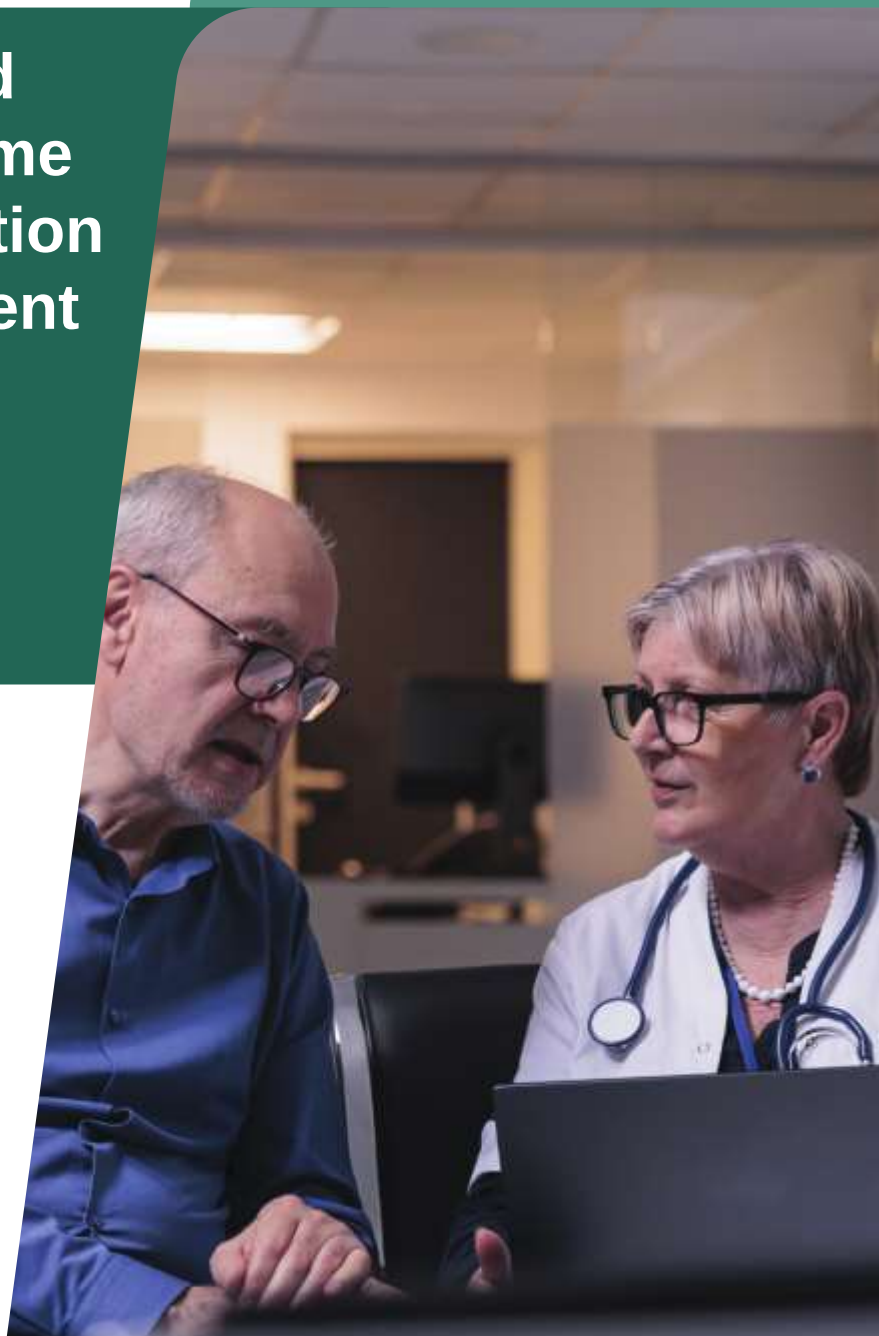
HSE Integrated Care Programme for the Prevention and Management of Chronic Disease Newsletter

Issue 3
March 2024



Integrated Care Programme for the Prevention and Management of Chronic Disease

Welcome to the Spring 2024 edition of the HSE Integrated Care Programme for the Prevention and Management of Chronic Disease Newsletter

There is huge momentum and progress across all ICP CD sites. Engagements are ongoing with the Integrated Care Programme for the Prevention and Management of Chronic Disease, and the National Clinical Programmes of Respiratory, Heart and Diabetes have now visited all of the operational ICP CD Community Specialist Teams. It is clear that the model is having a positive impact on the health outcomes of individuals living with chronic disease and multi-morbidity in the Community. We have lots of interesting updates within this newsletter from Cardiology "Echo in the Park", Model of Care for Cardiac Rehab, Respiratory "Bray Hub Transforms Respiratory Care" and "Diabetes Prevention Programme Update."

