Oifig an Stiúrthóra Cúnta Náisiúnta
Clár Cúraim Pobail Feabhsaithe &
Conarthaí Príomhchúraim
Feidhmeannacht na Seirbhíse Sláinte
Urlár 2, Páirc Ghnó Bhóthar na Modhfheirme,
Bóthar na Modhfheirme, Corcaigh, T12 HT02

Office of the Assistant National Director
Enhanced Community Care Programme &
Primary Care Contracts
Health Service Executive
Floor 2, Model Business Park,
Model Farm Road, Cork, T12 HT02

www.hse.ie
T: 021-4928512
E: primarycare.strategy@hse.ie

Deputy Jim O Callaghan,
Dáil Eireann,
Leinster House,
Dublin 2.

14th May, 2024

PQ - 55292/23 To ask the Minister for Health the main initiatives he has taken to develop and expand primary care services since 27 June 2020; the additional funding provided in successive budgets; his plans for 2024; and if he will make a statement on the matter.

Dear Deputy O'Callaghan,

I refer to your parliamentary question, which was passed to the HSE for response and I want to apologies for the delay in responding.

Enhanced Community Care
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 (a multiyear investment programme) with an indicative allocation of 3,500 WTE and €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. To date, significant progress has been made, with the establishment of:

- All 96 Community Healthcare Networks
- 27 Community Specialist Teams for Older People
- 26 Community Specialist Teams for Chronic Disease
- All 21 CITs
- Significantly improved access to diagnostic services.

Alongside this broader implementation, almost 2,810 staff have been onboarded or are at an advanced stage of recruitment under ECC.

Community Healthcare Networks (CHNs)

Community Healthcare Networks are a foundational step in building a better health service in Ireland. They contain the structures that enable a better level of service to be delivered to those using our health and social care services, and for the staff delivering them. Community Healthcare Networks provide the framework for future healthcare reform and support Sláintecare's vision of integrated community-based care in the Right Place and at the Right Time. Improving the experience for people using our services is at the heart of implementing the Community Healthcare Networks.

Further to this, the ECC Model provides the organisational structure through which integrated care is being enhanced to deliver locally at the appropriate level of complexity, with GPs, HSCPs, Nursing Leadership & staff, empowered at a local level, driving integrated care delivery and supporting egress to the community.

Since their inception, the Community Healthcare Networks, on average serving a population of 50,000 have been moving towards more integrated end-to-end care pathways, providing for more local decision making and integrated ways of working. The number of CHNs per CHO ranges from 8 - 14.

Community Specialist Teams

The work that has been undertaken by the Integrated Care Programmes for Older People (ICPOP) and Chronic Disease (ICPCD), respectively, over recent years has shown improved outcomes through a model of care that allows specialist multidisciplinary teams to engage and interact with GPs and services at CHN level, in the diagnosis and ongoing care of relevant patient groups. These multidisciplinary teams were established from existing specialist staff, with the incorporation of new resources to fulfil the team complement as per the ECC Model:

- ICPOP improves the lives of older persons by providing access to integrated care and support that is planned around their needs and choices, supporting them to live well in their own homes and communities through the early diagnosis and prevention of the progression of health issues
- ICPCD is targeted at service users who have a specified chronic disease such as cardiovascular disease, COPD, asthma and/or Type-2 diabetes. ICPCD aims to facilitate better access to care, reduce specialist waiting lists, emergency department presentations and hospital stays while also enabling prevention, earlier diagnosis and intervention.

These models are now being implemented at scale to support CHNs and GPs to respond to the specialist needs of these population cohorts, bridging and linking the care pathways between acute and community services with a view to improving access to and egress from acute hospital services, as well as improved patient outcomes.

These Community Specialist Teams service a population of 150,000, equating on average to 3 CHNs. Ideally, the teams are co-located together in 'hubs', in or adjacent to Primary Care Centres, reflecting a shift in focus away from the acute hospital

Community Intervention Teams (CIT)

A CIT is a team of health professionals, primarily nursing, with access to a range of additional dedicated resources which may include Health Care Assistants, Physiotherapy and Occupational Therapy.

The purpose of a CIT service is to prevent unnecessary hospital admission or attendance, and to facilitate / enable early discharge of patients appropriate for care. The model of service enhances the overall Primary Care system, providing access to nursing and home care support, usually from 8am to 9pm, seven days per week.

To support the roll out of ECC, a significant Capital Infrastructure Programme was developed in 2021 to deliver the accommodation requirements of the CHNs & CSTs. This involved the development of 34 permanent ECC proposals, consisting of 31 hubs and 3 spokes across all 9 CHOs. In November 2021, €340m Capital Costs and €25m ongoing revenue for leasing costs was identified to deliver these permanent ECC proposals, over the course of 4 - 6 years. In the intervening period between the operationalisation of these long term permanent solutions, a number of interim solutions have been progressed and implemented, to ensure the ECC service model can be delivered at a local level.

Enhanced Community Care & General Practice

GP Agreement 2019

The role out of the ECC 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 roll out of the GP Chronic Disease Management programme which saw 430,000 GMS / GP visit care holders participating in the structured programme by the end of 2022. This programme received a prestigious United Nations award for developing a structured illness and preventative care programme in general practice.

GP Agreement 2023
The Government announced in Budget 2023 the expansion of GP Visit Cards to all Children under 8 years of age and to people earning up to the median household income. Following a period of negotiations, the Department of Health, the HSE and the Medical Organisation (IMO) signed an agreement in July 2023 to support this expansion of eligibility. The agreement with the IMO put in place a series of capacity supports to allow GPs to recruit additional staff, as well as increases in fees to take account of the likely increase in demand for services. The total financial package will amount to approximately €130 million in a full year.

The GP Agreement 2023 also provides for the expansion of the CDM Prevention Programme to include all GMS/DVC card holders with hypertension over 18 years, and all women (cardholders and private patients) over 18 years who had Gestational Diabetes Mellitus or Pre-Eclampsia in a pregnancy since January 2023. Women diagnosed with Gestational Diabetes Mellitus or Pre-Eclampsia since January 2023 who develop Diabetes will be eligible for registration on the Treatment Programme.

GP Access to Community Diagnostics
GP Access to Community Diagnostics (GPACD) is an integral component of the Enhanced Community Care (ECC) programme available nationally for all GPs. In 2024 an appropriate level of diagnostic tests and radiology scans are available in line with the parameters of the scheme, with the substantial investment to date being maintained with a total allocation of €47.9 million for continued provision of the scheme in year.

In addition, in 2024 initiatives to increase general practice capacity are being progressed with an increase in GP training places to 350, a 23% increase from the intake in 2023 and an increase in the non-EU Doctor Scheme with a planned intake of up to 250 in 2024.

I trust this is of assistance.

Yours sincerely,

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