

 **Heart failure**

policy and
practice
in Europe

Ireland



The Heart Failure Policy Network is an independent, multidisciplinary platform made possible with financial support from Novartis Pharma, AstraZeneca and Vifor Pharma. The content produced by the Network is not biased to any specific treatment or therapy. All outputs are guided and endorsed by the Network's members. All members provide their time for free.



**The Heart
Failure Policy
Network**



November 2020

About the Heart Failure Policy Network

The Heart Failure Policy Network (HFPN) is an independent, multidisciplinary network of healthcare professionals, advocacy groups, policymakers and other stakeholders from across Europe. It was established in 2015 with the goal of raising awareness of unmet needs and seeking meaningful improvements in heart failure policy and care. Our aim is to help reduce the burden of heart failure – on people living with it, those supporting them, health systems and society at large.

All members of the HFPN provide their time for free. All Network content is non-promotional and non-commercial. The Secretariat is provided by The Health Policy Partnership Ltd, an independent health policy consultancy based in London, UK.

Acknowledgements

This report is based on desk research undertaken in 2020 and interviews with experts who provided insights as to the national context. Research, coordination, drafting, expert interviews and member consultations were led by Sara C Marques and Ed Harding, with research assistance from Emily Kell. The report was edited by Madeleine Murphy and Kasia Trojanowska, and designed by Catarina Correia Marques.

The HFPN would like to thank the following experts for sharing their knowledge in interviews and supporting the development of this country profile:

- ▶ **Norma Caples**, Lead Nurse for National Heart Programme; Clinical Nurse Specialist, University Hospital Waterford; President, Irish Association of Heart Failure Nurses; Vice-President, Irish Nurses Cardiovascular Association
- ▶ **Joseph Gallagher**, General Practitioner; Clinical Lead in Cardiovascular Disease, Irish College of General Practitioners
- ▶ **Chris Macey**, Head of Advocacy, Irish Heart Foundation
- ▶ **Ken McDonald**, Clinical Lead for National Heart Programme; Founder and Medical Director, Heart Failure Unit, St Vincent's University Hospital; Medical Director, HeartBeat Trust
- ▶ **Ambrose McLoughlin**, Chairman, HeartBeat Trust; former Secretary General, Department of Health

We would also like to acknowledge the Project Advisory Group for *Heart failure policy and practice in Europe*, with special thanks to:

- ▶ **Elizabeth Killeen**, Heart Failure Specialist Nurse, Community Healthcare West, Galway
- ▶ **Neil Johnson**, Chief Executive, Croí, West of Ireland Cardiac Foundation; President, Global Heart Hub

For a full list of members of the Project Advisory Group, please see www.hfpolicynetwork.org/project/heart-failure-policy-and-practice-in-europe/

Please cite this report as: Heart Failure Policy Network. 2020. *Heart failure policy and practice in Europe: Ireland*. London: HFPN

Contents

About Heart failure policy and practice in Europe	5
Heart failure in Ireland	6
Heart failure policy in Ireland	8
Formal plans on HF	8
Investment in integrated HF models and facilitative tools	9
Development of the HF healthcare workforce	10
Guidance and local care pathways for delivery of quality care	11
Public audits of performance and high-level assessment initiatives	12
Heart failure practice in Ireland	13
Diagnosis	13
Hospital care and discharge	15
Key components of quality care in community settings	15
Tools and methods to support multidisciplinary and integrated ongoing HF care	17
The way forward	19
References	22

About Heart failure policy and practice in Europe

Heart failure (HF) is a common and complex condition responsible for extensive avoidable morbidity, mortality and healthcare costs. There is a clear need to advance HF policy and practice across Europe, and this requires recognition of the real challenge in each country.

To this end, the Heart Failure Policy Network (HFPPN) has developed *Heart failure policy and practice in Europe* – a comprehensive analysis of key gaps and best practice both in HF policy and in clinical performance across 11 European countries. In this work, we investigate each country's progress in addressing the HF challenge, for example in terms of the existence and implementation of HF policies and the provision of multidisciplinary and integrated HF care. Findings are presented in an overarching report, which outlines the methodology for this work and includes a pan-European narrative, and in standalone country profiles with dedicated national-level analysis.

Urgent action is needed to address the growing burden of HF and ensure the sustainability of our healthcare systems. This country profile aims to assist HF advocates across Ireland in engaging healthcare system leaders to demand constructive changes to HF policy and care provision, to reduce the impact of HF on people living with the syndrome, their families and carers, the healthcare system and society.

Heart failure in Ireland

SUMMARY

Heart failure (HF) places a heavy burden on people who live with it, their families and carers, as well as on health services in Ireland.¹ Governmental organisations have recognised the relevance and cost of HF, but existing strategies have yet to realise their full potential due to funding pressures. A reform of primary care services is currently ongoing and is expected to improve HF care in these settings, and several care models have been implemented to support people living with HF.²⁻⁴

While much has been achieved, several aspects of the challenge posed by HF still need to be addressed: the economic burden of HF is high, there are significant HF-related inequalities across the country and the HF specialist healthcare workforce is not sufficient to meet the demand.^{1,2,5-9} In addition, care pathways for HF are lacking, as are crucial elements of HF care, including cardiac rehabilitation.

