Integrated Care Programme for the Prevention and Management of Chronic Disease

Operationalisation of Integrated Care Chronic Disease Nursing roles

July 2025

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Acronyms and Abbreviations

ADON	Assistant Director of Nursing
ADPHN	Assistant Director of Public Health Nursing
ANP	Advanced Nurse Practitioner
cANP	Candidate Advanced Nurse Practitioner
cCNS	Candidate Clinical Nurse Specialist
CD-CST	Chronic Disease Community Speciality Team
CHO	Community Health Organisation
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disorder
CPD	Continuous Professional Development
CVD	Cardiovascular Disease
DON	Director of Nursing
DONMs	Director of Nursing and Midwifery
DPHN	Director of Public Health Nursing
ECC	Enhanced Community Care
ED	Emergency Department
GDPR	General Data Protection Regulation
GP	General Practitioner
HSCP	Health and Social Care Professionals
HSE	Health Services Executive
IC	Integrated Care
ICPCD	The Integrated Care Programme for the Prevention and Management of Chronic Disease
ICT	Information and Communications Technology
KPIs	Key Performance Indicators
NMBI	Nursing and Midwifery Board of Ireland
MCPs	Modernised Care Pathways
MoC	Model of Care
MoU	Memorandum of Understanding
ONMSD	Office of the Nursing & Midwifery Services Director
OPD	Out Patient Department
PPPG	Policies, Procedures, Protocols and Guidelines
RANP	Registered Advanced Nurse Practitioner
SLA	Service Level Agreement
SOP	Standard Operating Procedure
WTE	Whole Time Equivalent

Glossary

CD-CST	The CD-CST is the term used to describe all members of the Chronic Disease Community Teams in Cardiology, Type 2 Diabetes and Respiratory (Asthma and COPD) integrated care services. These CD-CSTs are based in the community in various locations nationwide, depending on local arrangements (i.e. Integrated Care Hubs, Community Centres, and Primary Care Centres etc.) where they provide ambulatory specialist integrated care services to the local population.
IC nurses / IC nursing	cCNS / CNSs and cANP / RANPs are members of the integrated care CD-CST. For ease of reference these Integrated Care (IC) nursing posts will be referred as IC nurses / IC nursing throughout the document.
Inter-team speciality referral	Referrals between HSCPs on the specialty-specific team to support multidisciplinary approach to IC as required e.g. referral from Diabetes Dietician to Diabetes CNS.
Intra-team speciality referral	Referral between specialities within a CD-CST, to support multidisciplinary IC for patients with multi-morbid conditions e.g. referral from member of the IC cardiology team to a member of the IC respiratory team.
National Nurse Reference Groups (3)	There is one Nurse Reference Group for each of the 3 specialities of Cardiology, Diabetes (Type 2) and Respiratory (Asthma & COPD) to provide essential specialist nursing subject matter expertise and leadership, consisting of CNS, cANP and ANP representatives, ECC ICPCD Change Manager and chaired by the ICPCD DON.

1. Aim of the Guidance Document

Integrated Care for chronic disease is defined by the HSE (2020) as healthcare that is provided at the lowest appropriate level of care complexity, with services that are responsive and built around the needs of the patient, to support patients and empower them to optimise their health, so they are able to live well with chronic disease. The National Framework for the Integrated Prevention and Management of Chronic Disease describes an integrated approach to the prevention and management of chronic disease in Ireland (HSE, 2020). The Integrated Model of Care for the Prevention and Management of Chronic Disease (ICPCD MoC) is at the heart of this framework and demonstrates how "end-to-end" care can be provided within a health service that offers a spectrum of preventive, diagnostic, care and support services which are integrated, collaborative, person-centred and provided as close to home as possible.

Integrated care (IC) nursing posts were funded in the MoC across the three specialities; Cardiology, Diabetes (Type 2) and Respiratory (COPD and Asthma) and include Clinical Nurse Specialists (CNSs) and Advanced Nurse Practitioners (ANPs).

A significant number of IC Clinical Nurse Specialists (IC CNSs) and Integrated Care Advanced Nurse Practitioners (IC ANPs) are now in position across community and secondary care chronic disease services. The lived experience of these IC CNSs and IC ANPs have identified regional variations in the operationalisation of the IC components i.e. the 80:20 / 50:50 of the nursing roles across the Chronic Disease Community Speciality Teams (CD-CSTs) in the community ambulatory IC services and associated hospitals.

The aim of this guidance document is to inform the following key stakeholders on the background and key principles in the implementation and provision of the IC ANPs and IC CNSs chronic disease roles.

The key stakeholders include:

- Integrated Care Clinical Nurse Specialists
- Integrated Care Acute Clinical Nurse Specialists
- Integrated Care Advanced Nurse Practitioners
- Assistant Directors of Public Health Nursing
- Directors of Public Health Nursing
- Assistant Directors of Nursing
- Directors of Nursing
- Integrated Care Consultants (or relevant secondary care Consultant).
- Chronic Disease Operational Leads
- Regional DONMs
- Chief DONMs
- Office of the Nursing & Midwifery Services Director
- National Clinical Advisor & Group Lead for Chronic Disease
- Integrated Care Programme for Chronic Disease

National Clinical Programmes:

- National Clinical Programme for Diabetes
- National Heart Programme
- National Clinical Programme for Respiratory

The document will assist the key stakeholders in mapping the work flow and patient caseload of the IC nursing roles in implementing the IC component of the roles across both the CD-CST and secondary care settings, whilst maintaining fidelity to the MoC and aligning with the Sláintecare vision. The document also outlines examples of good practice received from IC nursing chronic disease post holders in demonstrating how to embed new ways of working.

