CÚRAM SLÁINTE POBAIL
CORCAIGH CIARRAÍ
CORK KERRY
COMMUNITY HEALTHCARE

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12th February, 2024

Mr. Michael Healy-Rae., T.D.,
Dáil Éireann,
Dublin 2

PQ ref 46405/23 Diabetic clinic - Caherciveen"

"To ask the Minister for Health if a service will be retained (details supplied); and if he will make a statement on the matter."
Details supplied: Caherciveen Diabetes Centre

Dear Deputy Healy-Rae,

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.

As part of the roll out of Sláintecare and the Enhanced Community Care (ECC) programme three models of care - Cardiac, Respiratory and Diabetes are being progressed. In advance of the ECC Programme, a number of demonstrator projects for Chronic Disease (CD) were in place, which are now mainstreamed through the ECC Programme. This has included clinical nurse specialists working directly with GP's. The elements of the demonstrator posts align with the ECC Programme particularly for the following areas:

- Developing a collaborative care plan between the patient and the healthcare team
- Provide expert care at the lowest level of complexity in an integrated manner
- Less reliance on hospitalisation and emergency room services
- Enabling early detection with community diagnostics

The clinic you have referenced was in place before the expansion of community services and the advent of the Chronic Disease Management (CDM) programme in General practice. The CDM programme provides funding to GPs to support patients in General practice and is completely in line with the Sláintecare programme of providing care closer to home.

Patients should not require to see a CNS Diabetes unless there are specific concerns in relation to the patient and specific referral criteria have been developed which inform when a patient should see a CNS. 80% of the care a patient needs can be provided in General practice.

Where CNS support is required, I would like to confirm that care will be provided where appropriate to patients closer to home in line with the ECC Programme. The patient will receive care from a multidisciplinary team inclusive of a Consultant, CNS, Dietetics & Podiatry, which provides a more holistic healthcare service to the person in receipt of care.

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

Yours sincerely,

Priscilla Lynch
Head of Service - Primary Care,
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