The ICP CD and Community Specialist Teams have featured in a number of written pieces, interviews and media queries which demonstrates huge interest in the changes that are happening in chronic disease service delivery in the community. We have published a range of patient and staff case studies highlighting the value of the ECC on #OurHealthService. Some Community Specialist Teams are also sharing their good news stories in Health Matters and on Viva Engage. We would encourage you, where possible, to support and interact with any online HSE platforms to share your positive experiences of the ECC services.

For the HSE, 2024 is a year of consolidation and while the recruitment pause is in place we need to place emphasis on demonstrating impact, and support the return of the ECC metrics so we can continue to demonstrate a positive impact on hospital avoidance, shortened length of stay and reduced waiting lists. We welcome the news that the Community Specialist Teams are already having an impact on these important measures of access to care. Nationally we are currently performing a team validation exercise to ensure all of the resources funded under ECC and MCP which are on boarded are working in accordance with the Model of Care for the Prevention and Management for Chronic disease, and that the expected activity of teams is clearly understood.

I hope you enjoy this issue of our newsletter and as always, please contact us with any comments or suggestions at :

Maireád Gleeson

General Manager, Office of National Clinical Advisor & Group Lead (NCAGL) for Chronic Disease & Integrated Care Programme for Chronic Disease

Email: mairead.gleeson1@hse.ie

New Appointment
Director of Nursing, Nurse Lead Integrated Care Programmes for Chronic Disease

In November 2023, Ms. Sandra McCarthy joined the ICPCD team as Director of Nursing, Nurse Lead Integrated Care Programmes for Chronic Disease. As Director of Nursing for ICP Chronic Disease, Sandra will provide nursing leadership, support nursing excellence, and build capacity in nursing workforce within chronic disease through her work at national level to drive and support the implementation of the National Framework for the Integrated Prevention & Management of Chronic Disease in Ireland. The role involves working across acute and community services.

Sandra is a Registered General Nurse and a Registered Nurse Tutor with extensive clinical, educational and managerial experience. She is an experienced health care provider with in-depth knowledge of operations management, administrative management and financial management. Sandra has over 28 years of experience in effectively delivering in the health arena, including direct and indirect patient care, graduate and postgraduate education. She has held the positions of Clinical Placement Co-Ordinator, Education Co-Ordinator, Head of Learning & Development and Director of Nursing in both model 3 and model 4 acute hospitals.

Her areas of interest are improving the delivery of safe, effective, quality care to patients and the professional development of health care staff. She is a keen advocate of developing Nursing Leadership and advancing nursing roles in the development of holistic and integrated care.

Two of Sandra's' key priorities for 2024 are;

Establishing Nurse Reference Groups for Nurses working in integrated care roles within Respiratory, Cardiology and Diabetes. This will provide a collaborative platform to ensure a national collective voice for nurses working in these roles.

There will also be several engagements with Senior Nurse leaders and key stakeholders e.g. Directors of Nursing and Directors of Public Health Nursing, to drive forward the ambitious programme for Chronic Disease Specialist Teams.

Please feel free to contact Sandra at sandram.mccarthy@hse.ie

The National Clinical Programme for Diabetes Documents Launch

The National Clinical Programme for Diabetes documents launch was held on the 28th February 2024 and was opened by Minister for Health, Stephen Donnelly.

The webinar was hugely successful and well attended. All participants who completed the post-launch survey rated the webinar as beneficial. The following documents were launched at the event

- Diabetes in Pregnancy: A Model of Care for Ireland (2024)
- Sick Day Advice leaflets
- National Insulin Titration Guideline for Nurses & Midwives working with people with Diabetes who require Subcutaneous Insulin Injections
- National Diabetes Prevention Programme report
- DISCOVER DIABETES – Type 2 report
- Language Matters document (in collaboration with Diabetes Ireland)
- Survey report: Transition of care of Adolescents/Young Adults with Type 1 Diabetes Mellitus from paediatric to adult outpatient services

Speakers at the event included Minister for Health Stephen Donnelly, National Clinical Advisor for Chronic Disease Dr. Sarah O'Brien, Prof Fidelma Dunne, Prof Mary Higgins, Clinical Lead Prof O'Keeffe, Prof Dinneen, Pw Diabetes, Midwifery, Nursing & HSCP NCP Diabetes leads, Self-Management Education team.