HF is a common syndrome

There are approximately 90,000 people living with HF in Ireland – almost 2% of the population – and every year there are around 10,000 new diagnoses.^{1,5} HF prevalence increases with advancing age, and people with lower levels of educational attainment and socioeconomic status are disproportionately affected.^{10,11}

HF is associated with significant hospitalisation and outpatient service use, as well as mortality

HF is a significant cause of hospital admissions. It accounts for 5% of emergency medical admissions, of which 80% are among people aged over 65.¹² Readmission rates are also high – around 16% of people are readmitted within 30 days of discharge,² increasing to 24% within 12 weeks and 44% within a year.⁷ Estimates suggest that HF incurs relatively long hospital admissions, ranging from 10.6 to 15.7 days,^{2,6} with estimates for total bed days per year ranging from 59,000 to 231,000.^{2,5}

HF accounts for around 96,000 outpatient department visits a year, with waiting times for referral of six to nine months on average.² HF mortality is also significant, having been reported as higher than mortality due to bowel and breast cancer combined.¹³

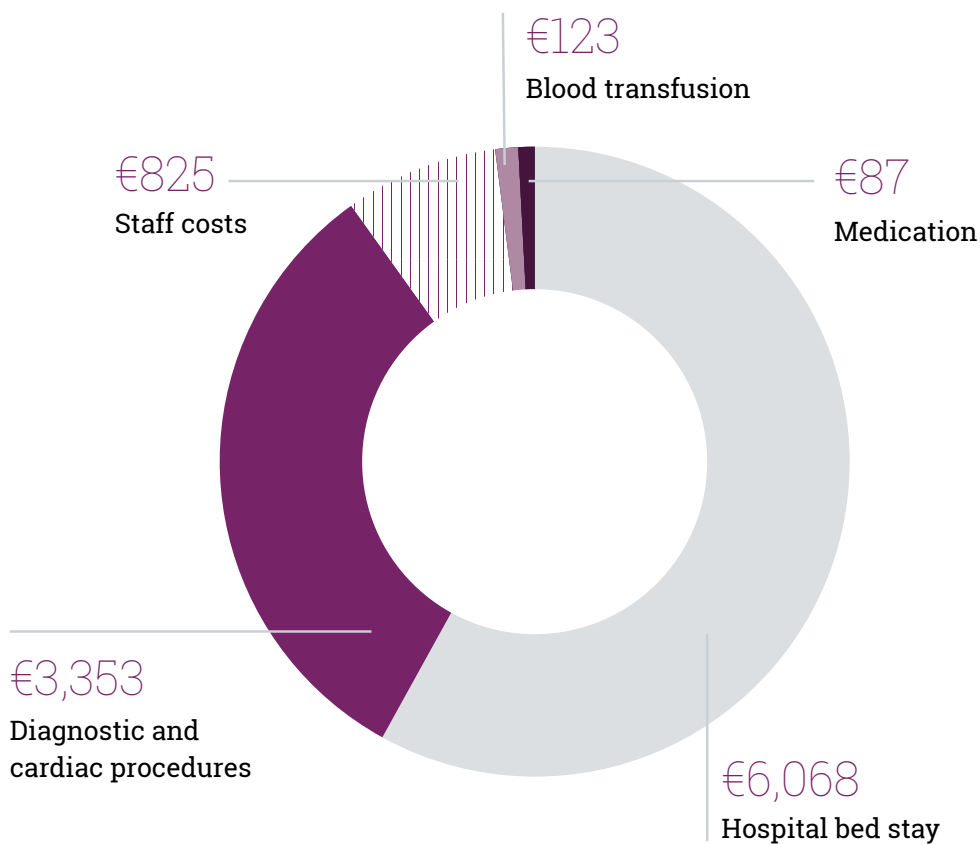
HF is associated with high expenditure

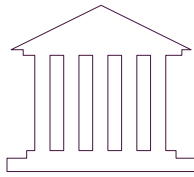
HF is responsible for significant costs. Estimates of direct costs linked to HF, including hospital and outpatient visits, range from €158 million to €277 million annually.^{1,5} Expenditure per HF admission has been estimated at more than €10,000, mostly due to hospital bed stay (see *Figure 1*).⁶ Medication, on the other hand, seems to account for a relatively small proportion of inpatient expenditure.⁶



Indirect costs linked to HF in Ireland are even higher than direct costs. For example, the total cost of HF in 2012 was estimated at approximately €660 million, with indirect costs accounting for around 55% of that figure (€364 million).¹

FIGURE 1. Estimated direct medical costs per episode of acute heart failure in 2015 in Ireland⁶





Heart failure policy in Ireland

Formal plans on HF

Ireland's formal plan to address HF is becoming dated and has suffered from lack of investment

In 2012, the Health Service Executive (HSE) launched the National Clinical Programme for HF. This ambitious plan included clear objectives in three areas – access, quality and cost – under the overarching aim of improving quality of life for people with HF.¹⁴ It also put forward recommended care models based on national guidelines and best-practice examples from Ireland and abroad. The vision of quality spanned the entire HF care journey, including prevention, hospital and community care, transitional care and self-care, among others. It stressed the importance of educating healthcare professionals on HF, for example via continuing medical education and professional development.