Effective partnerships and an agreed approach between relevant stakeholders in the community and hospital is key to continuing the operationalisation of the IC nursing chronic disease roles to facilitate the implementation of timely and equitable access for chronic disease patient care as close to their homes as possible.

2. Background

The ICPCD MoC focuses on improving the standard of care and providing care for four major chronic diseases that affect over one million people in Ireland: cardiovascular disease (CVD), Type 2 Diabetes, COPD and Asthma (HSE, 2020). The ICPCD MoC supports people to live well within the community, with ready and equitable access to General Practitioner (GP) review, diagnostics, Consultant, nursing and Health and Social Care Professionals (HSCP) input and specialist opinion, as required. The focus is on keeping people well and moving to provide the vast majority of health care to outside of the hospital setting.

The integrated approach with the chronic disease roles will support the hospital to become more community facing and will enable effective working relationships between the hospital and CD-CSTs to support hospital admission avoidance and early discharge activities, to facilitate the provision of person-centred care as close to home as possible. The CD-CSTs work with GPs and practice nurses in their respective catchment areas, to support the delivery of specialist and multidisciplinary care in the community for individuals with more complex chronic disease and / or multi-morbidity. Community specialist ambulatory care services, comprised by the multidisciplinary CD-CSTs also provide support to the GP to care for patients in the community through access to diagnostics, pulmonary and cardiac rehabilitation and diabetes structured patient education services.

Prior to the publishing of the MoC for Integrated Care Programme Chronic Disease and Modernised Care Pathways, there were existing nursing posts (both ANP and CNS grade) working in community settings with a specific caseload of patients with Asthma, COPD, Type 2 Diabetes and Cardiovascular Disease. These IC nurses are also working within the CD-CSTs structures. The CD-CST, along with the Acute IC Staff in Chronic Disease, make up the Integrated Chronic Disease Team that will deliver services in line with the National Framework across community and hospital settings.

As per the nationally agreed job descriptions, the breakdown of the allocated time in the CD-CST and secondary care / hospital of the Cardiology, Diabetes and Respiratory (COPD and Asthma) IC nursing posts funded in the chronic disease MoC are as follows:

- IC CNSs 80:20 posts – 80% CD-CST, 20% working alongside the IC Consultant in the CD-CST and / or in Secondary Care (Outpatient Department) OPD
- IC Acute CNSs 50:50 posts – 50% hospital, 50% CD-CST
- IC Candidate or Registered ANPs 50:50 posts - 50% hospital, 50% CD-CST

The IC nursing roles enhance skillset development for nursing staff as well as promoting service integration and they will, alongside the CD-CST, support continuity of care for the patient across primary and secondary care. IC nursing roles ensure competence is maintained in complex cases and educational and CPD opportunities are availed of across both community and secondary care settings. They promote team building between the CD-CST and hospital teams. The IC nursing team will also ensure that the principles of prevention, early intervention, early discharge where clinically appropriate, and self-management support are deployed to drive the delivery of care at the lowest appropriate level of complexity to support patients to live well with chronic disease in the community. The close integration between the CD-CST and the GP, will be facilitated by sharing information and using a case management approach. This will enable the nursing staff within the hospital, community sector and GP Practices, to manage patients who have complex chronic disease, multi-morbidity or deteriorating conditions in a holistic and person-centred manner.

ICPCD Nursing Roles

Nursing within ICPCD is led by the Director of Nursing, Nurse Lead Integrated Care Programmes (DON ICPCD) for Chronic Disease. The DON ICPCD provides nursing leadership, supports nursing excellence and builds capacity in healthcare delivery. The DON ICPCD works at national level to drive and support the implementation of the National Framework for the Integrated Prevention and Management of Chronic Disease in Ireland. The role involves working across secondary care and community services. On behalf of the ICPCD and the Office of Nursing & Midwifery Services (ONMSD), this senior nursing role represents ICPCD nursing nationally. To provide essential specialist nursing subject matter expertise and leadership in the specialties of Cardiology, Diabetes (Type 2) and Respiratory (Asthma & COPD), the DON ICPCD established respective National Nurse Reference Groups. These groups provide specialty-specific clinical input to the DON ICPCD and assist with the implementation of the Integrated MoC for the Prevention and Management of Chronic Disease.

3. Context

As outlined in the “ECC Chronic Disease Services guide in developing a Memorandum of Understanding (MOU) for the CHO and associated hospital (2024)” chronic disease specialists nursing posts will spend a specific percentage of their WTE working in the relevant specialist CD-CST and secondary care service to support the creation of the integrated service in accordance with / as outlined in the relevant ICPCD job descriptions and in line with the MoC.

The MOU guidance document sets out an agreed framework which enables integrated posts (i.e. working across hospital and community) to deliver IC and outlines the principles of partnership, processes and structures which are linked to shared goals and objectives. It recommends that the community and the associated hospital agree to jointly collaborate with respect to developing an operational plan, in line with agreed job descriptions, for each of the posts that have a commitment to work across hospital and community, ensuring alignment with the chronic disease MoC.

20% of the IC CNS role is envisaged working alongside the IC Consultant in the CD-CST and / or in Secondary Care OPD, or otherwise as appropriate to enable hospital avoidance and early discharge initiatives. The proportion of time allocated to working in secondary care service is specifically to support the relevant chronic disease specialist service in the hospital. The relevant DPHN and DON will agree to maintain this as protected time, ensuring the IC nursing roles are not subsumed into the general workforce in the hospital, thereby supporting the delivery of the end-to-end integrated chronic disease pathways. The IC nursing posts will support continuity of care across community and secondary care and follow the patient journey, through early specialist patient review and hospital avoidance (through Direct GP referral in the community and participating in outpatient clinics in the hospital), and early supported discharge activities (through arrangement of community follow up where appropriate).