The full webinar recording will be available on the ECC HSELand Hub and the HSE Youtube channel. Diabetes Programme Documents & Resources are available at: https://www.hse.ie/eng/about/who/cspd/ncps/diabetes/resources/programme-documents-resources.html

"Seamless - congratulations on an absolutely fantastic webinar from every perspective: content, collaboration, resource flagging, webinar flow, NCP overview."

"Excellent update and great to have these documents published. Well done to all involved."

"Well done on a super webinar. It was impressive and inspiring to see such high level outputs and collaboration across a wide range of stakeholders, along with endorsement from Minister Donnelly. And also, it is much appreciative to have moved with the times to have this event held online, and not the traditional face-to-face approach inaccessible to many. Well done to all involved!"

"It was one of the best events I have ever experienced online"

Congratulations!

The NCP Diabetes wish to acknowledge and congratulate Prof Fidelma Dunne on her selection by the American Diabetes Association as the Norbert Freinkel recipient for 2024 for contributions to Diabetes in Pregnancy. This has not previously been given to an Irish person.

Prof Dunne co-chaired along with Prof Mary Higgins the Diabetes in Pregnancy Model of Care Development Group and presented at our recent launch of the document which is available at https://www.hse.ie/eng/about/who/cspd/ncps/diabetes/moc/

Diabetes Prevention Programme Update

	National Diabetes Prevention Programme - Key Milestones to date
2020 **2021** **2022**	Slaintecare funding secured to design, develop pilot and evaluate a DPP for Ireland Programme designed and piloted in six CHO's – 2,3,4,5,8 & 9 Staff training and roll-out of DPP implementation in other CHO areas
2023 **2023**	**Pilot phase evaluated**: Results show positive clinical and health behavioral outcomes. **50% of cohort returned to normoglycemia at 1 year.** Participants reported high levels of satisfaction with the programme. **QISMET Accreditation Awarded**: The programme meets the standards set for good practice in self-management education, ensuring the highest possible quality service is provided for people living with this condition.
2024	Full Diabetes Prevention Programme Evaluation Report published. Available on request from liz.kirby@hse.ie or to download from HSEland/ECC/ICPCD/Diabetes/Reports (March 2024) In person face to face group programmes starting Spring/Summer 2024 DPP is currently being adapted for women Post Gestational diabetes. A pilot underway in Tallaght hub, CHO 7. Diabetes Prevention – A guide to Healthy Living A5 resource information booklet published www.hse.ie/pre-diabetes and hard copies available to order from www.healthpromotion.ie (March 2024)

What is the National Diabetes Prevention Programme?

The National Diabetes Prevention Programme (DPP) is an evidenced based, quality assured lifestyle and behaviour change group intervention programme for people with pre-diabetes.

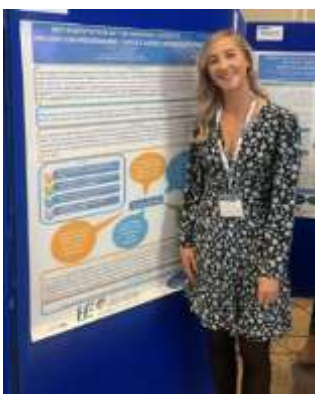
It supports those at highest risk of type 2 diabetes to reduce their risk through a 12 month programme of care offered as 6 weekly sessions followed by 8 monthly sessions. It is delivered by trained community dietitians in their role in the hub community specialist teams.

Who can access DPP?

Eligible participants are those with pre-diabetes, defined as having HbA1c 42-47mmol/mol and/or fasting plasma glucose of 6.1-6.9 mmol/l. It is open to private patients and those with a GMS/GPVC and is FREE for all to attend.

How can people access the DPP?

By a GP referral to the community dietitian in the community specialist teams. For GP practices using healthlink simply choose Diabetes Prevention Programme on the drop-down menu (in areas where it has been activated).