However, the programme received insufficient investment, attributed to the economic crisis that Ireland was facing at the time.¹⁵ This has stalled the progress that was so promising at the beginning. For example, while the plan aimed to increase the capacity of primary care to diagnose and manage HF,¹⁴ the available investment was mostly dedicated to the development of HF units, with no funds allocated to primary care.⁸ Although the plan has led to several important pilot initiatives in HF across Ireland and is still considered robust by key stakeholders, it requires financial resources and stronger political leadership to achieve its goals.⁹ In 2020, the National Clinical Programme for HF was combined with the programme for acute coronary syndrome to form the National Heart Programme.¹⁶

The current reform of primary care services is likely to improve HF care, but may not go far enough

The Department of Health, HSE and the Irish Medical Organisation are working on a system-wide reform that presents an important step in shifting chronic disease management from acute settings to the community and in improving integration of care, including in HF.² The programme aims to reach 75% of eligible adults over a four-year period.² Reportedly, the reform will ensure structured management of HF in primary care settings and will start to address the primary care elements of the 2012 National Clinical Programme for HF.⁸

Implementation of the primary care reform, which started in January 2020, was interrupted by the COVID-19 pandemic but resumed in July 2020.⁸ Experts report that the reform's main shortcoming is limited access, as it only serves people who have a medical card;⁸ in adults under 70, this depends on the household income level.¹⁷ In addition, the reform proposes that people with chronic diseases visit their general practitioner (GP) twice per year, but this may not be sufficient for people with HF, who often require additional consultations to ensure proper management of the syndrome and associated comorbidities.

The primary care reform provides a framework for better management of chronic conditions, but many primary care centres throughout the country may need further support, in terms of workforce and infrastructure, to deliver high-quality HF care. As noted above, primary care largely missed out on funding from the 2012 national plan, and gaps remain.

Investment in integrated HF models and facilitative tools

HF diagnostic tests are not consistently reimbursed, missing opportunities to streamline resource use and care pathways

Limited reimbursement of core diagnostic tests likely constitutes a barrier to HF diagnosis. Natriuretic peptide (NP) testing is available for prescription in hospitals, for both inpatient and outpatient visits, but availability for GPs is inconsistent.¹⁸ Securing access to echocardiography, the most accurate diagnostic test,¹⁹ is also challenging for GPs, as direct access (without requiring prescription by a specialist) is limited to a small number of hospitals.⁸ While echocardiography is reimbursed in community settings when prescribed by a cardiologist, experts state that access can still be difficult due to waiting times, which can be much longer in the public health system than for people who pay out of pocket or use private health insurance.⁸ Given the importance of rapid diagnosis of HF to long-term outcomes,²⁰ the lack of public reimbursement of key tests and the long waiting times are likely to accentuate inequalities.

Inadequate information technology systems hinder integration of HF care, but recent investment has led to some improvements

The absence of a standardised or comprehensive information technology (IT) system in the acute setting is a significant barrier to integrated care, hindering communication both between hospitals and between hospitals and primary care.^{8,18} Despite the National Clinical Programme calling for a new national IT system and the establishment of HF registries and audits, these are still lacking. Experts note the lack of electronic health records or a unique personal identification number for residents in Ireland as significant barriers to developing more capable IT infrastructure.¹⁸ They add that the IT system in primary care is more supportive of integrated working than that used in hospital HF care, as it typically allows for greater communication between professionals working in those settings.^{8,18} Policymakers are reported to be aware of the need for a better IT system to support communication between healthcare professionals at all levels of care, but the requirement for significant investment has delayed its development.¹⁶

Ireland has seen some recent investment in virtual communication for the management of HF. This includes funding of weekly consultations between GPs and cardiologists aiming to improve HF care in community settings.^{2,4} Experts report that the COVID-19 pandemic has increased awareness of the importance of remote follow-up of people living with chronic diseases: a financial incentive for telephone appointments was implemented in the first months of the pandemic, but this has now ended.⁸

Development of the HF healthcare workforce

Ireland formally recognises the role of HF specialist nurses via accreditation, but faces a wider shortfall in healthcare professionals

Ireland faces a significant shortfall in cardiologists, with a ratio per population reported to be lower than in almost every country in the European Union.^{21,22} Numbers of trainees to replace retiring specialists are insufficient.⁷ Experts also highlight that the workforce is significantly deprived of cardiologists with specialist training in HF.¹⁸

Encouragingly, the role of HF specialist nurses is formally accredited via professional certificates, and there are opportunities for training.²³ The lead nurse for the National Clinical Programme for HF has organised regional meetings for community nurses delivered by HF specialist nurses.¹⁶ While this has faced disruptions from the COVID-19 pandemic, a new HF programme is being organised for launch on the HSE online platform later in 2020.¹⁶

Overall, however, experts maintain that there are not enough HF specialist nurses in Ireland.⁹ The limited number of cardiologists who focus on HF also limits the involvement of HF specialist nurses in care, as strong collaboration between specialist cardiologists and nurses is required.¹⁸ Experts have also indicated that a bigger HF team is needed – including, for example, dietitians and psychologists¹⁶ – and that the role of patient organisations in providing some aspects of care in a formal and integrated manner, such as self-care education, should be further explored.⁹

