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29th May, 2024

Deputy Niamh Smyth, TD
Dáil Éireann
Leinster House
Kildare Street
Dublin 2

RE: 22013/24

To ask the Minister for Health the steps his Department is taking to provide additional resources for survivors of stroke and other cardiovascular conditions in the community who are supported by an organisation (details supplied); and if he will make a statement on the matter

Details supplied: the Irish Heart Foundation

Dear Deputy Smyth,

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 Clinical Programme (NCP) for Stroke and the National Heart Programme (NHP) on your question and have been informed that the following outlines the position.

There are currently a number of initiatives available to support stroke patients. These include:

Early Supported Discharge (ESD) Teams: ESD teams enable an accelerated discharge from the acute hospital setting, through the provision of specialist and stroke-specific rehabilitation in the home setting. There are currently 11 ESD teams operating nationally from the following acute sites:

1) Our Lady of Lourdes Hospital, Drogheda (CHO 8)
2) Beaumont Hospital (CHO 9)
3) Mater Hospital (CHO 9)
4) Connolly Hospital (CHO 7/9)
5) St James's Hospital (CHO 7)
6) Tallaght University Hospital (CHO 7)
7) St Vincent's University Hospital (CHO 6)
8) Sligo University Hospital (CHO 1)
9) Galway University Hospital (CHO 2)
10) University Hospital Limerick (CHO 3)
11) Cork University Hospital (CHO 4)

Collaborations; voluntary sector:
A number of initiatives have been developed jointly with the voluntary sector such as Irish Heart Stroke Connect Service - Irish Heart, to provide practical and emotional support to stroke survivors nationally through on-line resources and telephone supports.

Other voluntary agencies that provide support to stroke survivors include:

- Croí Heart and Stroke Charity - Croí Connects • Croi Heart & Stroke Charity
- Cork Stroke Support - Cork Stroke Support

Current work of the National Heart Programme (NHP) is focussed on supporting national implementation of the ***HSE's Integrated Model of Care for the Prevention and Management of***

Chronic Disease[1]. The NHP is currently supporting a number of initiatives aimed at providing support for heart failure patients. These include:

ECCP implementation: includes the national roll out of 30 Community Specialist Teams (CSTs) providing integrated specialist cardiology services. These teams, led by newly appointed Integrated Care Cardiologists, are being established across all 9 CHOs and linked locally to the acute hospital sector. The specialist teams include clinical nurse specialists, cardiac rehabilitation co-ordinators, psychology supports and senior physiotherapists. Additionally, 32 cardiac physiologist positions have been funded to support GP direct access to echocardiography (ECG) services in the community.

Models of Care: The NHP is supporting implementation of the ***HSE's Model of Care for Integrated Cardiac Rehabilitation (MOC CR)***[2] to deliver a high quality, equitable, person-centred and evidence-based cardiac rehabilitation (CR) service. This includes delivery of CR services across 30 community and 28 acute CR services. There is strong evidence indicating the benefits of early access to cardiac rehabilitation in terms of improving both physical and mental health outcomes for patients with cardiovascular disease.

Heart Virtual Consultation: The HSE's Heart Virtual Consultation (HVC) service, being rolled out nationally as part of the ECCP, 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 are older, frailer and have significant medical conditions. They also are more likely to live further away from the hospital outpatients. Without the HVC, 93% of cases would have been referred to face-to-face hospital services. Instead, HVC resulted in only 9% of cases being referred to hospital services[3].

Psychological Supports: The ***HSE's National Heart Programme's (NHP) Heart Failure Model of Care (2021)***[4] 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 for 1 day per week (for two years) to provide a psychologist as part of cardiac rehabilitation teams in the 30 new Specialist Ambulatory Care Hubs for chronic disease, currently being established in the community as part of the Enhanced Community Care Programme (ECCP). This service will include the treatment of heart failure patients.

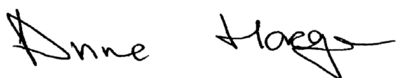
Supporting patient-focussed initiatives: A service level agreement (SLA) has recently been finalised with the Irish Heart Foundation (IHF) to support a prevention behaviour change programme. The IHF is leading out on the implementation of a high risk prevention programme across a number of Sláintecare Healthy Community sites.

Structured Chronic Disease Management Programme in General Practice: any individual who is over the age of 18, who has a medical card and who has been diagnosed with heart failure, is eligible to join this free programme. Over 90% of GPs in Ireland are offering this programme. Once enrolled, a patient is entitled to 4 visits per annum: a visit with the practice nurse and a visit with the GP every 6 months.

Aside from undertaking a physical exam and diagnostic investigations, an important focus of these visits is the development of a care plan which is jointly agreed by the patient and their GP. This care plan centres on the patient's chosen areas of concern regarding their health and supports them in managing their condition, while also recognising the red flags associated with their condition and when to seek help. The patient will be linked in with appropriate services in the community to support them in addressing their health needs e.g. accessing cardiac rehabilitation, smoking cessation services, specialist cardiologist opinion etc.

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
General Manager

References:

1) HSE's Integrated Care Programme for the Prevention and Management of Chronic Disease. https://www.hse.ie/eng/about/who/cspd/icp/chronic-disease/

2) HSE's National Heart Programme Model of Care for Integrated Cardiac Rehabilitation (2023) https://www.hse.ie/eng/about/our-health-service/making-it-better/hse-launches-ireland-s-first-ever-model-of-care-for-integrated-cardiac-rehabilitation.html

3) Wong B, McCambridge J, Barrett M et al (2003)
Heart failure virtual consultation: caters for frailer, multimorbid and remote patients Open Heart 2023; 10:e002329. Doi: 10.1136/openhrt-2023-002329. Available at: https://openheart.bmj.com/content/10/2/e002329

4) HSE's National Heart Programme Model of Care for Heart Failure (2021) https://www.hse.ie/eng/about/who/cspd/icp/chronic-disease/moc/national-heart-failure-model-of-care-2021.pdf