Eimear Gibbons, Dietitian, CHO 1 conducted a service user evaluation of DPP in Errigal Hub and shared the positive feedback at the Autumn NIPC Conference, Sligo

"I have received great support towards making some lifestyle changes to prevent diabetes"

David Johnson, Dietitian and Team in CHO 7, Tallaght hub, actively promote and deliver DPP online and currently pilot In-person programmes. Presenting their experience of service delivery at the All-Ireland Conference on Integrated Care, 23rd March 2023.

"Great support from the facilitators and the interaction with the other participants was always helpful"

Where to find more information
To find out about courses running in your area contact the Community Dietitian in the Community Specialist Teams in local hubs.
Pre-diabetes information on the HSE A-Z www.hse.ie/pre-diabetes
DPP information video available to share with patients/service users/colleagues https://www.youtube.com/watch?v=hiJF9Gwon_4

Thank You to the Senior Community Dietitians who shared their knowledge skills and expertise in the delivery of DISCOVER DIABETES -Type 2 and DESMOND, group self-management education and support to pilot the DPP in 2021/2022. Katriona Kilkelly & Ciara Heverin (CHO 2-Galway), Maria Barrett & Sinead Cunneen (CHO 3- Limerick), Lisa Cronin (CHO 4- Cork), Nadine Drew (CHO 5- Waterford), Mary O'Sullivan (CHO 5 – Carlow/Kilkenny), Olive Tully and SallyAnn McLaughlin (CHO 8- Louth).

Echo in the Park

Dublin North West Integrated Care Centre

My name is Louise Kiernan and I have been working as a Cardiac Physiologist for 40 years. I have accreditation from the British Society of Echocardiography and I have recently been appointed as Senior Cardiac Physiologist in the Community Health Organisation 9 (CHO 9). The Dublin North West Integrated Care Centre is based in Cuan Aoibheann in the Phoenix Park and provides community based health care for people living in Blakestown, Blanchardstown and Finglas.

The Cardiology service is led by Dr Lavanya Saiva, Consultant Cardiologist. Our team consists of 1 Cardiac Physiologist, 1 Cardiac Rehabilitation Nurse Coordinator, 1 Heart Failure (HF) cANP, 4 Clinical Nurse Specialists and administrative support team.

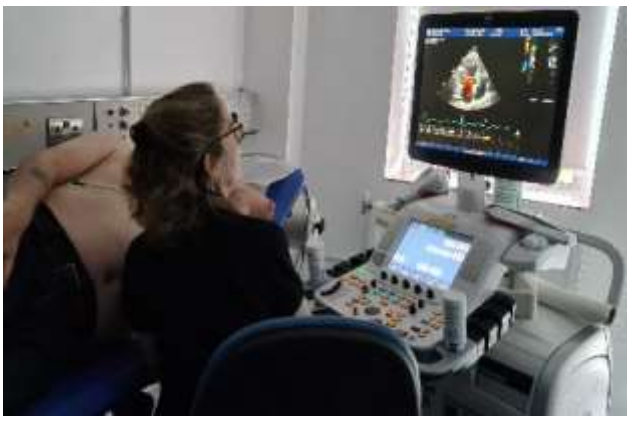
As we celebrate our first anniversary in Cuan Aoibheann, I would like to highlight the success of the cardiac diagnostic service provided in the Connolly hub. To date the team have provided;

- 790 OPD reviews comprising 466 new patients and 324 return visits
- 466 ECGs
- 266 ECHOs

The establishment of the service at Cuan Aoiheann allows timely diagnosis and management of patients with chronic disease in the community. From 21/11/22 to 03/08/2023, 423 patients (41% of the overall total) were taken off the Connolly Hospital waiting list. This has reduced the wait time in Connolly Hospital from 13 months to 8 months.

The advantages of visiting this location includes a shorter waiting time for clinic appointments and investigations. These are usually done on the same day avoiding multiple visits and improving scheduling efficiency.