Guidance and local care pathways for delivery of quality care

National guidance supports HF management, and the recent development of referral pathways is expected to help improve care

The Irish Cardiac Society has formally endorsed the 2016 European Society of Cardiology (ESC) HF guidelines as the national recommendations for HF care.¹⁸ In addition, in 2019 the Irish College of General Practitioners (ICGP) published a guide to HF care.^{24 25} The document includes a summary of the ESC HF guidelines and offers practical advice on HF diagnosis and management, for example on the side effects of common medicines, management of acute HF and provision of palliative care. It discusses comorbidities, their links with HF and treatment options. Finally, the HSE has published guidance on HF management during the COVID-19 pandemic to support ongoing care in the community and reduce the risk of hospitalisation for HF.²⁶

While existing HF guidance has provided a roadmap for diagnosis and management, a specific national pathway for referrals has been developed only recently. Experts report that this has established an electronic referral system that ensures consistency of the process,¹⁹ and has further supported the virtual consultation model between cardiologists and GPs.¹⁶ Implementation of the referral pathway is ongoing at a national level. Locally, some hospitals and other care settings have developed their own referral pathways to support management of chronic HF. As for acute HF, a new care protocol – requiring that people with HF admitted to a hospital be reviewed by a member of the cardiology team – is planned to be rolled out nationally soon.¹⁶

Public audits of performance and high-level assessment initiatives

There is a lack of national or regional audits allowing for oversight of HF services, and existing assessment initiatives focus on primary care settings

There is no national registry allowing for a comprehensive assessment of HF care services and patient outcomes. This may partly be addressed by the National Review of Specialist Cardiac Services, established by the Minister of Health in 2017.²⁷ This high-level policy review also seeks to identify international examples of best practice to support care improvement.²⁸ While HF falls within the review's remit, next steps and forthcoming outputs specific to HF are not clear.

Experts report that HF patient data in primary care settings typically offer good opportunities to analyse local performance and highlight key areas for improvement.⁸ To this end, in 2014 the Irish Primary Care Research Network developed a range of primary care data tools taking advantage of the IT system in those settings (see *Case study 1*).²⁹

CASE STUDY 1.

Tools to support HF care assessment

In 2014, the ICGP and the Irish Primary Care Research Network developed HF-specific tools to support the assessment of HF care and clinical practice:²⁹

- The **HF finder tool** can identify people who may have HF but have not been formally diagnosed. It filters patients by combinations of medications and conditions. GPs can review a person's notes to confirm whether they have an earlier HF diagnosis and add them to the system.
- The **HF register tool** can support auditing by creating a list of people with HF and including some basic parameters, such as blood pressure, to help characterise the HF population and challenge.
- The **HF safe prescribing** tool allows GPs to identify people with HF who may be taking medications that can exacerbate HF.
- The **HF audit tool** provides a detailed breakdown of the population with HF in the IT system, allowing for comparison of care across clinics.

In addition to these tools, in 2019 the ICGP launched a sample audit for HF care, where it included examples of criteria suitable for inclusion in HF care assessment initiatives.³⁰ Suggested criteria cover HF diagnosis, choice of medication, and recommendations on smoking cessation and vaccination. For each criterion, the guiding document suggests data collection tools.



Heart failure practice in Ireland

Diagnosis

Access to HF diagnostic tools is limited and, despite recent pilot initiatives, there has so far been no national concerted effort to improve this

Delays in diagnosis, often caused by limited access to HF diagnostic tools, are critical challenges in the management of HF in Ireland.^{8,18} In 2015, HeartBeat Trust assessed that the objective in the national strategy to diagnose every case of HF correctly and without delay was not yet realised and was heavily dependent on local resources.¹ In 2016, the Irish Cardiac Society echoed this view in calling for faster access to HF diagnosis.³¹ It stated that the period from presentation to diagnosis should last two to six weeks depending on severity at presentation, with validation by a specialist within a further four weeks. The society estimated that a six-month delay in HF diagnosis increased the rate of emergency hospitalisation for people with suspected HF by 23%.³¹

Longer-term issues with diagnosis are apparent in the historical data. A postal survey of 233 GPs conducted in 2012–13 reported on their limited access to HF diagnostic procedures, such as echocardiography, to which fewer than 1% of surveyed GPs had access.³² Only around half of the GPs reported accessing NP testing and 24-hour electrocardiography (ECG).

The National Clinical Programme for HF has led to several individual initiatives across Ireland aiming to prevent HF (see *Case study 2*) or improve HF diagnosis (see *Case study 3*). While these pilot initiatives are promising proof-of-concept models with attractive evidence of benefit, wider implementation will require investment.

CASE STUDY 2.

