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Mr. Colm Burke, T.D.,
Dáil Éireann,
Dublin 2

PQ Ref: 46119/21
"To ask the Minister for Health the progress that has been made to date on the roll-out of community hubs for cardiology services in Cork city and county as part of Sláintecare; the status of same and of the plans going forward; and if he will make a statement on the matter."

Dear Deputy Burke,

The Health Service Executive has been requested to reply directly to you in the context of the above Parliamentary Question, which you submitted to the Minister for Health for response.

Sláintecare, Ireland's ten-year plan for delivering a health and social care service that meets population need, has provided the impetus for developing and implementing an Enhanced Community and Primary Care service that is person-centred, holistic, proactive and preventive in its approach and delivered within the community. To implement this Enhance Community Care (ECC), Commuity Services are being restructured and will deliver services through Community Healthcare Networks (CHNs), each network focusing on the delivery of services to approx. 50,000 population. In the Cork Kerry Community Healthcare area there will be 14 CHNs.

In addition to supporting the ECC services through the provision of additional staff for Primary Care, the Sláintecare framework is also supporting the delivery of Specialist Integrated Programmes through a Hub model. There will be two specific type of Integrated hubs- the Integrated Care Programme for Older People (ICPOP), which is a specialist integrated Multidisciplinary Team for older people, and the Integrated Care Programme for the Prevention and Management of Chronic Disease (ICPCD).

The Integrated Care Programme for the Prevention and Management of Chronic Disease (ICPCD) focuses on improving the standard of care for four major chronic diseases that affect over one million people in Ireland:

- Cardiovascular disease
- Type 2 diabetes
- Chronic Obstructive Pulmonary Disease (COPD) and
- Asthma

Integrated Care for chronic disease is defined as healthcare provided at the lowest appropriate level of complexity, with responsive, connected services built around patient need, to support and empower individuals to optimise their health, actively address and minimise their risk factors for chronic disease and to live well with chronic disease. This will provide an 'end-to-end' model for the prevention and management of chronic disease. It will be delivered in an integrated way with GPs, Primary Care and Acute Care Multidisciplinary teams and aims to improve the healthcare experience and health outcomes for individuals living with chronic disease in Ireland.

The Hubs will provide a continuum of health promotion, disease prevention, diagnosis, treatment, disease management and rehabilitation services that are coordinated across different healthcare providers and healthcare settings. The aim is to shift from an over-reliance on acute sector services to the provision of person-centred care provided as close GPs who refer their patients in to the specialist ambulatory care hub for chronic disease will work closely with the specialist team in managing care for their patients. The Integrated Care Consultants will work across the acute hospitals and the specialist ambulatory care hubs and will support continuity of care across the community and acute settings. Self-management support services e.g. cardiac rehab, pulmonary rehab, diabetes prevention, weight management, and diabetes self-management education will be provided in the hubs.

The ECC and Specialist Integrated Hubs are being rolled out in two phases. Within Cork Kerry Community Healthcare, Phase One provided resources to support 2 ICPCD Hubs in Cork City, one to support the North City area and one for the South City area. These will be aligned with the CUH and MUH acute services. A staffing resource of 32 WTE was provided for each hub and supported by 7 WTE for the acute hospitals to work across both Hubs. This acute allocation included an additional Consultant Cardiologist, Consultant Endocrinologist and a Consultant in Respiratory Medicine for the city along with key specialist Nursing Services.

Specific to the Cardiovascular aspect for Phase 1 in Cork City, the additional Consultant Cardiologist and CNS posts aligned to CUH will support both city Hubs. The staffing within each hub specific to Cardiology is as follows:

- 3 WTE Clinical Nurse Specialists (CNS) & 1 Staff Nurse
- 1 WTE Senior Physiotherapist
- 1 WTE Cardiac Rehab Coordinator
- 1 WTE Staff Nurse in Cardiology

In addition, each hub will have access to diagnostics and will have administrative and management posts working in an integrated way across all 3 disease types and integrated with the Acute Hospitals and the larger Community Service. Cardiac Rehabilitation and ongoing education and self-management programmes will also operate from the Hub. Progress to date has been on the recruitment of posts (Consultant Cardiologist has been approved, advertisement is underway, Acute CNS posts have been advertised & interviews are scheduled, Nursing, Physiotherapy & Administrative staff are being progressed via National/Local panels), along with all the other development posts for the Community provided in Phase 1.

There is an overall project Group in place to roll out the hubs across Cork and Kerry which has three working groups in place – for each of the three conditions to be managed within the Hubs, each of these groups has representation from acute and community staff and linkages with GPs. These groups are utilising the care pathways and processes as identified through the National Clinical Care Programmes, and working with local staff on implementation within the city for phase 1.

If I can be of any further assistance please do not hesitate to contact me.

Yours sincerely,

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