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 Richard Bruton,
Dáil Eireann,
Leinster House,
Dublin 2

21st June 2024

PQ - 13529/24 To ask the Minister for Health the performance reports which he receives on the HSE's enhanced community care initiatives and its component elements to illustrate its reach, its intensity and its impact; and if he will make a statement on the matter. -Richard Bruton

Dear Deputy Bruton,

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

In line with Sláintecare, the Enhanced Community Care Programme's (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 on-boarded 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.

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 towards a general practice, primary care and community-based service model.

In response to your query, the performance reports shared with the Department of Health are outlined below.

As a key element of Sláintecare, ECC provides regular updates on the progress of the rollout of the programme, activity, impact and outcomes. These include reports to the Sláintecare Programme Board, Chaired jointly by the Secretary General of the Department of Health and CEO HSE, minutes available here . ECC also provides regular updates on progress through the Sláintecare Action Plan. These updates are published in, mid-year and annual progress reports.

On a monthly basis the Department of Health are provided with an update in relation to ECC implementation from the programme governance oversight group - ECC Steering Group - Chaired jointly by the National Director for Services and Schemes and the National Clinical Director for Integrated Care. These updates include details on programme implementation, activity, impact and outcomes as well as miscellaneous updates. This is in addition to monthly oversight meetings with the Department regarding ECC.

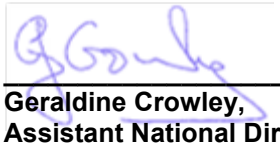
ECC is reported through the Board Strategic Scorecard to the DoH. The scorecard outlines progress against key performance indicators as well as deliverables and is reported on a monthly basis and shared with the Department of Health. Progress is measured against an ambition statement with defined targets set out for the year in consultation with the DoH. Where progress does not meet targets, performance improvement plans are required.

The Second Report of the Structured Chronic Disease Management Programme (CDM), which is a key pillar of ECC, sets out the impact of ECC in terms of the Chronic Disease Management Programme in General Practice and moving care out of the hospital and into the community. The HSE Annual Report includes updates on ECC in terms of progress in implementation and activity and is available to the DoH once published.

In addition to the above the DoH have access to the databases which set out the activity of ECC staff/teams versus the targets set through the National Service Plan process. These databases are updated on a monthly basis and are used to track the activity across the CHOs and now Health Regions.

I trust this is of assistance.

Yours sincerely,



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