Preventing HF via screening of NP levels

STOP HF/STOP HF Midlands is a service aimed at preventing HF.³ It is based on a trial conducted in Dublin, which reduced new-onset HF and hospital admission for other major cardiovascular events.³³

STOP HF/STOP HF Midlands, which is supported by HeartBeat Trust, is available at St Michael's Hospital in Dun Laoghaire and certain general practices in the Midlands region.³⁴ It consists of community-based screening for NP levels to identify people with asymptomatic left ventricular dysfunction, which may lead to HF.³³ If this is suspected, the person is then referred for additional tests and, if their diagnosis is validated, appropriate management is initiated or their current medication adjusted to attempt to prevent progression to HF.³³ The service has been shown to prevent one cardiovascular hospitalisation per year for every 125 people enrolled. It is estimated that rolling out the service across Ireland could prevent 17,250 admissions per year, which may be equivalent to 138,000 bed days.³⁴

CASE STUDY 3.St Vincent's University Hospital, Dublin:
rapid-access diagnostic clinic

Since 2002, St Vincent's University Hospital has held a rapid-access diagnostic clinic allowing GPs to refer potential new HF cases presenting in the community to cardiology specialists with little delay.³⁵ Between 2002 and 2012, 733 people with suspected HF attended the clinic, of whom almost 40% were diagnosed with HF. Their prognosis was better than suggested by previous studies, which could be due to timely diagnosis, improved treatment options and care within an integrated management structure.

Hospital care and discharge

The limited number and unequal distribution of HF units hinders consistency in hospital-based HF care

There are several issues in the management of acute HF. Most prominently, HF units are not available in all hospitals and are unevenly distributed, generating regional inequalities in access.¹⁸ In 2018, six of the country's 12 HF units served Dublin.⁷ In addition, as a result of diagnostic barriers, GPs must often resort to referral to emergency departments in cases of suspected HF.³²

Where they exist, HF units lead a structured specialist service for acute HF.³ Care in these units is integrated and follows international best practice, in line with the model developed by the National Clinical Programme for HF.³ However, this is not standard practice in hospitals without an HF unit. In such cases, patients may be admitted to non-cardiology departments and discharged without seeing a member of the specialist team, but this is expected to change in hospitals that have a cardiology team following the implementation of the new care protocol.¹⁶

Provision of discharge planning is inconsistent between HF units and other settings

Experts report that discharge planning and post-discharge care in HF units is highly structured.¹⁸ It includes inpatient HF education sessions not only for the person living with HF but also for their family.¹⁶ Following discharge, the team in the HF unit typically follows up with people by phone within the first week of discharge, and again before an in-person appointment with a doctor within two weeks.

Elsewhere, however, discharge practices are likely to vary significantly. Historically, GPs have reported that the timeliness and quality of HF patient information received from hospitals is generally poor, hindering their ability to support people with HF in the community and therefore to prevent rehospitalisations.³²

Key components of quality care in community settings

Community settings do not consistently provide all of the services crucial for ongoing HF care

Three main barriers seem to prevent optimal management of HF in community settings: the lack of access to diagnostics, which obstructs specialist referral, initiation of treatment and adjustment of medication; difficulties in accessing specialists in a timely manner or at all; and low number of planned visits per year.⁸

Experts report that pharmacological treatment is typically aligned with clinical recommendations and several aspects of HF care follow international norms, or in fact lead the way internationally.¹⁸ Yet despite notable achievements, ongoing HF

management still faces many challenges. For example, a postal survey of GPs conducted in 2012–13 found that only 40% reported using HF guidelines in their practice.³² A study from 2014 in 12 HF specialist clinics found that only around two thirds of people with stable chronic HF had a heart rate of less than 70 beats per minute, as recommended in ESC guidelines.³⁶ Overall, this would suggest at least equivalent, and potentially greater, issues with HF management across other community settings. In addition, the basic infrastructure often encountered in community settings may be an obstacle to the involvement of HF specialist nurses in community care – for example, a lack of room where privacy could be ensured for the nurse to deliver care.¹⁶

Limited access to cardiac rehabilitation hinders effective long-term management of HF

In 2013, the Irish Association of Cardiac Rehabilitation issued guidelines covering a number of cardiac conditions, including HF.³⁷ However, in 2014, the HSE found that Ireland's capacity to provide cardiac rehabilitation met only 39% of the needs of people living with chronic heart disease, a capacity level ranging between 9% and 75% depending on the county.³⁸ Barriers include the fact that these services typically focus on post-acute coronary syndrome and are therefore usually based in hospitals.⁸

Patient therapeutic education is not consistently provided to people with HF

Experts state that while patient empowerment to self-care is common practice in HF units managing acute HF, it is lacking from care provided in other settings, primarily due to a shortage of HF specialist nurses and cardiologists.^{8,18} This results in people with HF and their families/carers often being unaware of self-care behaviours they should follow. Provision of self-care education is anticipated to improve with the 2020 primary care reform and increased awareness of the potential of virtual consultations that has arisen during the COVID-19 pandemic, which may facilitate remote support by HF specialist nurses.⁸

Provision of psychological support and palliative care for people with HF is insufficient

According to experts, few centres in Ireland include psychological support as a formal component in the management of HF.^{9,16} In efforts to address this gap, the Irish Heart Foundation provides its members with free access to six counselling sessions for the person living with HF and one family member.

