other non-profit organisations play an important role in delivering many social care and community services including services for older people. COPE Galway has seen cuts to its funding for its Older Peoples Services from €176,573 in 2009 to €158,132 in 2012 and since 2013 this funding has remained static at €154,000. This reduced funding leaves these vital services reliant on funding from other sources including fundraising to ensure that a quality service is continually provided. COPE Galway would like to remind the Government that the Fine Gael Election 2016 manifesto stated *"we are committed to significantly enhancing older peoples' services over the next 5 years"* (Fine Gael. 2016. Pg. 70) as well as committing to *"making our older years better years, and ensuring Ireland is a supportive country to grow old in"* (Fine Gael. 2016. Pg. 100). With this in mind Section 39 funding for services such as those operated by COPE Galway and other non-profit organisations that are similar or ancillary to those provide by the HSE should be increased.

The number of home help hours provided in 2016 was approximately 10,570,000 nationally and the same amount is expected in 2017(Health Service Executive. 2016. Pg. 35). This is a decrease from the 11,092,436(Health Service Executive. 2012. Pg. 58) home help hours delivered in 2011. The number of people receiving a home care package in 2011 was 15,270 (Health Service Executive. 2012. Pg. 57), while in 2016 this was estimated to be 16,450 (Health Service Executive. 2016. Pg. 106), an increase in number of

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people receiving home care packages but a decrease in number of hours available. There are currently 4,500 people are on a waiting list for home help hours or home care packages and that number will grow(Moran, J. 2017). While a review of the homecare package is welcomed, homecare hours need to be increased.

With changing demographic pressures, there is a need to change the approach to meet these healthcare challenges and to develop person-centred, co-ordinated models of care for everyone, thereby improving outcomes, patient experiences and effectiveness of care. While integrated care programmes have been established on a phased basis in five areas,

- Integrated Care Programme for Patient Flow
- Integrated Care Programme for Older People
- Integrated Care Programme for the Prevention and Management of Chronic Disease
- Integrated Care Programme for Children
- Integrated Care Programme for Maternity.

However it has been reported that the development of primary care centres has been too slow. The introduction of integrated care which began 2016, with the creation of primary care networks within community health organisations needs to be prioritised and requires incentivised payments for General Practitioners. There needs to be a grants or direct provision to General Practitioners to provide diagnostic services leading to less unnecessary referrals to Emergency Departments. An increased fee on Primary Care Reimbursement Service to General Practitioners is needed. Along with Social Care Workers and Social Workers, General Practitioners will be an essential part of the integrated care preventing people from going to an Emergency Department (O'Connor, T. 2017).

In order to properly introduce Universal Health, the actions mentioned above would need to properly resourced and funded. There needs to be a move in the balance of funding towards primary care services, preventative care services and mental health services. This means ending the push towards privatisation and investing in a public healthcare system. It requires the better management and planning of resources with priority given to addressing the under-funding of primary care and mental health services and for implementing funding commitments for staffing levels in primary care and mental health (Pillinger, J. 2012. Pg. 48)

What do you consider the priorities for capital investment over the next 15 years.

There needs to be an overall priority to continue to invest in Irelands Healthcare. Areas of Priority would be

Primary Care. There needs to be a continued investment in Primary Care. Primary Care needs to become the first place to turn to when sick; it needs to be well-equipped, flexible and accessible seven days a week with services available out of hours. These services must be extended throughout the country. Provision must also be provided for the development of a Primary Health and Social Care Hubs where homeless people can attend for nursing and medical care from doctors, nurses, dentists, physiotherapists, chiropodists and occupational therapists.

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Intermediate Care for those who are homeless. Funding needs to be provided for the development of Intermediate Care Centres for those who are homeless and leaving hospital. Homeless people being discharged from healthcare need time to recuperate but without suitable accommodation regaining health is extremely difficult.

Addiction Services. Additional funding for the development of additional capacity among drug treatment services and services providers needs to be prioritised. Increased capacity will enable a greater number of people to access treatment and respond to the changing needs of people in addiction, such as dual diagnosis as well as changing trends in drug use.

Mental Health. Investment in Mental Health must be equal to that of physical health. Mental health disorders affect one in four adults in Ireland. A Vision for Change put in place a plan the transfer of mental health services to a community-based setting over a period of 7-10 years. Progress on this plan has been slow however, and implementation has been poor with inadequate and uneven distribution of resources(Irish Medical Association, 2016, Pg. 6.) . There needs to be increased investment in mental health services including increasing the capacity of counselling and psychotherapeutic services in the community reducing the numbers with mental health issues requiring referral to specialist mental health services (Irish Medical Association, 2016, Pg 7.).

Homecare. In order to ensure statutory, equitable homecare services for all those in need adequate funding needs to be prioritised. Without the certainty of a home care allocation, those with low to moderate levels of dependency, who could continue to live at home have no other option but to go into long term residential care with a substantial cost to the state (Age Action, 2016, Pg. 9).