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14th May, 2024

Deputy Darren O'Rourke, TD
Dáil Éireann
Leinster House
Kildare Street
Dublin 2

RE: 18740/24

To ask the Minister for Health if he is aware of concerns that heart failure patients are not sufficiently supported when out of hospital; his plans to address this; and if he will make a statement on the matter

Dear Deputy O'Rourke,

The Health Service Executive (HSE) 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 (NHP) on your question and have been informed that the following outlines the position.

The National Heart Programme (NHP) is integral to the development of care pathways that support the implementation of Sláintecare and focus on the entire spectrum of healthcare delivery, including expansion of capability in the community and an emphasis on integrated models of care that enhance prevention and support population health improvements.

The NHP is currently focussed on supporting implementation of the HSE's Integrated Model of Care for the Prevention and Management of Chronic Disease through the Enhanced Community Care Programme (ECCP) and the HSE's Modernised Care Pathways (MCPs). This model of care supports people to live well within the community, with ready and equitable access to general practitioner (GP) review, diagnostics, health and social care profession (HSCP) input and specialist opinion, as required. The focus is on keeping people well and on providing care as close to home as possible.

The NHP is currently working on/ supporting a number of initiatives aimed at providing support in the community for heart failure patients through reducing re-admissions and improving quality of life. Implementation of ECCP includes the roll-out of 30 Specialist Cardiology Teams providing specialist cardiology services in the community. These specialist teams include clinical nurse specialists (CNSs), cardiac rehabilitation co-ordinators, psychology supports and senior physiotherapists. Additionally, 32 cardiac physiologist positions have been funded to support GP direct access to echocardiography (Echo) services in the community. The hubs include direct GP access for diagnostic referrals for NTProBNP (early indicator for Heart Failure) and Echo.

These teams offer an additional layer of care for patients with cardiovascular disease (CVD) in the community and facilitate timely access to specialist care in a flexible manner, e.g., through virtual consultation, virtual clinical queries or direct face to face contacts. These teams will support more timely access to specialist opinion for patients to support admission avoidance, early hospital discharge, community follow-up, as well as a reduction in outpatient department (OPD) waiting lists for cardiology.

While continuing to support and develop hospitals aspects of cardiology service the NHP/ ECCP also is working towards:

- A focus on self-management support and education for cardiovascular conditions, cardiovascular disease (CVD) prevention, 'Making Every Contact Count (MECC)', education sessions, goal-setting and the development of action plans to support chronic disease management at home;
- Supporting general practice - general practice care is provided at Community Health Network (CHN) level;

- A new Structured Chronic Disease Management Programme (CDMP) in General Practice is providing additional supports to GPs in caring for individuals living with chronic disease in the community;
- Developing capacities to provide specialist care for prevention/ management of chronic CVD
- Evolving of roles and training with respect to cardiology profession.

The NHP's **Model of Care for Heart Failure** (MoC HF) outlines the standards of care to deliver a high quality, person-centred service to patients living with or who are at risk of heart failure. The model of care details how patients should be able to access care at various stages of this syndrome of heart failure and also the roles of health care professionals who play important roles in providing this care.

A **Heart Virtual Consultation** (HVC) service provides for web-conferencing between cardiac specialists and GPs to discuss complex patient and prepare care plans for them. Recent research has shown that patients discussed at these virtual consults (VC) are older, frailer and have significantly more medical conditions than those in the hospital outpatients highlighting their complexity. They also are more likely to live further away from the hospital outpatient departments, showing how this enables specialist care for this group. Without the VC, 93% of cases would have been referred to face-to-face hospital services. Instead, VC resulted in only 9% of cases being referred to hospital services.

The HSE's National Heart Programme's (NHP) **Heart Failure Model of Care (2021**) advises a psychologist as a one of the key community staff requirements to support General Practitioners (GPs) in the treatment of heart failure. Funding has been made available to provide a psychologist for 1 day per week (for two years) as part of cardiac rehabilitation teams in the 30 new Specialist Chronic Disease Community Ambulatory Care Hubs being established as part of the Enhanced Community Care Programme (ECCP). This service will include the treatment of heart failure patients.

The HSE's Model of Care for Integrated Cardiac Rehabilitation (2023) is the first model of care for cardiac rehabilitation (CR) in Ireland and presents best evidence and practice for an integrated, high quality, equitable and person-centred service for those living with cardiovascular disease, including heart failure. The development of this national model of care for integrated cardiac rehabilitation is a major step forward, in that it will ensure that patients living with cardiovascular disease across the country have access to timely high quality cardiac rehabilitation care, no matter where they live. In line with best international evidence and practice, the model advocates for a person-centred approach, with a focus on helping the patient to manage their condition, set individualised goals and receive their rehabilitation service as close to home as possible. There is robust evidence to support its positive impact on improving patient quality of life, improving morbidity and mortality from CVD and reducing hospital admissions due to CVD.

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

Anne Horgan

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Anne Horgan
General Manager