In 2015, emerging community-based HF models were reported not to include a palliative care component,³⁹ despite people with HF having high palliative care needs, similar to people with cancer.⁴⁰ Experts report that the limited provision of palliative care is often due to lack of training of healthcare professionals and unwillingness to discuss end-of-life issues, such as deactivation of cardiac devices.⁹

Tools and methods to support multidisciplinary and integrated ongoing HF care

The implementation of tools and working methods to provide high-quality HF care is growing, but they need to be adopted more widely

Several initiatives have focused on promoting multidisciplinary and integrated HF care in Ireland, but many of them are pilots or local in scope. This means that integration of care is not yet a consistent reality across the country.

Some of the efforts to integrate care include the recognition of the role of HF specialist nurses and their collaboration with other professionals, such as primary care teams.¹⁴ One such example is the Heart Failure Integrated Care Project in the Community in the counties of Carlow and Kilkenny, which aims to integrate management of HF across primary and hospital settings.³ In this care model, specialist nurses visit an outpatient clinic, attend virtual clinics, provide same-day advice to GPs for emerging HF exacerbation, and support rapid but non-urgent decisions via email.³ The vital role of HF specialist nurses can also be seen in care provided in County Galway, where each specialist nurse provides care in several locations in collaboration with cardiologists and primary care teams.⁴¹ Other efforts in promoting multidisciplinary HF care include virtual consultations between GPs and cardiologists (see *Case study 4*).

CASE STUDY 4.

Promoting communication between GPs and cardiologists via virtual consultations

The Heart Failure Virtual Clinic has been an important pilot for advancing multidisciplinary care for HF in Ireland via remote consultation. The service was developed by HeartBeat Trust, St Vincent's Healthcare Group and the HSE to connect GPs with cardiologists.⁴² It provides GPs with rapid access to HF specialists remotely to help them manage HF in the community, aiming to minimise HF referrals and delays in seeking specialist involvement, as well as to reduce hospital admissions.^{2,4}

A review of the pilot showed considerable benefits – a 95% decrease in HF hospital admissions and an 87% decrease in referral to outpatient departments among the patients involved.² Other benefits included increased knowledge and confidence among GPs in managing HF and the avoidance of unnecessary travel for the person with HF.⁴ The pilot has been expanded to cover 150 GPs,⁴² and the model has been viewed by all stakeholders involved as a potential proof of concept for other disease areas, including diabetes, asthma and chronic obstructive pulmonary disease.²

The way forward

HF poses a challenge to the sustainability of healthcare systems in countries across Europe, including Ireland. It is a manageable – and often preventable – syndrome, yet it continues to affect a great number of people and its burden on the national health system and society is significant.

The HSE and the Department of Health outlined an effective response to HF in 2012, but since then significant opportunities have been missed to secure the required transformation of care and improvement of patient outcomes. In addition, the COVID-19 pandemic has disrupted existing services, making the improvement of the national response to HF even more pressing.

SEVERAL ACTIONS ARE ESSENTIAL TO ADDRESS THIS CHALLENGE.

Renew the strategic focus on HF with adequate funding

The development of the National Clinical Programme for HF in 2012 was an important step in addressing the HF challenge, but the programme was underfunded. The HSE and the Department of Health should re-engage stakeholders to renew the HF strategy as part of the recently created National Heart programme, with commitments for adequate funding for improvement of HF services. For example, the programme should ensure an HF unit in every hospital and develop the workforce with additional HF specialist cardiologists and nurses, as well as other crucial professionals.

Improve HF management in primary care settings by modifying the primary care reform and expanding access to NP testing

The ongoing primary care reform is expected to significantly improve chronic disease management, but it should recognise that people living with HF have specific needs and may require additional considerations, such as an increased number of GP visits per year. In addition, access to the services should be expanded to all people living with HF in Ireland. It is also crucial to ensure that GPs can instigate seamless diagnostic processes by allowing them direct access to key diagnostic tests, particularly NP testing. This can have a positive impact on reducing waiting times, facilitating access to treatment and HF management, and ensuring more appropriate use of specialist resources. It is equally important to tackle referral barriers to enable GPs to refer people with suspected acute HF directly to specialists rather than emergency care.

Invest in tools to support communication across care settings, including a comprehensive and integrated IT system and referral network

There is a clear need for investment in an IT system that fosters communication and collaboration across care settings, for example between cardiologists and other healthcare professionals, to enhance access to support and exchange of knowledge. It is also crucial to implement electronic health records and enable linkages between hospitals and the more advanced system available in primary care settings.

Develop a national HF registry or audit and incentivise wider use of existing data collection and assessment tools

The creation of the National Review of Specialist Cardiac Services was a valuable step taken by central government, which now must lead a full and substantial assessment of HF, without delay. Crucially, though, there remains a need for regular assessment of HF data through a formal registry or audit so the real challenge, as well as the impact of care and different care models, can be understood. In the meantime, at the local level, the tools developed by the ICGP offer opportunities to analyse local performance and highlight key areas for improvement in primary care. They can also support the development of national HF assessment initiatives, and their use should be incentivised.

