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27th October 2021

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

RE: PQ 50277/21 & 50279/21

To ask the Minister for Health if he will provide details on services and programmes for heart failure and heart failure patients that make up part of the Enhanced Community Care Programme and those delivered as part of the Integrated Care Programme for Chronic Disease; and if he will make a statement on the matter

To ask the Minister for Health if he will provide details on the integrated care cardiology service to be provided as part of the Enhanced Community Care Programme Integrated Care Specialist Ambulatory Care Hubs; 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.

Integrated care cardiology community teams will act as a specialist support to general practice and an important link to acute specialist services.

The *Integrated Care Programmes for Chronic Disease (ICP CD) - Model of Care (MoC) for integrated prevention and management of chronic disease (cardiology)* - is being rolled out as part of the Enhanced Community Care Programme (ECCP). The ICP CD MoC cardiology service will include referral options to specialist nurse education, virtual consultation service, diagnostic services and cardiac rehabilitation programmes. Examples of cardiovascular conditions and services it is proposed to address in the community hub include: heart failure, atrial fibrillation, ischaemic heart disease, complex risk factor management and prevention.

As part of the engagement process for the roll out of the ICP CD MoC through the ECCP, the National Heart Programme (NHP) is hosting a series of discussion groups with the relevant acute sites and associated CHOs to discuss the proposed services. The community care teams, in collaboration with

CHO management, GPs and acute hospital colleagues, are now tasked with re-evaluating and reconfiguring existing service delivery to implement ambulatory care pathways to manage complex cardiovascular care and associated co-morbidities within the community setting, where appropriate. The specific detail of the service to be rolled out in each area will be determined to meet local need and guided by the ICP CD/ NHP.

In line with the proposed service, examples of care to support heart failure patients which may be delivered in the community hubs include:

- Initial work-up of undifferentiated dyspnoea;
- Medication Titration;
- Triage of clinical deterioration;
- Low-risk annual review.

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