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Deputy Ruairí Ó Murchú,
Dáil Éireann,
Leinster House,
Dublin 2.

8th March, 2022

PQ Ref: 9784-22 - To ask the Minister for Health the status of the HSE chronic disease management community hubs; the status of the recruitment process; and if he will make a statement on the matter. - Ruairí Ó Murchú

Dear Deputy Ó Murchú,

I refer to your parliamentary question which was passed to the HSE for response.

In line with Sláintecare, the Enhanced Community Care Programme (ECC) objective is to deliver increased levels of health care with service delivery reoriented towards general practice, primary care and community-based services. The focus is on implementing an end-to-end care pathway that will care for people at home and over time prevent referrals and admissions to acute hospitals where it is safe and appropriate to do so, and enable a "home first" approach.

The ECC Programme was allocated €240m for the establishment of 96 CHNs, 30 Community Specialist Teams for Older People, 30 Community Specialist Teams for Chronic Disease, national coverage for Community Intervention Teams and the development of a volunteer-type model in collaboration with Alone.

The rollout of the ECC Programme is closely aligned with the implementation of the "GP Agreement 2019", through which targeted funding of €210m has been provided to general practice to support phased development and modernisation over the period 2019 to 2022. This included €80m for new developments including rollout of the GP Chronic Disease Management Programme, which will see 430,000 GMS / GP visit care holders participating in the structured programme by the end of 2022. This programme recently received a prestigious United Nations award for developing a structured illness and preventative care programme in general practice.

While general practice will provide the core service at CHN level, the Community Specialist Team for Chronic Disease will support general practice in the provision of specialist opinion and input to people with more complex / specialist needs, in respect of Diabetes, Respiratory and Cardiology, with the teams consisting of 32.5 WTE. These Community Specialist Teams will service a population on average of 150,000 equating on average to 3 CHNs. Ideally, the teams will be co-located together in 'hubs' located in or adjacent to Primary Care Centres reflecting a shift in focus away from the acute hospital towards general practice, a primary care & community-based service model. The services are fully aligned with the acute system with clinical governance being provided though the relevant model 4 or 3 hospitals, but with the services being delivered in the community setting.

In line with best international practice, each team consists of a variety of specialists including physicians, nursing, health and social care professionals, as well as administrative support. The allocation of resources across the system was undertaken following a comprehensive engagement with local CHOs and acute hospitals, taking account of and incorporating initiatives that had already been initiated through the Sláintecare Integration Fund as well as other demonstration sites and initiatives. The average cost per Community Specialist Team for Chronic Disease in the community amounts to €2.05m.

I trust this information is of assistance to you.

Yours sincerely,

Geraldine Crowley,
Assistant National Director,
Enhanced Community Care Programme &
Primary Care Contracts