Expand best-practice programmes shown to reduce hospitalisation and improve patient outcomes

To help reduce the number of hospital admissions for HF, it is essential to improve support available in the community and increase access to crucial elements of care, including cardiac rehabilitation. This requires both investment in community-based programmes and broader eligibility parameters to include people living with HF. Local and regional decision-makers should urgently examine the case for roll-out of successful initiatives such as the Heart Failure Virtual Clinic into regional or national models that provide multidisciplinary, integrated and person-centred HF care.

Focusing on these priority areas will likely offer a cost-effective opportunity to improve life for people with HF, reduce hospitalisations and mitigate future pressures.

This is an investment in a more resilient and prepared health system, not just for HF but for chronic diseases more generally.

The creation and maintenance of national strategies and plans in HF is likely to be vital to long-term success. There are many strengths and existing resources within the healthcare system on which to build. Lasting success will require effective central oversight of inequalities and unacceptable variations, as well as long-term collaboration and commitment from decision-makers, patient representatives, healthcare professionals and the private sector. Failure to pursue the actions recommended in this report will allow HF to continue to challenge the sustainability of the healthcare system in Ireland.

References

1. The Heartbeat Trust, Irish Heart Foundation, NUI Galway. 2015. *The Cost of Heart Failure in Ireland: The social, economic and health implications of Heart Failure in Ireland*. Dublin: The HeartBeat Trust
2. Health Service Executive. 2019. Terms of agreement between the Department of Health, the HSE and the IMO regarding GP contractual reform and service development. Available from: <https://www.hse.ie/eng/about/who/gmscontracts/2019agreement/agreement-2019.pdf> [Accessed 14/05/20]
3. Health Service Executive. 2018. Heart failure: Programme progress. Available from: <https://www.hse.ie/eng/about/who/cspd/ncps/heart-failure/achievements/> [Accessed 15/05/20]
4. Gallagher J, James S, Keane C, et al. 2017. Heart Failure Virtual Consultation: bridging the gap of heart failure care in the community - A mixed-methods evaluation. *ESC Heart Fail* 4(3): 252-58
5. Caples N, Cronin E, O'Connor CT, et al. 2018. Turning the tide of heart failure: The Irish experience in the implication of a modern community outreach programme. *Eur Heart J* 39(Suppl 1): 1198
6. Morgan RB, McCullagh L, Barry M, et al. 2017. The cost of inpatient management of heart failure patients: A microcosting study in the Irish healthcare setting. *Ir J Med Sci* 186(2): 293-303
7. Shannon J. 2018. Deficiencies in care for heart patients highlighted. [Updated 27/08/18]. Available from: <https://irishheart.ie/news/submission-highlights-deficiencies-in-care-for-heart-patients/> [Accessed 14/05/20]
8. Gallagher J. 2020. Interview with Sara C Marques at The Health Policy Partnership (Secretariat for Heart Failure Policy Network) [telephone]. 24/06/20
9. Macey C. 2020. Interview with Sara C Marques at The Health Policy Partnership (Secretariat for Heart Failure Policy Network) [videoconference]. 03/07/20
10. Barrett A, Burke H, Cronin H, et al. 2011. *Fifty plus in Ireland 2011: first results from the Irish Longitudinal Study on Ageing (TILDA)*. Dublin: The Irish Longitudinal Study on Ageing
11. Kenny RA, Hernández B, O'Halloran A, et al. 2020. *TILDA report to inform demographics for over 50s in Ireland for COVID-19 crisis*. Dublin: The Irish Longitudinal Study on Ageing
12. Health Service Executive. 2018. National clinical programmes: heart failure. Available from: <https://www.hse.ie/eng/about/who/cspd/ncps/heart-failure/> [Accessed 14/05/20]
13. HeartBeat Trust. Welcome to HeartBeat Trust. Available from: <https://www.heartbeattrust.ie/> [Accessed 13/08/20]
14. Health Service Executive. 2012. Heart failure model of care. Available from: <https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/heart-failure-model-of-care-jan-2012.pdf> [Accessed 21/05/20]
15. McLoughlin A. 2020. Interview with Sara C Marques and Stephanie Whelan at The Health Policy Partnership (Secretariat for Heart Failure Policy Network) [videoconference]. 17/08/20
16. Caples N. 2020. Interview with Sara C Marques at The Health Policy Partnership (Secretariat for Heart Failure Policy Network) [videoconference]. 02/09/20
17. Citizens Information. Medical card means test: aged under 70. [Updated 20/07/20]. Available from: https://www.citizensinformation.ie/en/health/medical_cards_and_gp_visit_cards/medical_card_means_test_under_70s.html [Accessed 28/08/20]
18. McDonald K. 2020. Interview with Sara C Marques at The Health Policy Partnership (Secretariat for Heart Failure Policy Network) [videoconference]. 21/08/20
19. Ponikowski P, Voors AA, Anker SD, et al. 2016. 2016 ESC guidelines for the diagnosis and treatment of acute and chronic heart failure. *Eur J Heart Fail* 18(8): 891-975
20. The Heart Failure Policy Network. 2018. *Pressure point 1: Presentation and diagnosis*. London: HFPN
21. The Medical Independent. 2019. Irish Cardiac Society 2017 Annual Scientific Meeting and AGM. Available from: <https://www.medicalindependent.ie/irish-cardiac-society-2017-annual-scientific-meeting-and-agm-2/> [Accessed 06/10/20]
22. Slachta A. 2019. Ireland suffering from lack of qualified cardiologists. Available from: <https://www.cardiovascularbusiness.com/topics/healthcare-economics/ireland-suffering-lack-cardiologists> [Accessed 06/10/20]
23. University College Dublin. 2016. Professional certificate heart failure nursing. Available from: <https://www.nmhs.ucd.ie/study-with-us/graduate-programmes/courses/professional-certificate-heart-failure-nursing> [Accessed 28/05/20]
24. Gallagher J, McDonald K. 2019. *Heart failure in general practice*. Dublin: Irish College of General Practitioners
25. Gallagher J, McDonald K. 2019. *Heart failure in general practice: Appendices*. Dublin: Irish College of General Practitioners
26. Health Service Executive. 2020. Guidance for Heart Failure Management during Covid-19 pandemic (CD 19-057 001/28.04.20). Available from: <https://hse.drsteevenslibrary.ie/c.php?q=679077&p=4865643> [Accessed 08/10/20]