Scope of Practice and Reporting Relationships

Every nurse is responsible and accountable for making decisions regarding their own Scope of Practice (NMBI, 2025). This entails working within a defined and agreed scope of practice and in accordance with approved protocols, policies, procedures and guidelines (PPPGs). All nurses working within IC must adhere to Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (NMBI, 2025). The revised code incorporates *The Scope of Nursing and Midwifery Practice Framework, Ethical conduct in Research, Recording Clinical Practice and Social media and Social networking.*

IC Nurses must also adhere to national professional and standards documents such as (but not limited to);

- Prescriptive authority : practice standards and guidelines
- Guidance for Registered Nurses & Midwives on Medication Administration
- Advanced Practice (Nursing) Standards and Requirements

Governance and reporting relationship of IC nursing roles (as per nationally agreed Job Descriptions):

IC CNS

- The IC CNS professional reporting relationship is to the Director of Public Health Nursing; or designated Nursing Manager – which may be the ADPHN; with collaborative agreements with the Director of Nursing in the associated service area.
- The clinical reporting relationship is to the IC Consultant or to the senior clinical decision maker who has responsibility for the service / service user.
- The IC nurse will report to the Operational Lead IC ICPCD Specialist Community Team on operational and administrative matters.

IC Acute CNS

- The IC Acute CNS professional reporting relationship is to the acute Director of Nursing; or designated Nursing Manager – which may be the ADON; with collaborative agreements with the Director of Public Health Nursing in the associated service area.
- The clinical reporting relationship is to the IC Consultant or to the senior clinical decision maker who has responsibility for the service / service user.

IC ANP

- The IC ANP professional reporting relationship is to the acute Director of Nursing; or designated Nursing Manager; with collaborative agreements with the Director of Public Health Nursing in the associated service area.
- The clinical reporting relationship is to the IC Consultant or to the senior clinical decision maker who has responsibility for the service / service user.
- The IC nurse will report to the Operational Lead IC ICPCD Specialist Community Team on operational and administrative matters.

Through the continued implementation of the ICPCD MoC, and the evolution of the IC nursing roles within the CD-CSTs, collaborative arrangements between DPHNs and DONs have been established to further strengthen the professional reporting relationships.

4. Clinical Nurse Specialist (CNS) Role

The purpose of IC CNS post is to provide expertise and specialist nursing services to patients with a chronic condition (as outlined in the MoC) both in the hospital outpatient settings and in the community. The IC CNS liaises between integrated services in the community and hospital services along with other agencies to deliver effective evidenced based care. While developing this guidance document, the five core concepts of the Clinical Nurse Specialist role set out in the Framework for the Establishment of Clinical Nurse / Midwife Specialist Posts, 4th edition, National Council for the Professional Development of Nursing and Midwifery (NCNM) 2008, were considered;

Clinical focus

The CNS must have a strong patient focus whereby the specialty defines itself as nursing and subscribes to the overall purpose, functions and ethical standards of nursing. The clinical practice role may be divided into direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to patients and their families. The IC nurse may follow the patient journey; this may involve collaboration and / or communication with the GP and Practice nurses, this may entail reviewing a known patient in ED or as an inpatient. This may also attend the Hospital OPD clinic of the relevant IC Consultant; they may utilise their IC acute allocation discussing patients whom they have reviewed in the CD-CST with hospital colleagues. Indirect care relates to activities that influence others in their provision of direct care, to include a proactive role in the formulation and provision of evidence based PPPGs relating to Integrated Care and related care pathways.

Patient advocate

The CNS role involves communication, negotiation and representation of the patient values and decisions in collaboration with other health care workers and community resource providers.

Education and training

The CNS remit for education and training consists of structured and impromptu educational opportunities to facilitate staff development and patient education. Each CNS in tandem with their line manager is responsible for their continuing professional development, including participation in formal and informal educational opportunities, thereby ensuring sustained clinical credibility among nursing, medical and HSCPs colleagues.

Audit and research

Audit of nursing practice and evaluation of improvements in the quality of patient care are essential requirements of the CNS role. The CNS must keep up to date with relevant current research to ensure evidence-based practice, and contribute to nursing research relevant to the speciality.

- Agreement with stakeholders to participate in clinical audit, evaluate audit results and research findings to identify areas for quality improvement in collaboration with nursing and multidisciplinary team colleagues (primary and secondary care) to ensure alignment of services to the MoC.
- The CNS maintains a record of clinically relevant data aligned to National Key Performance Indicators (KPIs) as directed and advised by the DPHN / DON / Services in conjunction with the senior clinical decision maker. Refer to National KPIs / metrics associated with the speciality. Collate data (agreed KPIs / metrics / clinical targets) which will provide evidence of the effectiveness of the CNS interventions. Any outcomes of audit and / or research should contribute to the next service plan.

Consultant

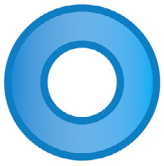
Inter-team and intra-team consultations and referrals, across sites and services are recognised as key functions of the CNS. This consultative role also contributes to improved patient management.

Clinical – Patient Caseload

As per the MoC, job descriptors and aligned to The Guide for Referral of Patients to the Chronic Disease Specialist Integrated Services (HSE, 2024) the patient caseloads for the chronic disease IC CNSs for the specialities are as follows:

Cardiology

- Heart Failure
- Atrial Fibrillation
- Ischaemic Heart Disease
- Patients at high risk of developing cardiovascular disease
- Structural / Valvular Heart Disease
- Heart Murmur
- Arrhythmias



Diabetes

- Type 2 Diabetes patients only

Respiratory

- Respiratory (COPD & Asthma).

