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ag freastal ar Ghaillimh, Maigheo agus Ros Comáin

Community Healthcare West
serving Galway, Mayo and Roscommon

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17th July 2019

Deputy Anne Rabbitte
Constituency Office
Main St.,
Loughrea
County Galway

PQ 30202/19
To ask the Minister for Health if a chronic disease programme has been established in CHO2 to develop integrated care for patients managed by their general practitioners and the acute hospitals.

Dear Deputy Rabbitte,

The Health Service Executive has been requested to reply directly to you in the context of the above Parliamentary Question which you submitted to the Minister for Health for response. I have examined the matter and the following outlines the position.

National Clinical Programmes (NCPs) for each of four chronic illnesses aligned to the Integrated Care Programme: Diabetes, COPD, Asthma and Heart Failure were established nationally to bring together health professionals, HSE management, medical colleges and the Department of Health to improve and standardise patient care in their respective clinical areas. Each of the NCPs has a Clinical Lead, a multi-disciplinary Working Group (including patient representatives), and a Clinical Advisory Group. The overall aim is to reform and improve service delivery for patients and clients.

A number of posts were allocated to Community Healthcare West initially in 2013 and in 2017. These posts are aligned to the hospital service with the clinicians appointed providing support to general practices in the catchment area of the hospital.

The Local Implementation Governance Group (LIGG) for Chronic Illness in Community Healthcare West set up in 2017, Chair Mr Seamus Beirne GM, provides the governance mechanism overseeing implementation of the Integrated Care Programme for Chronic Disease in the region, including the governance of integrated care staff delivering integrated care services improvement initiatives in the community. This group has representatives from both Hospital and Primary Care. Dr Therese O'Reilly is the GP representative.

Diabetes Integrated Care: Type 2 Diabetes
In a step towards the reimbursement of general practice for chronic disease management, the Cycle of Care was introduced by the government in 2015. It provides remuneration for GPs to

provide two review visits per year for people with uncomplicated type 2 diabetes who are in receipt of a medical-card / GP-visit card (both means-tested). In 2018 the HSE published a national Model of Integrated Care for People with Type 2 Diabetes, which outlines a care pathway in which the vast majority of people with type 2 diabetes will be managed in Primary Care.

The national model of care for people with Type 2 diabetes espouses the concept of 'Integrated care', where primary, secondary and tertiary care come together and communicate effectively and coherently to manage the person with Type 2 diabetes. Care is delivered by a community based Integrated Care Clinical Nurse Specialist (Diabetes) and a Community Dietitian for Diabetes working with patients, general practice and the acute sector. This includes patient self-management group education 'DESMOND' delivered in the Primary Care setting. Diabetes Podiatry Posts are designed to support the National Foot Care Model.

Community Healthcare West Posts:

- University Hospital Galway Diabetes CNS & Diabetes Dietitan in post 2013
- Mayo University Hospital Diabetes CNS 2013 & Diabetes Dietitan 2017
- Portiuncula University Hospital Diabetes CNS & Diabetes Dietitan in post 2017 Co Roscommon Diabetes Podiatrist post 2017

Respiratory Integrated Care: COPD/Asthma

The Respiratory Integrated Care Demonstrator Project will begin to develop a service at Primary Care level to support the general practice management of patients with COPD and Asthma to improve patient outcomes and reduce emergency attendance and admission. The project will deliver Chronic Pulmonary Airways Disease (COPD) and Asthma management in the Primary Care setting to patients with evidence of poorly controlled disease. It will also provide objective diagnosis and initial management of patients who are suspected of having undiagnosed COPD and asthma. Care will be delivered by a community based Integrated Care Clinical Nurse Specialist (Respiratory) and Senior Respiratory Physiotherapist. This includes Pulmonary Rehabilitation classes for groups of patients delivered in the Primary Care setting.