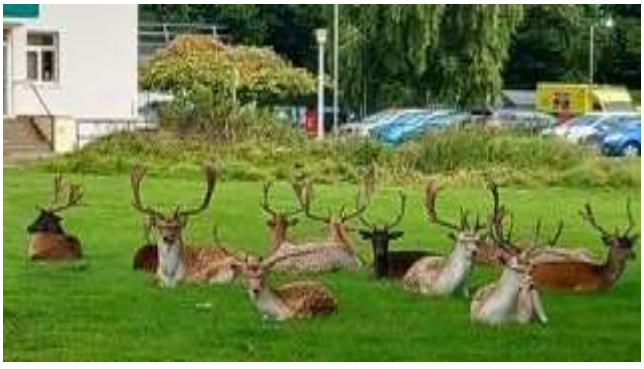
A new initiative is the joint Cardio-Respiratory clinic which is led by the Consultant Cardiologist, Dr Saiva and Dr Abirami Subramaniam, Consultant Respiratory Physician. This clinic was launched in April 2023 and is held once a month. The inter-speciality team approach has been beneficial in reducing the number of visits required for diagnostics. Currently onsite diagnostics including ECG, ECHO and Pulmonary function tests are available for patients with complex cardiopulmonary disorders.



The MDT meetings provide a collaborative learning space and help make the staff feel part of a team. These joint clinics provide a one stop solution under one roof. The waiting time for ODP review for these patients has now been reduced from 12 months to 2 months.

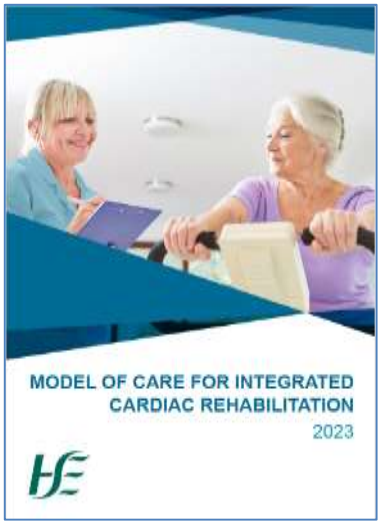
A GP direct ECHO referral service for patients with new Atrial Fibrillation or signs of heart failure was launched in October 2023. Again, this is in an effort to offer prompt assessment and help the GP in the management of such patients.

To date we have received positive feedback from our service users including patients and family members attending the service. In particular, they refer to the friendly “meet and greet” approach and ample free car parking. Many patients say that the clinics do not seem as busy as in a larger hospital and they feel that they have more time with the clinicians. Additionally, many patients find that experiencing the natural beauty of Phoenix Park makes them more relaxed.



The Model of Care for Integrated Cardiac Rehabilitation

The first-ever model of care for cardiac rehabilitation in Ireland has recently been published. The *Model of Care for Integrated Cardiac Rehabilitation* presents best evidence and practice for a high quality, equitable and person-centred cardiac rehabilitation service for those living with cardiovascular disease In Ireland.



Access to Cardiac Rehabilitation

For people who have been hospitalised with cardiovascular disease, prevention of repeat events and hospitalisations is paramount, but many lack access to vital preventive services. Cardiac rehabilitation has consistently been demonstrated to significantly reduce illness, hospital admissions and death amongst patients with established cardiovascular disease, while also increasing their quality of life. Access to cardiac rehabilitation is severely limited, with 40% of eligible patients waiting at least three months.

A Person-Centred Approach

The development of this national *Model of Care for Integrated Cardiac Rehabilitation* is a major step forward that 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. The model also places a focus on encouraging and supporting referral to, and attendance at, cardiac rehabilitation for those who are traditionally under-referred to cardiac rehabilitation, such as women, older patients and marginalised groups.

Reflecting Sláintecare

The Model of Care was developed by the Prevention Sub-Group of the Clinical Advisory Group of the National Heart Programme in partnership with key stakeholders. Reflecting the Sláintecare vision, the model recommends the integration of cardiac rehabilitation services across hospital and community settings to provide person-centred care by a multidisciplinary team of nursing, health and social care professionals, medical and administration staff.

Dr. Colm Henry, Chief Clinical Officer, welcomed the model of care: ***"I greatly welcome this Model of Care for Integrated Cardiac Rehabilitation, which was developed by a multi-disciplinary group, led by Prof William McEvoy and supported by the HSE National Heart Programme and Integrated Care Programme for Chronic Disease. The development of this Model of Care is a major step forward in that it will ensure that eligible patients across the country receive standardised care, in a timely manner and based on the best available evidence. I would like to acknowledge the work of all involved to make this Model of Care available for patient care to further improve the management of chronic cardiovascular disease in Ireland."***

