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4th August, 2023

Deputy John Paul Phelan, TD
Dáil Éireann
Leinster House
Kildare Street
Dublin 2

RE: PQ 35964/23

To ask the Minister for Health to provide an update on the commitment in the HSE's National Service Plan 2023 to roll-out 30 new specialist teams for the management of chronic diseases, which includes T2DM in communities; and if he will make a statement on the matter.

Dear Deputy Phelan,

The Health Service Executive has been requested to reply directly to you in relation to the above parliamentary question, which you submitted to the Minister for Health for response. I have consulted with the HSE's National Clinical Advisor and Group Lead for Chronic Disease (NCAGL CD) on your question and have been informed that the following outlines the position.

In 2020, the Health Service Executive (HSE) published *The National Framework for the Integrated Prevention and Management of Chronic Disease (2020-2025),* which adopted a whole system approach to integrated care for people with Type 2 Diabetes Mellitus (T2DM), Cardiovascular Disease (CVD), chronic obstructive pulmonary disease (COPD) and Asthma. This framework describes a significant programme of reform in how to deliver chronic disease care. These reforms are now well underway as part of the HSE's Enhanced Community Care (ECC) Programme.

In line with the vision set out by Sláintecare, the HSE's Enhanced Community Care (ECC) programme is a targeted reform programme that aims to resource and scale-up community healthcare services nationally. The ECC programme includes a number of components towards enhancing and expanding the delivery of primary care services in the community. One key component is the implementation of the *Model of Care for the Integrated Prevention and Management of Chronic Disease,* through the provision of 30 Community Specialist Teams (CSTs) working in community-based specialist ambulatory care hubs.

These ambulatory care hubs have been allocated resources such as integrated care consultants, specialist nurses and health and social care professionals (HSCPs) to enable timely access to specialist advice and care for people with living with Type 2 Diabetes Mellitus (T2DM), Cardiovascular Disease (CVD), chronic obstructive pulmonary disease (COPD) and Asthma. This development coincides with the *GP Agreement 2019* that provides general practitioners (GPs) with reimbursement for opportunistic case finding (OCF), prevention and care for people with these four long-term conditions. It also coincides with the rollout of the nationwide *GP Access to Diagnostics* programme, which is enabling timely chronic disease diagnosis through improved access to spirometry, echocardiography and natriuretic peptide testing (NT-Pro-BNP).

There are currently 24 Community Specialist Teams (CSTs) for Chronic Disease operational, with focused efforts in place to enable all 30 CSTs to become operational as soon as possible.

In the first half of this year (2023), there were in excess of 55,000 patient contacts with these new community-based specialist services, of which 30,000 of these contacts were with the diabetes specialist team. This shift from a hospital-centric model of healthcare delivery towards more comprehensive and accessible primary and community care service provision is enabling timely access to specialist care, closer to people's homes in communities across the country.

I trust this information is of assistance to you, but should you have any further queries please do not hesitate to contact me.

Yours sincerely

Anne Horgan
General Manager