5. Candidate Clinical Nurse Specialist (cCNS) Role

The candidate CNS is required to progress to CNS grade within 2 years of commencement of the cCNS pathway and formally apply for entry onto the ONMSD CNS interim database, when the pathway is completed. The cCNS pathway will facilitate the post holder to be supported professionally and clinically develop the skills and knowledge required to achieve the competencies of the CNS role.

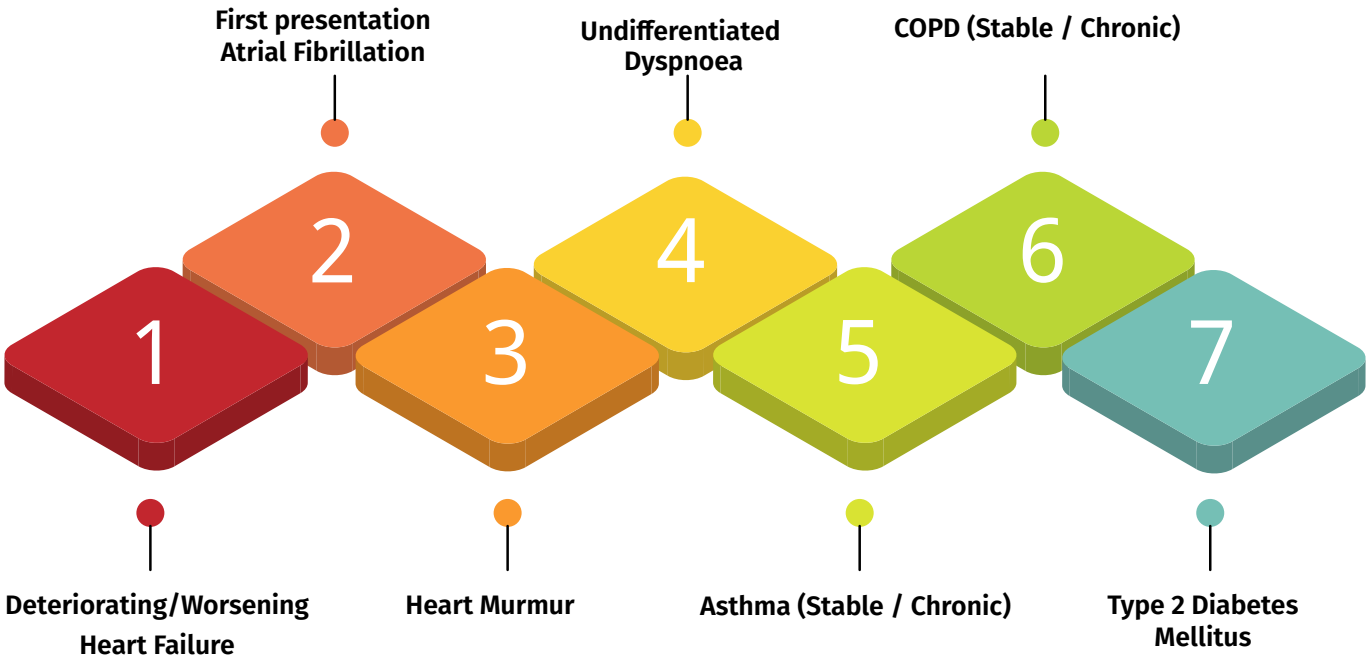
The cCNS post holder will be enabled to deliver care in line with the five core concepts of the CNS role outlined above. This cCNS pathway may also be open to nurses who wish to work in IC chronic disease and this pathway is valid from May 2023 to September 2026.

Further information, guidance and associated documents on the cCNS pathway can be found on the HSE website, on the ONMSD webpage as follows: https://healthservice.hse.ie/about-us/onmsd/advanced-and-specialist-practice/specialist-practice.html

6. Modernised Care Pathways and Advanced Nurse Practitioners

Timely access to specialist expertise is an important enabler to deliver end-to-end care pathways that focuses on the prevention, early diagnosis and proactive management of chronic disease and its associated complications. Implementation of the Modernised Care Pathways (MCPs) across the chronic disease specialist integrated services will support the delivery of timely specialist opinion in a more flexible, efficient and patient-centred manner in the MoC.

The 7 MCPs pertaining to ICPCD are as follows:



In 2023 a number of additional IC ANP posts (50% hospital and 50% CD-CST) were funded to support the implementation of the MCPs for service delivery across the 3 specialties. These autonomous nursing roles whilst based in the acute hospital, will provide specialist support to the IC Consultant, CD-CSTs and hospital services to manage chronic disease, and associated co-morbidities, within the hospital and community setting. Where the IC Consultant is not in post, there may be local arrangements agreed with existing secondary care Consultant post holders to support the delivery of chronic disease specialist care in conjunction with the candidate ANP (cANP) / Registered ANP (RANP) and other relevant stakeholders.

7. Candidate Advanced Nurse Practitioner (cANP) Role

The main purpose of the post is to develop the IC ANP service, under the direction of the Health Care Provider's Advanced Practice Stakeholder Governance Group, to enable the individual nurse to meet the NMBI Criteria for Registration as an Advanced Nurse Practitioner as set out in *Advanced Practice (Nursing) Standards and Requirements (NMBI, 2017)*. The individual will undertake the academic preparation and develop the clinical and leadership skills, competencies and knowledge required to meet the criteria to be registered as a RANP with NMBI.