Dr Angie Brown, Medical Director, Irish Heart Foundation, added***: "The Irish Heart Foundation whole-heartedly welcomes the Model of Care for Integrated Cardiac Rehabilitation, as it is an essential component of secondary prevention of cardiovascular disease. We know from supporting and advocating for patients living with cardiovascular disease and their families that these patients need ready access to cardiac rehabilitation. This Model of Care will support healthcare professionals to provide this service and provide a mandate to fund and equip cardiac rehabilitation centres. This will have a significant impact in saving lives and improving the quality of life of large numbers of cardiac patients all over Ireland."***

In 2024, the HSE Integrated Care Programme for Chronic Disease and the National Heart Programme are moving towards implementation of the Model of Care. They will support existing and newly-established cardiac rehabilitation centres.

Pictured: Mr David Kelly, Chair, Heart and Stroke Voice Ireland; Dr Susan Connolly, Consultant Cardiologist, Galway City Hub; Professor Bill McEvoy, Consultant Cardiologist, University Hospital Galway and Professor Ken McDonald, Clinical Lead, National Heart Programme, at the launch of the Model of Care for Integrated Cardiac Rehabilitation, 18 October 2023.

Watch Dr Susan Connolly, Integrated Care Cardiologist, and her team describe how they deliver an integrated cardiac rehabilitation service in Galway City Hub here.
The *Model of Care for Integrated Cardiac Rehabilitation* is available here.
Watch the webinar recording of launch of the *Model of Care for Integrated Cardiac Rehabilitation* here.

News Update: Integrated Chronic Disease Care Study Day

Integrated Care: Bringing Care Closer to Home

Chronic diseases are increasing in Ireland and posing a challenge for healthcare professionals. The HSE Enhanced Community Care (ECC) programme provides healthcare services closer to people's homes. This approach aims to reduce hospital waiting lists and prevent repeat admissions.

Practice nurses are essential in providing quality care to patients across GP practices. That's why we at HSE Dublin South, Kildare & West Wicklow Community Healthcare (DSKWW CH) prioritise their continuous education on chronic disease, which is crucial to improving patient care. By equipping practice nurses with the necessary knowledge and skills to manage chronic conditions effectively, we aim to provide high-quality care to patients. Therefore, we have made continuous professional development of practice nurses a critical component of our overall strategy.

Members of DSKWW CH developed and facilitated a comprehensive study day on the 22nd of November 2023 at the Trinity Rooms in the Russell Building in Tallaght to ensure practice nurses were kept up-to-date with evidence-based treatment and guidelines for managing chronic disease within their practice and identifying who and how to refer to the community ambulatory care hubs for specialist intervention.

Organisational Group: Naas Hub: Dawn Healy Clinical Specialist Podiatrist, Geraldine Cully Operational Lead, Una ONeill cANP in Diabetes, Stephanie Cronan Administrator , Melissa Murray Project Officer, Tallaght Hub: Gillian O'Loughlin Operational Lead.

Christina Doyle, Terenure Hub Gillian O'Loughlin, Tallaght Hub, Neil Dunne, DPHN, Dublin South City Geraldine Cully, Naas Hub, Sandra McCarthy, Director of Nursing, Nurse Lead Integrated Care Programmes for Chronic Diseases. Una O'Neill cANP Integrated Diabetes Naas Hub,Tara Creighton, Cherry Orchard Hub. Pauline Whistler General Practice Nurse, The Woods Surgery Clane, Co Kildare

During the study day, various specialist speakers from nursing, dietetics and podiatry from DSKWW CH shared their knowledge and expertise through presentations and workshops. Some of the topics covered included heart failure, diabetic kidney disease, the role of the ANP in diabetes care, carbohydrate awareness, and how to carry out a comprehensive diabetic foot assessment. The workshops offered the participants with a hands-on experience in practicing techniques that could be utilised in their practice.

Guest Speaker: Hub 4, Olivia Lee Integrated ANP Respiratory. Hub 2: Fiona Fullam Integrated Diabetes CNS, Fiona O'Shea Senior Diabetes Dietitian, Sandra Shaughnessy Integrated Respiratory CNS. Hub 1: Louise Connelly Integrated Diabetes CNS. Dorothy Moore ANP in Diabetes Carlow-Kilkenny.

The demand for the study day was evident with seventy-one practice nurses out of 110 healthcare professionals registered and in attendance at the event. The feedback was extremely positive, and the attendees requested that the study day be run annually.