Community Healthcare West Posts:

- University Hospital Galway Respiratory CNS & Respiratory Physiotherapist in post 2017
- Mayo University Hospital Diabetes Respiratory CNS & Respiratory Physiotherapist in post 2017 – CNS post vacant at present

Heart Failure Integrated Care:

In Co Galway there were local appointments in 2009 of two Cardiovascular CNS Heart Failure, one linked to UHG and one linked to Portiuncula University Hospital Ballinasloe.

The heart failure service in Co Galway is supported by the Community Heart Failure Management Programme (CHaMP) where patients can be cared for in a timely manner within their own community in collaboration with the appropriate Hospital services, with the focus on improving their health behaviours, health promotion and empowering patients to self-manage. This service is in keeping with the implementation of chronic disease programme which aims to provide a structured approach to the management of patients with heart failure

optimising care for patients, reducing hospital admissions and improve mortality rates and quality of life. The community CNS supports General Practitioners in the management of their patients using a protocol developed locally which supports alignment of services, diagnostic procedures, treatment and medication plans between Primary and Secondary care.

To ensure patients living in rural areas have access to and support from specialist care, community nurse led clinics are held in several Primary Care locations across Co Galway. Patients referred to the CNS who is a registered nurse prescriber are supported in the management of their condition which includes structured education, guideline directed medical therapy and supportive interventions for patients and their families. Acting as a liaison the CNS can refer complex patients and those requiring further investigation to the hospital heart failure service in a timely matter enhancing collaborative working between primary and secondary care for the benefit of patients living with HF.

- University Hospital Galway - CNS Heart Failure 100% community based, holding nurse led clinics in Primary Care Centres and Health Centres in West Galway working in conjunction with Hospital based CNS Heart Failure, Cardiologists and General Practitioners
- Portiuncula Hospital Ballinasloe - CNS Heart Failure based in PUH and providing nurse led outreach clinics in East Galway area.

Self-management Support – implementation of national framework in Community Healthcare West

Chronic conditions are recognised as a major component of health services activity and expenditure, as well as a major contributor to mortality and ill-health. 38% of Irish people over 50 years have one chronic condition, and 65% of adults over 65 years have 2 or more chronic conditions. Self-management support, through systematic provision of education and supportive interventions, increases patients' skills and confidence and improves outcomes – ranging from quality of life and clinical outcomes, to reduced healthcare utilisation, including hospitalisation. Self-management support is key to delivering person-centred care, in which patients are empowered to actively participate in the management of their condition.

Healthy Ireland in the Health Services - National Implementation Plan recommended the need for a national framework for self-management support and development of services accordingly. In recognition of this, the *Living Well with a Chronic Condition: Framework for Self-management Support* was launched in October 2017.

Some recommendations have been prioritised for early implementation based on likelihood of maximum beneficial impact, and strongest evidence. These include recommendations to increase the provision of Cardiac Rehabilitation, Pulmonary Rehabilitation and Diabetes Structured Patient Education.

Self-management Support Co-ordinators have been appointed in each CHO to ensure the national framework is implemented in an integrated way at local level; across the CHOs, Hospital Groups and community, voluntary and other statutory organisations. The Co-ordinators will focus initially on mapping existing services and identifying gaps; developing

local directories of services and promoting awareness and engagement by healthcare professionals and patients.

A mapping exercise of all self-management support services in Galway, Mayo and Roscommon is underway by the Self-management Support Co-ordinator. This mapping process will inform the development of a directory of services in each county. This directory will facilitate HCPs in referring/signposting their service-users to appropriate condition-specific and generic self-management supports.

Community Healthcare West Posts:

- Self-Management Support Co-ordinator for Chronic Conditions appointed to Community Healthcare West

In order to roll out a comprehensive service resources are required. Current ratio of CNS Diabetes in Community Healthcare West with a population of 453,413 (CSO 2017) is 1 WTE per 151,138 population with no service in Co Roscommon. Recommendation is 1 WTE per Health & Social Care Network or population of 75,000.

I trust this information is of assistance to you, but should you have any further queries please contact me.

Yours sincerely

Frank Murphy
Head of Primary Care Services
Community Healthcare West