The scope of the IC cANP role must reflect the incremental development of expertise and as such, the IC cANP role cannot deliver care as an autonomous practitioner. The individual will complete and submit the necessary documentation to meet the requirements for registration as an RANP with NMBI.

Once the IC cANP registers as an RANP they have the role in the ongoing development and implementation of the RANP-Led services across the hospital and CD-CST for adults requiring advanced nursing management in their specific speciality of Cardiology or Diabetes (Type 2) or Respiratory (COPD and Asthma) (age 16 and upwards).

8. Registered Advanced Nurse Practitioner (RANP) Role

The specific contribution of the IC RANP is to improve outcomes for patients who fall within the RANP scope of practice and agreed patient caseload, improve access to timely, quality healthcare for patients with the specific chronic disease being treated in the IC service provided in the hospital and the associated CD-CST.

The RANP service is provided by nurses who practice at a higher level of capability who are independent, expert advanced practitioners, and autonomous in their clinical decision making. The overall purpose of the service is to provide safe, timely, evidenced based nurse-led care to patients at an advanced nursing level. This involves undertaking and documenting complete episodes of patient care, which include comprehensively assessing, diagnosing, planning, treating and discharging patients in accordance with collaboratively agreed local PPPGs and / or Service Level Agreements (SLAs) / or a Memoranda of Understanding (MOU).

9. Advanced Nurse Practitioners Competencies and Caseload (Candidate and Registered ANPs)

The cANPs practice is based on developing a higher level of capability across the six domains of competences as defined by Advanced Practice (Nursing) Standards and Requirements (NMBI, 2017). Whereas, the IC RANP (within the relevant chronic disease speciality), practices to a higher level of capability across the six domains of competence outlined below:

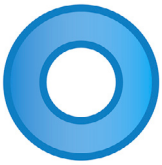
The domains are:

Clinical – Patient Caseload

As per the MoC and job descriptors, and in accordance with the Guide for Referral of Patients to the Chronic Disease Specialist Integrated Services (HSE, 2024) the patient caseloads for the chronic disease IC cANPs / RANPs for the specialities are as follows:

Cardiology

- Heart Failure
- Atrial Fibrillation
- Patients at high risk of developing cardiovascular disease



Diabetes

- Type 2 Diabetes patients only

Respiratory

- Respiratory (COPD & Asthma).

The caseload and scope of practice for the RANP will evolve to reflect changing service and population needs, as per locally agreed SOP / PPPGs in line with the MoC.

The IC RANP will work alongside the IC Consultant to implement the MCPs across their hospital and aligned CD-CST. The IC cANP in their training role will support the Consultant with this process also, under the Consultants supervision. The focus will be on reduction in waiting times for patients for hospital-based outpatient services through provision of outpatient services in both the CD-CSTs and hospital settings. This will involve the triaging and review of patients across a number of streams including:

- Rapid access in person hospital outpatient clinic
- Nurse led clinic (as per agreed pathways) – in person / virtual reviews
- In person outpatient clinic

The IC cANP will also be involved in the following:

- Development and agreement on integrated pathways focusing on timely access to specialist services and early intervention, early patient discharge, outreach services and patient admission avoidance programmes.
- Implementation of pathways that will support GP-led primary care, efficient discharge back to the community where appropriate and reduce the need for repeated hospital-based outpatient reviews.

Research & Audit

- Agreement with stakeholders to participate in clinical audit, evaluate audit results and research findings to identify areas for quality improvement in collaboration with nursing and multidisciplinary team colleagues (primary and secondary care) to ensure alignment of services to the MoC.
- Identify and develop Nursing KPIs for their area of practice in collaboration with key stakeholders. Refer to National KPIs / metrics associated with the speciality. Collect and collate data which will provide evidence of the impact and effectiveness of the interventions undertaken. Audit patient outcomes and implement strategies to improve care.
- Introduce evidence-based practices (e.g., digital health tools, multidisciplinary case reviews).
- Contribute to policy development in both primary and secondary care settings.

Education & Training

- Provide education training and education programmes for colleagues in the CD-CST, hospital chronic disease services and primary care teams and for the wider nursing and HCP community to promote and lead on chronic disease patient management.
- Lead and deliver education programs for patients with Cardiology, Diabetes Type 2 or Respiratory (COPD and Asthma) chronic disease, focusing on self-care, lifestyle changes, and medication adherence.
- Attendance at relevant education e.g. Nursing Grand Rounds / Journal Clubs / CPD events.

Interdisciplinary & Patient Advocacy

- Work alongside IC Consultants, GPs, and colleagues across the 3 specialities in the CD-CSTs and the hospital to provide holistic chronic disease patient management.
- Act as the liaison between hospital and community diabetes teams, ensuring smooth discharge planning and continuity of care.
- Advocate for patients by developing patient-centred care plans, particularly for complex cases (e.g., patients with comorbidities).
- Support health equity by ensuring access to chronic disease services for vulnerable populations (e.g., learning disabilities, socioeconomically disadvantaged patients).

Clinical Leadership & Service Development

- Lead the development of an integrated chronic disease pathways that improves coordination between hospitals, CD-CSTs and GP practices.
- Development of local and national PPPGs across both CD-CST and hospital settings.
- Establish early intervention patient clinics to prevent complications of cardiovascular disease, Type 2 Diabetes and Respiratory (COPD and Asthma) and to reduce hospital admissions.
- Analyse service delivery, implement evidence-based practice and contribute to quality improvement initiatives to enhance patient outcomes and streamline workflows.
- Implement virtual patient consultations.

