Priscilla Lynch
Head of Service, Primary Care,
Cork Kerry Community Healthcare,
Coolnagarrane, Skibbereen, Co. Cork
Email: Priscilla.Lynch@hse.ie

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David Stanton TD,
Dáil Éireann,
Dublin 2.

PQ ref 6767/22
"To ask the Minister for Health the details with respect to enhanced community care chronic disease hubs to be established in County Cork; the geographical areas that each hub will cover; the population serviced by each hub; if there will be outreach services provided to towns and areas that are distanced from such hubs; and if he will make a statement on the matter."

Dear Deputy Stanton,

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, Enhanced Community Care (ECC) Commuity Services are being restructured and will deliver services through Community Healthcare Networks (CHN's), each network focusing on the delivery of services to approx. 50,000 population.

In the Cork Kerry Community Healthcare area there will be 14 CHN's, 11 in Co. Cork and 3 in Co. Kerry.

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 types of integrated hub: (1) the Integrated Care Programme for Older People (ICPOP), which is a specialist integrated Multidisciplinary Team for older people, and (2) 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 – the initial focus of the Chronic Disease hubs in Cork is specific to heart failure
- Type 2 diabetes
- Chronic Obstructive Pulmonary Disease (COPD) and adult 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 currently being rolled out in 3 areas within Co. Cork.

1. Cork City (2 Hubs):-
    a. Two ICPCD Hubs are being rolled out in Cork City. One hub will be based in the St. Mary's Health Campus and will support the North City area [aligned with CHN area 7 (Cobh, Glanmire/Riverstown, Carrigtwohill: population 44,225), CHN area 8 (Mayfield, Montenotte, Tivoli, The Glen, Blackpool, Carrignavar, St. Patricks: population 32,059) and CHN area 9 (Blarney, Sunday's Well, City Centre, Farranree, Gurranebraher, Knocknaheeny: population 50,257)].

    b. The second city hub, which will be located in the south of the city, will support the South City area: CHN 11 (Douglas, Blackrock, Mahon: population 44,925), CHN 12 (Ballincollig, Bishopstown, Macroom: population 66,943), CHN13 (Bandon, Kinsale, Carrigaline, Passage West: population 64,644) and 14 (Turners Cross, Grange, Frankfield, Togher, Ballyphehane, Greenmount, The Lough: population 42,206). This South City hub will provide an Enhanced Team for delivery of Chronic Disease services into the West Cork area CHN 10 (Beara, Bantry, Mizen, Drimoleague, Dunmanway, Ballineen, Rosscarbery, Skibbereen, Clonakilty: population 59,444).

2. The third hub in Co. Cork, with the main base to be in Mallow, will be aligned to North and East Cork [CHN's 4 (Charleville, Buttevant, Kanturk, Mallow, Millstreet, Newmarket: population 60,382), CHN 5 (Castlelyons, Fermoy, Mitchelstown: population 32,344) and CHN 6 (Midleton, Youghal: population 45,441)].

The service provision arrangements will be further clarified as the roll of the programme progresses. A staffing resource of 32 WTE was provided for each of the three Cork hubs, with a further staffing resource of 13 WTE provided to support the Enhanced Team into West Cork. In addition, these teams are supported by 17.5 WTE for the acute hospitals (CUH, MUH, MGH & BGH) to work across all of County Cork. The acute allocation includes additional Consultants along with key specialist Nursing and Allied Health Professional Services.

As the services become established and fully operational, it is intended that some outreach clinics will take place for Hubs with large Geographical spread, in particular for North and East Cork, and for South City into West Cork, as well as the integrated hub to be located in Kerry.

The below is a sample staffing breakdown per hub:

Speciality	**WTE**
DIABETES	
CNS Diabetes	3.0
Clinical Specialist Podiatrist	1.0
Senior Grade Podiatrist	1.0
Basic Grade Podiatrist	1.0
Senior Dietitian	3.0
Staff Grade Dietitian (Weight Mgt/ DPP)	3.0

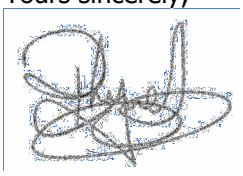
CARDIOLOGY	
CNS Cardiology	3.0
Senior Physiotherapist	1.0
Cardiac Rehab Co-ordinator	1.0
Staff Nurse Cardiology	1.0
Cardiac Rehab Admin	0.5
Clinical Psychologist	0.2
RESPIRATORY	
CNS Respiratory	3.0
Senior Physiotherapist	3.0
CS Physio Rehab Co-ordinator	1.0
CNS Rehab	1.0
Staff Grade Physio Rehab	1.0
Pulmonary Rehab Admin	0.5
GP Lead with Specialist interest	
GP Lead with Specialist interest	0.2
Admin / Management	
Team Co-ordinator for ICP CD Community Specialist team	1.0
Project Officer	1.0
Administration staff	2.0
Total WTE per hub	**32.4**

In addition, each hub will have access to diagnostics and will have administrative and management posts working in an integrated way across all three 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.

Key elements in the implementation of the Chronic Disease hubs are at an early stage of progress; recruitment, sourcing of accommodation, equipping and the development of pathways. It is envisaged that as the Chronic Disease Hubs become more established there will be an element of outreach services to other specific locations for those with large geographical spread. As the hubs are still in the early stages of development the detailed plan of this has to be worked through in collaboration with colleagues in Primary and Acute care to ensure optimal use of available resources in the roll out of the Chronic Disease programme across County Cork.

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

Yours sincerely,



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