Feedback Outcome (N=62)

· 96 % agreed their learning needs where met
· 95% agreed the presentation and workshops offered useful and applicable information that can be implemented in their clinical practice.
· 99% are interested in future education and would recommend this study day to their colleagues.
· 98% believed the topics were relevant to their practice

The appetite for practice nurses to remain equipped and up-dated to best practice was evident throughout the day. The event created a venue for healthcare professional to collaborate and network, promoting a supportive integrated community.

Brian Kearney, Head of Service, Primary Care, Geraldine Cully Operational Lead, Ann Fitzpatrick Guest Speaker, ANP Integrated Diabetes, Gillian O'Loughlin Operational Lead, Neil Dunne, DPHN, Dublin South City, Dublin South, Kildare West Wicklow

Transforming Respiratory Care: A Breakthrough in the Bray Chronic Disease Hub

"As we enter the Springtime, NCP Respiratory would like to say a sincere 'Thank you!' for all your continued dedication to improving the care for people with COPD and Asthma in Ireland. Throughout 2023 and early 2024 we visited you and saw all the great work that is being done around the country implementing the Models of Care for COPD and Asthma. In this quarter's Newsletter, NCP Respiratory would like to highlight the recent work of the St. Vincent's University Hospital/CHO 6 Integrated Respiratory Service, specifically showcasing how they are now delivering direct access diagnostic spirometry for GPs within a Hub and Spoke Integrated Pulmonary Function Laboratory model."

The inauguration of the Respiratory Physiology Service at the Bray Integrated Care Hub on January 15, 2024, marked a pivotal moment in respiratory care, providing patients in CHO 6 with advanced diagnostics and streamlined healthcare pathways. This innovative service not only sets a new standard for patient-centred care but also serves as a model for effective collaboration and integration within the healthcare system.
The initial vision for the Respiratory Physiology Service was ambitious yet crucial for enhancing patient care. The goal was to connect the Pulmonary Function Testing (PFT) equipment in the hub to the server at St. Vincent's University Hospital (SVUH), thus establishing a network that would include all PFT equipment at SVUH, St. Michael's Hospital and the integrated care hubs in CHO 6. This network now allows remote access to reports through an application on the SVUH portal for all Spirometry and PFTs performed by Physiologists across these areas. With easy access to GP requested Spirometry and PFT reports, consultants can add their interpretation and comments before the comprehensive report is sent to the GP. Importantly, the integration also allows the Chief Physiologists to include diagnostic tests performed in the community in the department's quality assurance practices, further ensuring adherence to technical guidelines and the accuracy of reports.

Emma Smyth, Geraldine Nolan, Alessandro Franciosi and Rachel Anglin

The integration process, a complex undertaking, involved coordination between the HSE ICT department, SVUH's ICT department, and the ICT specialist from the equipment supplier. Overcoming the challenge of linking HSE site equipment to a non-HSE hospital group server was no small feat, and the collaborative efforts of all parties involved deserve commendation.

Our service model builds upon the foundation laid by Sláintecare's project SIF159, where Senior Respiratory Physiologists conducted bronchial responsiveness testing and respiratory reviews in the community. In addition to delivering GP direct-access Spirometry, our model has been refined and expanded to incorporate full pulmonary function tests as deemed necessary by the Physiologist, along with onward referrals to members of the Respiratory Integrated Care (RIC) team for further review. These developments are consistent with both the NCP Respiratory Models of Care for COPD and Asthma and the published *ICPCD Patient pathway Direct GP Access Spirometry +/- Reversibility Service* Flow Chart.

The service also addresses the holistic needs of patients, with Respiratory Physiologists working closely with the Respiratory CNS team. 32% of patients are directly referred to the CNS team following assessments, saving time for both the patient and the GP. 24 Smoking cessation referrals have been directly made by the Respiratory Physiology team, underscoring the service's commitment to comprehensive patient care.

A novel addition to the service is the reflex peak flow monitoring for patients where asthma cannot be ruled out. This post-assessment monitoring, accompanied by informative materials and digital resources, provides the CNS with valuable insights into the patient's condition before their first visit, streamlining the patient journey. The innovative use of QR codes on the peak flow information sheet represents a forward thinking strategy that enhances patient education and engagement while facilitating more efficient healthcare delivery.