10. The Key Working Principles for a quality approach to IC Nursing Roles

1 

A patient-centred service is the key consideration underpinning all discussions and decision making in the commitment to ensuring high quality patient outcomes.

2 

A shared vision across key stakeholders in acute and community services, including management and specialist nursing post holders in the implementation of IC nursing roles to deliver high quality, integrated care across hospital and community, underpinned by national health policy, the MoC and the National Framework.

3 

Establishing effective and quality working relationships by building mutual respect and trust with colleagues in both community and hospital settings.

4 

Collaboration and agreement of workflow and patient caseload for all aspects of the relevant nursing role i.e. 80:20 or 50:50 time in community and community / acute for effective transitioning care of the patient, with consideration in providing and offering.

5 

Reporting relationships, including operational, professional and clinical relationships working across sites requires clear delineation. This can be facilitated through local negotiation and through a locally developed MOU to include / SOPs / processes to identify clear roles of responsibility of operational, professional managers and clinical senior clinicians. Once clarity and agreement is reached subsequent robust communications pathways should be implemented for the purpose of information sharing on reporting relationships for all key stakeholders.

Refer to the "Roles and Responsibilities Matrix Guidance Document 2025" for further guidance to support all staff working in integrated chronic disease roles to have a shared understanding of the individual roles and responsibilities of the Operational Leads & the Assistant Directors of Public Health Nursing (ADPHN).

6 

Regular effective open and transparent communication (e.g. quarterly meetings) between ADPHNs / DPHNs and ADONs / DONs in reviewing processes, work practices and ensuring safe transition of patient care. An IC joint nursing governance forum is recommended for each Integrated Health Area to facilitate these processes.

7 

Commitment to effective and efficient management of emerging issues and problem resolution.

8 

Ensure the national role descriptors and the national job descriptions provided by the HSE & ICPCD will be utilised in the recruitment process and to support implementation and embedding of new ways of working.

9 

Review and consultation of ICPCD national guidance documents and chronic disease metrics to ensure work practices are aligned with the MoC. Refer to the “Roles and Responsibilities Matrix Guidance Document 2025”.

10 

Ensure the IC nursing patient caseload and corresponding services provided is in line with local CD-CST / hospital SOPs / pathways and is reflected in the MoC and aligned with “A Guide for Referral of Patients to the Chronic Disease Specialist Integrated Services, Version 2.0”.

11 

It is recommended that the IC CNS and IC ANP post holders produce an annual report of the service delivered to both the DPHN and DON to identify service delivered, trends and recommendations for service improvements.

12 

Collaboration and agreement with colleagues regarding the process of collection and return of the chronic disease activity metrics for national submission (in accordance with location of contract of employment and as per agreed templates, timelines, and critical pathways) in line with the Modernised Care Pathways Programme and Enhanced Community Care Programme.

13 

The IC nurse is not intended as a resource to substitute workforce vacancies (permanent or temporary) that may exist in the hospital structures. The IC Nurse is a valuable resource that should be deployed to provide continuous and co-ordinated care across healthcare settings as part of a person-centre approach to care delivery with a focus on driving hospital avoidance / early discharge activities.

14 

Opportunity to maintain relevant nursing professional development and provide access for experiential learning and opportunities to work with and learn from colleagues across both community and hospital sites.

15 

Collaborate to provide the optimum clinical learning environment to facilitate the learning outcomes for both undergraduate and postgraduate Nursing students.

16 

Annual leave, parental leave, study leave and the shorter working year scheme must be pro rata between the community CD-CST and secondary care as outlined within the locally agreed MOU.

17 

The IC nurse must have access to hospital ICT systems, patient safety and risk procedures and GDPR in accordance with local agreements (MOU).

18 

Stakeholder agreement to support provision of a reformed outpatient service that utilises telehealth and other ICT measures to facilitate a more effective and efficient delivery of care.

11. Examples of good practices for IC Nursing roles

The National Framework for the Integrated Prevention and Management of Chronic Disease describes a whole-system approach to integration that encompasses population health and wellbeing, preventive, acute, non-acute and community based services (HSE, 2020).

The IC nursing posts aim to support and empower individuals to optimise their health, actively address and minimise their risk factors and to live well with chronic disease, with the ultimate goal aligned to the Sláintecare (2018) principles in providing a person-centred service by ensuring that individuals receive the right care, at the right time and in the right place.

In the development of this document and to support the guidance contained within, there was a request made with the Cardiology, Diabetes (Type 2) and Respiratory (COPD and Asthma) IC CNSs and IC ANPs post holders across both community and hospital settings to provide examples of nursing practices. The examples furnished demonstrate how the IC nursing posts are responsive and connected to the patients' needs in the chronic disease end-to-end specialist care pathways, incorporating the Sláintecare principles, by enabling and facilitating:

- Direct access for GPs to episodic specialist care within the CD-CST
- Hospital avoidance initiatives
- Early supported discharge
- Assist with patient discharge planning
- And hospital wait list initiatives.

The following tables outline existing nursing service and scenarios of effective nursing practices from the examples received from the IC CNSs and IC ANPs in post, to guide and support both professional and operational managers on the delivery of IC chronic disease nursing services. There are a number of examples collated and included under each nursing role and speciality in each table, which reflect variances in roles in areas depending on local circumstances and patient population needs.

Please note: These tables are not indicative of the expected activity of any individual post holder (in particular the 20% CNS role). Moreover, their inclusion is aimed to illustrate the extensive nursing activities, interventions and initiatives implemented and to also reflect the evolving nature of current services that can be employed by community and hospital chronic disease services to enable patient hospital avoidance, and facilitate patient assisted discharge and early supported discharge thereby reducing in-patient length of stay in hospitals.

