Oifig an Stiúrthóra Cúnta Náisiúnta
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Deputy Shortall,
Dáil Eireann,
Leinster House,
Dublin 2.

16th July, 2024

PQ 20973/24
To ask the Minister for Health how many people living with Type 2 diabetes have been treated in HSE ECC specialist ambulatory care hubs to date, by individual hub; and if he will make a statement on the matter.

Dear Deputy Shortall,

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 Chronic Disease Community Specialist teams (CD-CST), deliver services for patients with Type 2 Diabetes. The collection of Activity data for the CD CSTs commenced in January 2023 and up to the end of March

- 37,305 Patient referrals accepted by Diabetes Specialist Teams in CD CSTs
- 105,576 Patient contacts by Diabetes Specialist Teams in CD CSTs,

The Integrated Care Programme for Chronic Disease 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.

I trust this is of assistance.

Yours sincerely,

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