Looking forward to 2024, the Respiratory Physiology team is poised to expand its suite of tests by incorporating FeNO testing, offering additional diagnostic capabilities. Furthermore, plans include training a further senior team member in advanced practice and active participation in community-based traveller health clinics.

The Respiratory Physiology Service at the Bray Integrated Care Hub exemplifies a paradigm shift in respiratory care, showcasing the power of collaboration, integration, and innovative approaches for the benefit of patients in CHO6 and beyond.

CHO 6 NCP Respiratory & Integrated Respiratory Care site visit Jan 2024

NCP Respiratory are collaborating with Asthma Society of Ireland on their adviceline for COPD and Asthma. As part of this collaboration we are supporting making the adviceline more accessible by having an e-referral for healthcare professionals. This has just been launched and the platform, available on the Asthma Society website at https://www.asthma.ie/patient-e-referral, allows healthcare professionals all over Ireland to refer patients or carers with questions/concerns about asthma or COPD to the charity's Adviceline service. Through the Adviceline, respiratory nurse specialists and physiotherapist provide information and support, promote self-management, and signpost to appropriate healthcare interventions. Healthcare professionals can now, with the permission of the patient, complete a simple form on the asthma society website to refer patients or their carers to the service. The form gathers some basic contact information which will allow a member of the Asthma Society's Patient Services team to get in touch with the patient directly and arrange an appointment with a nurse specialist or physiotherapist.

ICPCD Staff Training Courses and Resources:

HSELand Resources:

There are additional resources for ICPCD staff available in the ECC HSELand Hub which can be located here: https://cnh.hseland.ie/icpcd/about/

The National Heart Programme E-Learning modules available on HSEland are located here: https://cnh.hseland.ie/icpcd/cardiology/ E-Learning modules available on HSEland include: Introduction to Heart Failure

The National Respiratory Programme E-Learning modules available on HSEland include:

- Introduction to COPD
- Introduction to Asthma Inhalers and Inhaler Technique
- Pulmonary Rehabilitation – Assessment and Exercise Programme

The National Diabetes Programme E-Learning modules available on HSEland include:

- Diabetic Foot Screening
- The Nursing Management of Adults with Type 2 Diabetes

Please search HSEland for the above e-learning modules

National Heart Programme	National Institute for Prevention and Cardiovascular Health: Delivering Evidenced Based Cardiac Rehabilitation in Practice https://nipc.ie/education/short-courses/
National Respiratory Programme	Pulmonary rehabilitation infographics for patients were developed with input from COPD Support Ireland, and pulmonary rehabilitation resources for and GPs were developed with input from ICGP. These infographics are available to print and online friendly versions here: https://www.hse.ie/eng/about/who/cspd/ncps/copd/pulmonary-rehabilitation/ Pulmonary rehabilitation telehealth guidelines and webex guidelines available here: https://cnh.hseland.ie/icpcd/respiratory-copd-asthma-resources/useful-tools/
National Diabetes Programme	• Model of Integrated Care for Type 2 Diabetes Diabetic Foot Model of Care 2021 • Diagnosis and Management of uncomplicated Type 2 Diabetes in Adults developed by the Irish College of General Practitioners (ICGP) • The Diabetes Technology Network UK/Association of British Clinical Diabetologists (ABCD) has expanded access to Glooko Academy to Ireland. Glooko Academy is an online educational programme available to all diabetes healthcare professionals in Ireland at no cost and was funded in part via sponsorships from global industry partners. The Academy provides educational videos and information to upskill and help clinicians stay up to date with Diabetes Technologies. There are up to date videos on topics such as Connected Pens (new course), Continuous Glucose Monitoring, Flash Glucose Monitoring, Pumps Continuous Subcutaneous Insulin Infusion, Self-Monitoring Blood Glucose (SMB) and Virtual Consultations. For more information on how to access these courses please go to https://go.glooko.com/academy • Trusted information on diabetes is available at www.hse.ie/diabetes • Book a place for people with type 2 diabetes on a local diabetes support course at www.hse.ie\diabetescourses • HSE Community Nutrition and Dietetic Care Guidelines for the management of type 2 diabetes • Are you a dietitian who is new to the hub? Contact the Self-Management Education office at John.Cowhig@hse.ie for training opportunities related to DISCOVER DIABETES-Type 2, the National Diabetes Prevention Programme, the Best Health weight management programme, Behaviour change training and group facilitation.