Examples of good practices CNS 80:20 (Table 1)

CNS 80:20	Cardiology	Type 2 Diabetes	Respiratory (COPD and Asthma)
80% CD-CST Community based	• Management of GP referrals within MoC caseload of patients • Weekly Nurse-Led clinics, and onward referral/social prescribing. • Mixture of face to face appointments and telephone appointments. Telephone reviews facilitated by Community Intervention Team for obtaining patient blood pressure, weight and bloods. • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment • Weekly MDT Consultant clinics. • Regular Inter-speciality MDT meetings in conjunction with Diabetes / Respiratory (COPD and Asthma) CD-CSTs • Provision of patient / staff education • Data entry and management • PPPG review and development • Audit, research and training	• Management of GP referrals for Type 2 Diabetes only patients • Nurse-Led clinics for Type 2 Diabetes only, and onward referral/social prescribing • Follow up with patients discharged from hospital with face to face and/or telephone appointments • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment • Weekly MDT clinic • Patient education • Provision of staff education • Inter-speciality MDT meetings at regular intervals in conjunction with Cardiology / Respiratory (COPD and Asthma) CD-CSTs • Data entry and management • PPPG review and development • Audit, research and training	• Management of GP referrals of COPD and Asthma patients • Weekly Nurse-Led clinics, and onward referral/social prescribing • Weekly MDT clinics with Consultant • Weekly link with Acute Respiratory CNS to review if any patients are been seen in respective services to avoid duplication and follow the patient journey patient. • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment • Inter-speciality MDT meetings at regular intervals in conjunction with Cardiology / Diabetes CD-CSTs • Engagement with COPD Outreach team • Provision of patient / staff education • Data entry and management • PPPG review and development • Audit, research and training
20% Hospital based	• If a patient known to the CNS is attending the acute services, the CNS may follow and support the patient journey in their episode of acute care. This may entail CNS patient review, +/- IC Consultant ward rounds, or review in ED, AMAU/MAU in conjunction with the IC Consultant. • Assist in streamlining patient transitions between hospital and community services. • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment. • Weekly Risk Factor/Atrial Fibrillation/ Heart Failure OPD clinic, and MDTs in conjunction with IC Consultant. • Clinics rotated amongst CNSs to ensure experience of the management of CVD patients. • Managing more complex patient cases, in conjunction with the hospital based team. • Provision of staff and patient education • Research, audit and training.	• If a patient known to the CNS is attending the acute services, follow and support the patient journey in the episode of care. This may entail CNS patient review +/- Consultant wards rounds, or review in ED, AMAU/MAU, in conjunction with the IC Consultant. • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment • Assist in streamlining patient transitions between hospital / community services. • Weekly OPD Diabetes Clinic and MDT meeting, in conjunction with the IC Consultant/Hospital Consultant and IC Diabetes nursing. • Work on wait list Type 2 Diabetes patients with IC Consultant who can be seen by the CD-CST with the aim of reducing and/or cleared these lists. • 6 weekly IC and hospital diabetes nursing team meeting for professional issues, service development, training needs, peer support, research / audit. • Provision of patient / staff education • Research, audit and training.	• If a patient known to the CNS is attending the acute services, follow and support the patient journey in the episode of care. This may entail CNS patient review +/- Consultant wards rounds, or review in ED, AMAU/MAU, in conjunction with IC Consultant. • Weekly OPD Clinic and MDT meeting, in conjunction with the IC Consultant/ Hospital Consultant and IC nursing team. • Assist in streamlining patient transitions between hospital and community services. • Respiratory CNS team rotate into Respiratory weekly OPD clinic in conjunction with IC Consultant. • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment. • Attendance at Respiratory MDT hospital team meeting on a weekly basis • Provision of staff and patient education • Research, audit and training.

Examples of good practices CNS 50:50 (Table 2)

CNS 50:50	Cardiology	Type 2 Diabetes	Respiratory (COPD and Asthma)
50% Hospital Based	• Cardiology in-patient case review and patient education (caseload within MoC). • Redirecting patients to their CD-CSTs for follow up. Onward referral to relevant services such a Cardiac Rehab near the patients' homes. • Following the patient journey and streamline patient transitions between acute and community services. • Manage patient referrals in conjunction IC Consultant which are referred via the Chronic Disease Management service • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment • Weekly cardiology MDT meeting • Provision of patient / staff education • Data entry and management • PPPG review and development • Audit, research and training	• Weekly Nurse Led clinics per week for Type 2 Diabetes only patients for patient review and education • Redirecting patients to their CD-CSTs for follow up. • Following the patient journey and streamline patient transitions between acute and community services. • Manage patient referrals in conjunction IC Consultant which are referred via the Chronic Disease Management service • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment • Weekly Diabetes MDT meeting • Provision of patient and staff education • Data entry and management • PPPG review and development • Audit, research and training	• Post Exacerbation Asthma (PEA) Clinic: Pilot PEA clinic, in conjunction with IC Consultant, to address a critical service gap. Initiative supports patients (~ age 35 yrs) with poorly controlled asthma who attended ED with exacerbation. The clinic emphasises early intervention, patient education, and self-management support to improved asthma control, reduce long-term complications and assist hospital avoidance. • Attend COPD Outreach MDT • Assist acute CNS team with ward-based respiratory care for COPD and asthma. • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment • Weekly Respiratory MDT meeting • Streamline patient transitions between acute / community services. • Provision of patient / staff education • Data entry and management • PPPG review and development • Audit, research and training
50% CD-CST Community based	• Weekly Nurse-Led cardiovascular clinic in conjunction with IC Consultant • Follow up on appropriate patients discharged from acute setting • Assist in streamlining patient transitions between hospital and community services. • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment • Weekly Heart Virtual Clinic, in conjunction with the IC Consultant • Weekly cardiology MDT meetings • Provision of patient / staff education • Data entry and management • PPPG review and development • Audit, research and training	• Weekly Nurse-Led clinics for Type 2 Diabetes in conjunction with the IC Consultant • Follow up on appropriate patients discharged from acute setting • Assist in streamlining patient transitions between hospital and community services. • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment • Patient education • Follow up on appropriate patients discharged from acute setting • Weekly Diabetes MDT meetings • Provision of staff education • Data entry and management • PPPG review and development • Audit, research and training	• Weekly Nurse-Led clinics for patients with asthma and COPD, focusing on chronic disease management and patient education and support • Assist in streamlining patient transitions between hospital and community services. • Follow up on appropriate patients discharged from acute setting • Facilitation of alternative virtual/ telehealth pathway with approved HSE virtual platform for patients that may not require face to face assessment • Weekly Respiratory MDT meeting • Weekly Cardio-Respiratory clinics (where in place) • Weekly Cardio-Respiratory MDT meetings (where in place) • Provision of patient / staff education • Data entry and management • PPPG review and development • Audit, research and training