27. Department of Health. 2018. National review of specialist cardiac services: summary. [Updated 11/06/18]. Available from: <https://www.gov.ie/en/consultation/13371106-national-review-of-specialist-cardiac-services/> [Accessed 26/05/20]
28. Department of Health. 2019. National review of specialist cardiac services. [Updated 28/06/19]. Available from: <https://www.gov.ie/en/collection/7eaa8d-national-review-of-specialist-cardiac-services/> [Accessed 26/05/20]
29. Gallagher J. 2014. Tools to identify heart failure patients and help you conduct an audit. [Updated 20/06/14]. Available from: https://www.icgp.ie/go/research/news_events/430FA1B8-F32C-163A-2BCD98A3F38C3144.html [Accessed 28/05/20]
30. Gallagher J, Collins C. 2019. Heart failure sample audit. [Updated 01/01/19]. Available from: https://www.icgp.ie/go/pcs/scheme_framework/clinical_audit/sample_audits [Accessed 14/05/20]
31. Irish Cardiac Society. 2016. Irish Cardiac Society calls for rapid community heart failure diagnosis. Available from: http://www.irishcardiacsociety.com/pages/news_box.asp?NewsID=19792213. [Accessed 14/05/20]
32. Marsden P, Gallagher J, Ledwidge M, et al. 2014. *A picture of general practice research in Ireland 2012-2013: Through research and audit activity - General practitioners' perception of heart failure services in Ireland highlights ready access to diagnostics and opinion as major deficiency*. Dublin: Irish College of General Practitioners
33. Ledwidge M, Gallagher J, Conlon C, et al. 2013. Natriuretic Peptide-Based Screening and Collaborative Care for Heart Failure: The STOP-HF Randomized Trial. *JAMA* 310(1): 66-74
34. Health Research Board. 2017. Stopping Heart Failure – More than 3,000 people benefit as result of Irish led trial. Available from: <https://www.hrb.ie/news/press-releases/single-press-release/article/stopping-heart-failure-more-than-3000-people-benefit-as-result-of-irish-led-trial/> [Accessed 09/09/20]
35. James S, Barton D, O'Connell E, et al. 2015. Life expectancy for community-based patients with heart failure from time of diagnosis. *Int J Cardiol* 178: 268-74
36. Moran D, Buckley A, Daly K, et al. 2014. Heart rate awareness in patients with chronic stable heart failure. A multi-center observational study. *Int J Cardiol* 177(2): 380-84
37. McCreery C, Cradock K, Fallon N, et al. 2013. *Cardiac rehabilitation guidelines 2013*. Dublin: Irish Association of Cardiac Rehabilitation
38. Mullaney C, Petty-Saphon N, Jennings S, et al. 2017. A needs assessment for cardiac rehabilitation in Ireland. *Int J Integr Care* 17(5): A382
39. Mater Misericordiae University Hospital, Connolly Hospital, St Francis Hospice. 2015. Heart failure and palliative care: report on an action research project. Available from: <http://hospicefoundation.ie/wp-content/uploads/2015/05/Heart-Failure-Report.pdf> [Accessed 14/05/20]
40. O'Leary N, Murphy NF, O'Loughlin C, et al. 2009. A comparative study of the palliative care needs of heart failure and cancer patients. *Eur J Heart Fail* 11(4): 406-12
41. The Heart Failure Policy Network. 2018. Pressure point 3: Clinical management. London: HFPN
42. eHealth Ireland. Heart Failure Virtual Clinic infographic. Available from: <https://www.ehealthireland.ie/Case%20Studies/Heart-Failure-Virtual-Clinic/Heart-Failure-Infographic.pdf> [Accessed 06/10/20]



The Heart Failure Policy Network

To find out more about the Heart Failure Policy Network and this work, go to **www.hfpolicynetwork.org**

If you have any comments or questions, please get in touch with the authors at **info@hfpolicynetwork.org**

© 2020 The Health Policy Partnership Ltd. This report may be used for personal, research or educational use only, and may not be used for commercial purposes. Any adaptation or modification of the content of this report is prohibited, unless permission has been granted by The Health Policy Partnership.