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5th July 2021

Deputy Louise O'Reilly, TD
Dáil Éireann
Leinster House
Kildare Street
Dublin 2

RE: PQ 21097/21

To ask the Minister for Health the status of the implementation of recommendation 4.8 of Changing Cardiovascular Health: National Cardiovascular Health Policy 2010 – 2019; the actions that were taken to ensure full implementation; the aspects outstanding; and if he will make a statement on the matter.

Dear Deputy O'Reilly

The Health Service Executive has been requested to reply directly to you in relation to the above parliamentary question, which you submitted to the Minister for Health for response. I have consulted with the National Heart Programme on your question and have been informed that the following outlines the position.

The National Heart Programme (NHP) (incorporating the former National Clinical Programme for Heart Failure) has been involved in the development and implementation of a number of initiatives and resources to increase and support the capacity of primary care to detect heart failure at an early stage and to provide pro-active care, including:

Education of Primary Care Team

- Development of a Heart Failure eLearning module available on HSELand, aimed at general practice staff and available to all involved in the care of HF patients;
- An information document for General Practice, i.e. Heart Failure in General Practice;
- Development of booklets for general practice including: (a) Heart Failure Diagnosis and (b) Management of Heart Failure and co-morbidities;
- NHP members have contributed to several Heart Failure informational videos and a webinar: Heart Failure in General Practice - Tips and Tricks;
- NHP signposts and highlights key resources available from other sources including the Heartbeat Trust, CROI, the Irish Heart Foundation (IHF) and HeartFailureMatters.org.
- NHP has also supported printing of patient heart failure resources and information packs.

Heart Failure Model of Care (HF MOC)

A Heart Failure Model of Care (HF MOC) was first developed in 2012 and has been in use in 12 Acute Heart Failure sites throughout the country. The Model of Care has been extensively rewritten and updated. This document is in the final stages of approval and should be available to clinical practice shortly. It aims to reflect the spectrum and levels of services outlined by Integrated Care Programme for the Prevention and Management of Chronic Disease. The spectrum of services is ideally delivered across all levels of service delivery settings. The HF MOC proposes to change how we deliver care to people with HF or at risk for HF and support a national model of integrated care, following international best practice and covering the full spectrum of care for HF. The MOC focusses on the development of partnerships between the acute hospital services, general practice led community services, the patient and families.

Heart Failure Integrated Care Clinical Nurse Specialists (IC CNS)

IC CNS provide specialist heart failure reviews in local GP practices and facilitate GP-provided optimal medical care for heart failure. They provide improved treatment in the community through CNS-GP aided care, reducing travel time for patients and families and reducing the need for attendance at hospital-based outpatient services. The IC CNS is an 80%/20% integrated nursing role - general practice and secondary care based respectively.

Virtual Consultation Service

Appropriate use of specialist advice and avoiding need for hospital and outpatient attendance has been a key target of this programme. Recognising that giving GPs access to senior specialist advice in a structured and timely manner will avert the need for Outpatient Department (OPD) and Emergency Department (ED) referrals has led to the development of virtual consultation (VC), where GPs, practice nurses and specialist staff interact using web conference technology to discuss and manage cases collaboratively. This VC also allows simultaneous education for the multidisciplinary group. VC allows direct specialist diagnostic access for patients discussed at VC, where appropriate. The VC service should lead to a reduction in the need for onward referral to routine outpatients, leading to a reduction in unnecessary travel for many.

These services were first piloted in the St Vincent's University Hospital (SVUH) catchment area and subsequently in Carlow-Kilkenny area. IC CNS support GPs to refer patients into the heart failure virtual consultation clinic in the St Vincent's/ St Michael's Hospital Heart Failure Unit. These services have now been mainstreamed. Consolidation and scale-up of these two integrated care services were the basis for the Slaintecare Integration Fund (SIF) Project 237 – Heart Failure Virtual Consultation Service with Integrated Care Clinical Nurse Specialist (IC CNS) Supports in the Community. This project has allowed expansion of the service in the East Coast, as well as establishment of a new service in the Dublin North/ Mater Hospital area. There are six IC CNS Heart Failure posts, however, due to COVID-19 pandemic and recruitment issues, three of these posts are currently vacant.

It is planned that the above service will now be subsumed into the **Enhanced Community Care Programme (ECCP)** and delivered as part of the **Integrated Care Programme for Chronic Disease**. As part of Phase 1 of the ECCP, funding has been made available to support 18 Integrated Care Specialist Ambulatory Care Hubs in the community, with an additional 12 hubs also planned. Each of these specialist community hubs will have 3 Cardiovascular Disease (CVD) Integrated Care CNS (IC CNS)

working in the community, serving a population of approximately 150,000 and their role will incorporate care of patients with heart failure. The will be part of a larger Integrated Care Specialist team, with access to diagnostics and additional supports, including cardiac rehabilitation, psychological supports and dietetics, as the hubs develop.

Additional Community Projects

The National Heart Programme (NHP) has piloted a number of community heart failure projects including:

- Midland STOP HF Prevention Programme - screening for Asymptomatic Left Ventricular Dysfunction in Diabetic Cohort in the Community;
- Community New Diagnostic Clinic (Gorey/ Wexford/ SVUH Group);
- A number of Medicines Management Interventions in Cardiovascular Disease.

Structured services for the management of Acute Decompensated HF (ADHF)

In the acute setting, structured specialist hospital services for patients presenting with acute decompensated HF (ADHF), including programmatic post discharge follow up, have been established at 12 sites. These sites deliver an integrated service through the HF MOC.

Tele-monitoring to support self-care

The role of tele-monitoring and how best to apply is still under investigation internationally. There is a close liaison between some of these international efforts and one of our HF units. Throughout the COVID-19 pandemic, remote monitoring, using routine telephone contact, has been provided but this is not envisaged as a platform for routine self-care delivery.

Information Technology (IT) capacity to facilitate communication between primary and secondary care, including establishment of registers and audits - Heart Failure Virtual Consultation (HFVC)

This innovative approach facilitates real-time, on-line specialist support to general practitioners (GPs) and prompt access to diagnostics. With the addition of IC CNS supports in the community GPs are enabled to safely manage an at-risk population in the community. GPs refer patient cases to a virtual online clinic with a Specialist Consultant. A number of GPs can join at any one time. The data from the referral is anonymised and transferred to a presentation template. Each case is discussed online and a consensus approach reached for the future management of each patient. This service will be rolled out as part of the ECCP to be delivered in the Community Ambulatory Care hubs.

Palliative Care

HF is a chronic progressive incurable disease. As such, many patients will develop physical, psychosocial or spiritual distress related to their illness and experience a reduced quality of life. Palliative care needs may arise at any point in an individual's illness journey, but they often become more severe and burdensome as the disease advances. The majority of patients die with, rather than from, Heart Failure. It is important to consider end of life care. HF symptoms can be troublesome and require management.

The national referral criteria for specialist palliative care recognise that specialist palliative care should be provided on the basis of need rather than diagnosis, thus recognising the contribution that specialist palliative care can make to the care of people with heart failure and their complex palliative

care needs. Services are requested on a needs-basis. The Model of Care for Heart Failure recommends that units establish links with local specialist palliative care services for patients with Acute decompensated Heart Failure (ADHF).

I trust this information is of assistance to you, but should you have any further queries please do not hesitate to contact me.

Yours sincerely

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Anne Horgan
General Manager