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Deputy Sorca Clarke,
Dáil Eireann,
Leinster House,
Dublin 2.

4th April, 2022

PQ Ref: 9341/22 - To ask the Minister for Health the status of the community healthcare networks supporting the expansion of services based on the need and size of local populations as outlined in the Programme for Government; and if he will make a statement on the matter. - Sorca Clarke

Dear Deputy Clarke,

I refer to your recent 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.

Community Healthcare Networks
Through the implementation of the ECC Programme, we are establishing 96 Community Healthcare Networks (CHNs), providing the foundation and organisation structure through which integrated care is delivered locally at the appropriate level of complexity, with GPs, HSCPs, Nursing Leadership & staff, empowered at a local level to drive integrated care delivery and supporting egress in the community.

The 96 Networks, on average serving a population of 50,000, will implement a population need and stratification approach to service delivery and will improve integrated team working in primary care service, moving towards more integrated end-to-end care pathways, providing for more local decision-making and involving communities in planning to map identified health needs in their local area. The number of CHNs per CHO ranges from 8-14.

Community Specialist Teams (Hubs)
The work that has been undertaken by the Integrated Care Programmes for Older People and Chronic Disease over recent years, has shown that improved outcomes

can be achieved particularly for older people who are frail, and those with chronic disease, through a model of care that allows the specialist multidisciplinary team engage and interact with services at CHN level, in their diagnosis and on-going care.

With the support of the DoH and Sláintecare, these models are now being implemented at scale, by the HSE, with the establishment and full rollout of 30 Community Specialist Teams for Older People and 30

Community Specialist Teams for Chronic Disease to support CHNs and GPs to respond to the specialist needs of these cohorts of the population, bridging and linking the care pathways between acute and community services with a view to improving access to and egress from acute hospital services.

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.

Current Status & Progress

- The ECC programme has been allocated funding of €240m for the recruitment of 3,500 WTE staff for the establishment of 96 CHNs, 30 Community Specialist Teams for Older People, 30 Community Specialist Teams for Chronic Disease, expansion of Community Intervention Teams and development of a volunteer model of support (Alone type model).
- Over 1,600 staff have been recruited to the programme or are at an advanced stage currently, with approximately 1,900 additional staff to be recruited for the remainder of 2022.
- Community Health Networks (CHNs) - 51 of 96 are now established with key leadership roles and a minimum level of core staff in place.
- Community Specialist Teams (CSTs) for Older Persons – 15 of 30 are now established with key leadership roles and a minimum level of core staff in place.
- Community Specialist Teams (CSTs) for Chronic Disease Management – 2 of 30 are now established with key leadership roles and a minimum level of core staff in place.
- Community Intervention Teams - 21 are now operational, with national coverage secured for the first time.
- Community Diagnostics – Over 138,000 scans completed in 2021, with 17,000 delivered in January, 2022
- Collaboration with Alone, a model to coordinate community and voluntary supports across each CHN is being implemented, leveraging in a structured way the informal supports and volunteerism in local communities.

The expenditure in 2021 amounted to €50m as recruitment was delayed due to the pandemic / vaccination programme and cyber-attack. However, an accelerated recruitment programme was implemented in the second half of 2021, with significant

improvement in recruitment, as reflected in the numbers above and with momentum continuing into 2022.

The combination of these new funded initiatives will support the implementation of a 'population needs' approach, enabling better local decision-making while communities will also be involved in determining the health needs of their local areas.

I trust the above information is of assistance to you.

Yours sincerely,

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