Examples of good practices ANP 50:50 (Table 3)

ANP 50:50	Cardiology	Type 2 Diabetes	Respiratory (COPD and Asthma)
50% Hospital Based	• Weekly ANP clinics incorporating virtual clinic/telehealth pathway and telephone patient reviews for assessment of diagnosis and new, review of cardiology patients in MoC. • New Diagnosis patient referrals from ED, Acute Assessment Unit and Coronary Care Unit • Review and triage of cardiovascular wait lists with IC Consultant/ Hospital based Consultant to identify appropriate patients for ANP review in hospital/ community and reduce wait lists. • Weekly MDT meetings with Consultant and hospital nursing ANP and CNSs to identify stable Heart Failure and cardiovascular patients to refer from the acute setting to the community. • Provision of patient / staff education • Leadership role: Service improvement, health policy implementation and evaluation • PPPG development • Research and audit and CPD	• Weekly ANP clinics, incorporating virtual clinic/telehealth pathway and telephone patient reviews for assessment of diagnosis and new, review Type 2 Diabetes only patients • Attend triage referral meeting to discuss / accept referrals within ANP inclusion criteria • Rapid Access ANP clinic for Type 2 Diabetes patients • Review and triage of Type 2 Diabetes wait lists with IC Consultant / Hospital Consultant to identify appropriate patients for ANP review in hospital or community and reduce wait lists. • Weekly MDT clinic with Consultant and hospital based staff • Provision of patient / staff education • Leadership role: Service improvement, health policy implementation and evaluation • PPPG development • Research and audit and CPD	• Weekly ANP clinics, incorporating virtual clinic/telehealth pathway and telephone patient reviews for assessment of diagnosis and new, review of Asthma & COPD patients. • Daily ED review for COPD or asthma patients who can avoid hospital admission with quick follow-up review in the community. • Management of severe asthma patients and offer these patients rapid access review if required. • Review and triage of COPD / Asthma wait lists with IC Consultant/ Hospital based Consultant to identify appropriate patients for ANP review in hospital or community and reduce wait lists. • Attend COPD Outreach MDT • Weekly Consultant clinics. • Weekly Radiology MDT • Weekly Respiratory MDT meetings • Provision of patient / staff education • Leadership role: Service improvement, health policy implementation and evaluation • PPPG development • Research and audit and CPD
50% CD-CST Community based	• ANP Clinic to follow up on new appropriate GP and/or CD-CST referrals incorporating virtual clinics, telephone appointments and patient education for patients within MoC. • Facilitate seamless care for patient moving from hospital to the community bypassing the Cardiology OPD Hospital system, impacting on waiting lists • Provision of staff education • Development of primary prevention initiatives such of collaboration with Diabetes and/or Respiratory CD-CSTs IC for chronic disease / multi-morbidity / Chronic disease joint clinics / MDT virtual reviews and transitions across the continuum of care • Leadership role: Service improvement, health policy implementation and evaluation • PPPG development • Research and audit and CPD	• ANP Clinic to follow up on new appropriate GP and/or CD-CST referrals incorporating virtual clinics, telephone appointments and patient education for Type 2 Diabetes patients. • ANP and joint MDT clinics • Facilitate seamless care for patient moving from hospital setting to the community bypassing the Diabetes OPD Hospital system, impacting on waiting lists. • Weekly MDT meeting: in depth discussion, questions and queries on each patient referral providing great learning opportunities. • Provision of staff education • PPPG development • Leadership role: Service improvement, health policy implementation and evaluation • Lead IC CDM Journal club / Advanced Practice Journal club • Lead IC nurse prescribing group • Research and audit and CPD	• ANP Clinic to follow up on new appropriate GP and/or CD-CST referrals incorporating virtual clinics, telephone appointments and patient education for COPD and Asthma patients. • Weekly ANP clinics per week in the community for review patient and rapid access clinics. • ANP and joint MDT clinics • Facilitate seamless care for patient moving from hospital setting to the community bypassing the Respiratory OPD Hospital system, impacting on waiting lists. • Provision of staff education • Weekly Respiratory MDT meetings • Leadership role: Service improvement, health policy implementation and evaluation • PPPG development • Research and audit and CPD

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  - Cardiology
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  - National Heart Programme
  - National Clinical Programme for Respiratory

Note


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