iii. Enhanced Community Care

What are we Funding?

Delivery of comprehensive specialist community diabetes teams under the Enhanced Community Care Programme (Sláintecare), which helps make community healthcare services more effective in managing chronic conditions inclusing diabetes.

Budget 2022 Ask: € Included in HSE Winter Plan

Why Fund This?

Community diabetes care is provided in line with the National Framework for the Integrated Prevention and Management of Chronic Disease.

If Not Funded...

Hospital resources remain under pressure from diabetes-related appointments and preventable acute complications.

Highlights

1. Comprehensive community and acute specialist teams will support GP colleagues to manage people with more complex diabetes issues in a community setting.
2. Care for diabetes, chest and heart conditions is integrated. Multiple hospital appointments in different departments are avoided.
3. Pressure on hospitals is reduced and the community setting may be perceived as more patient friendly.
4. Money has been allocated for posts which have long been identified, as necessary.

iii. Enhanced Community Care Programme

The HSE Winter Plan 2020 included provisions to commence a targeted reform programme, in line with the vision set out by Sláintecare, known as the 'Enhanced Community Care Programme' (ECCP). This programme aims to resource and scale-up community healthcare services including specialist chronic disease (Diabetes; Cardiology; Respiratory) services in line with the National Framework for the Integrated Prevention and Management of Chronic Disease.

Diabetes Ireland welcomes and gives its full support to these reforms in care and requests that the allocated funding be ringfenced and not reduced in any way.

As part of this initiative, funding has been secured to appoint specialist community diabetes teams to cover all community health networks across the country. These specialist diabetes teams are comprised of:

- Clinical Nurse Specialists Diabetes Integrated Care
- Senior Dietitians (Diabetes)
- Staff Grade Dietitians (Diabetes Prevention)
- Clinical Specialist, Senior and Staff Grade Podiatrists (Foot Protection)

In addition to these community posts, funding was also secured for a *limited* number of specialist diabetes posts in the acute setting comprised of:

- Consultant Endocrinologist, Lead in Integrated Diabetes Care (2 in total linked to Cork University Hospital and University Hospital Waterford)
- Advanced Nurse Practitioners (Diabetes)
- Diabetes Dietitians (Mixture of staff grade and senior grade)

Community and acute specialist diabetes teams will work together to support their colleagues in General Practice to develop and implement ambulatory care pathways and to

manage complex diabetes care, and associated co-morbidities, within the community setting (where appropriate) and in line with the Model of Integrated Care for Type 2 Diabetes.

The diabetes community support this model of integration for all people with diabetes and is calling for the community diabetes teams to be appointed.