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23rd September 2021

Deputy David Cullinane, TD
Dáil Éireann
Leinster House
Kildare Street
Dublin 2

RE: PQ 43156/21

To ask the Minister for Health the estimated cost of making heart failure community integration teams available nationally and standardising their roles across all CHO areas; and if he will make a statement on the matter

Dear Deputy Cullinane,

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.

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 – these posts will also incorporate provision of care for heart failure patients. 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

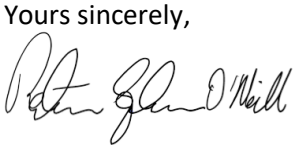
admissions. The close integration between the specialist team and the GP, which will be facilitated by the sharing of information and the case management approach, will enable both the staff within the acute and primary sectors to manage patients who have complicated chronic disease, multi-morbidity or deteriorating conditions in a holistic and person-centred manner.

The implementation of integrated care can be complex: a lack of a coordinated approach and a lack of clarity regarding goals are acknowledged as challenges to integration within the primary care setting. Key elements need to be in place to facilitate the integration of care and to ensure equity and standardisation of services for people with chronic disease. The Integrated Care Programme for the Prevention and Management of Chronic Disease (ICPCD), supported by the National Heart Programme has developed the 'National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland'. This framework builds on existing policies while also describing a continuum of health promotion, disease prevention, diagnosis, treatment, disease management and rehabilitation services that are coordinated across different healthcare providers and healthcare settings. It describes a new way of working together across the health continuum. There is strong evidence to support the positive impact of integrated care on the safety and healthcare experiences of patients, cost-efficiency of the health service and staff perceptions of the quality of care they are providing

The 'National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland: a 10-step guide to support local implementation' describes the key steps to enable the implementation, embedding, monitoring and evaluation of integrated care at the national and regional levels. The 10-Step Guide is intended to act as a guide to support local implementation of the ICPCD Framework. Integrating healthcare is complex, and this implementation guide accounts for local variation in geography, services and ways of working while also learning from the ICPCD's and ICPOP's practical experience on the ground. The role of the ICPCD and health services at the national level is to mandate and to provide support to local implementation groups. Better health system change is achieved by implementation "owned" in local areas, with a shared vision and agreement on locally-attuned pathways. Local groups are responsible for implementing the model of care in their specialist ambulatory care hub and networks, according to the national blueprint developed by the ICPCD.

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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Patricia Gilsenan O'Neill
General Manager, Business Management Office