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**15th October 2021**

**Deputy Sorca Clarke**
**Dáil Eireann,**
**Leinster House,**
**Kildare Street,**
**Dublin 2.**

**PQ 48370/21**
**To ask the Minister for Health the costs associated with the national roll-out of heart failure integrated core projects in the community.**

**-Sorca Clarke**

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Dear Deputy Clarke,

The Health Service Executive (HSE) has been requested to reply directly to you in the context of the above Parliamentary Question, which you submitted to the Minister for response.

SIF Project 237 Heart Failure Virtual Consultation (HFVC) Service, with integrated care clinical nurse specialist (IC CNS) support in the community was based in two sub-areas:

1) St. Vincent's University Hospital/St Michael's (SVUH/ SMH) and Community Healthcare East (CHO 6)
2) Mater Misericordiae University Hospital (MMUH) and/ CHO Dublin North City & County (CHO 9).

This project built on the success of the Carlow/Kilkenny HFVC pilot project, and that service has now been mainstreamed in the Carlow-Kilkenny area of South East Community Healthcare.

This innovative approach facilitates real-time, on-line specialist support to GPs, and provides prompt access to diagnostics. With the addition of community based IC CNS's, GPs are enabled to safely manage an at-risk population in the community. A local hub team in both SVUH and MMUH consisting of the following: Clinical Lead (Consultant Cardiologist), Project Co-ordinator, HFVC Clinical Nurse Specialist, IC CNS's, Admin support, Clinical Physiologist support and GP advice, supported by a Change Manager was responsible for the implementation of the project.

The objective of the project was to provide an efficient service for Heart Failure patients presenting to GPs in the targeted areas, building on the excellent results achieved to date in Carlow-Kilkenny. The aim of the extended service was to reduce unnecessary referrals to both in-patient and out-patient hospital services, provide improved treatment in the community through CNS-GP aided care, as well as save traveling time for our patients and families. This service provides both HFVC's to GP's and patient appointments with IC CNS's in the community. SIF

237 was nominated by Slaintecare/ DOH for the Civil Service Excellence and Innovation Awards and has been shortlisted in the Excellence in Innovation category.

As part of the Enhanced Community Care Programme, funding has been made available in phase one to support 18 Integrated Care Specialist Ambulatory Care Hubs in the community, with an additional 12 hubs planned. Each of these specialist community hubs will have 3 Cardiovascular Disease (CVD) CNS's and a cardiac rehabilitation team serving a population of approximately 150,000 and their role will incorporate care of patients with heart failure. To support the roll out of the community hubs some acute hospital gaps have also been addressed with funding being allocated in phase one for 8.2 WTE Acute CVD CNS's and 7 Consultant Cardiologists – this integrated care cardiology team will incorporate provision of care for heart failure patients, including a virtual consultation service for GP's.

An integrated care cardiology team, including the acute staffing element of the team, costs approximately €655k.

Additional acute gaps will also be addressed in alignment with ECC Phase two developments and the detail of this is currently being finalised.

These medical consultants will provide services in the specialist ambulatory care hubs and this will support ready access to specialist opinion for individuals living with chronic disease including heart failure. Outpatient services will be offered from the hub with a focus on reducing waiting list times for outpatient services and supporting rapid review of urgent cases in an effort to avoid hospitalisation. This rapid access to specialist opinion can be critical in enabling GPs to continue to manage their patients in the community and to reduce Emergency Department and Acute Medical Assessment Unit admissions. The close integration between the specialist team and the GP, which will be facilitated by the sharing of information and the case management approach, will enable both the staff within the acute and primary sectors to manage patients who have complicated chronic disease, multi-morbidity or deteriorating conditions in a holistic and person-centred manner.

I trust this information is of assistance to you.

Yours sincerely,

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Yvonne O'Neill
National Director
Community Operations