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**27th June, 2022**

**Deputy David Cullinane**
**Dáil Eireann**
**Leinster House**
**Dublin 2**

Dear Deputy Cullinane,

The Health Service Executive (HSE) has been requested to reply directly to you in the context of the following Parliamentary Question, which was submitted to this Department for response:

**PQ: 29908/22 - To ask the Minister for Health the cost of an additional community specialist hub for older people.**

In line with Slaintecare 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 was allocated €240m for the establishment of 96 CHN's, 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.

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 will see 430,000 GMS / GP visit care holders participating in the structured programme by the end of 2022. This programme recently received a prestigious United Nations award for developing a structured illness and preventative care programme in general practice.

While general practice will provide the core service at CHN level, the Community Specialist Team for Older People will provide for improved outcomes for older people who are frail, and those with chronic disease, through a model of care that allows the specialist multidisciplinary team to engage and interact with services at CHN level, in their diagnosis and on-going care. In line with best international practice each team consists of a variety of specialists including physicians, nursing, health and social care professionals, as well as administrative support.

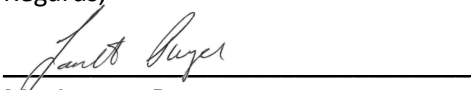
The allocation of resources across the system was undertaken following a comprehensive engagement with local CHO's and acute hospitals, talking account of and incorporating initiatives that had already

been initiated through the Slaintecare SIF fund as well as other demonstration sites and initiatives. The average cost per Community Specialist Team for Older People in the Community amounts to €1.058m.

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, 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.

I trust this information is of assistance to you.

Regards,



**Ms. Janette Dwyer**
**Assistant National Director,**
**Services for Older People, Change & Innovation**