#HSEConference2026

Integrated Healthcare Conference

Delivering Integrated Care Together

Shifting Care to the Community

Liffey A, Convention Centre Dublin

3 September, 14:20 – 15:45

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Welcome and Introduction

Geraldine Crowley

AND, Enhanced Community Care and Primary Care Contracts

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Transforming Paediatric Speech and Language Therapy Services

Leveraging Technology to Deliver Care Closer to Home and Reduce Waiting Times

Dr Fiona Ryan

Speech and Language Therapy Manager, Wexford, HSE Dublin and South East

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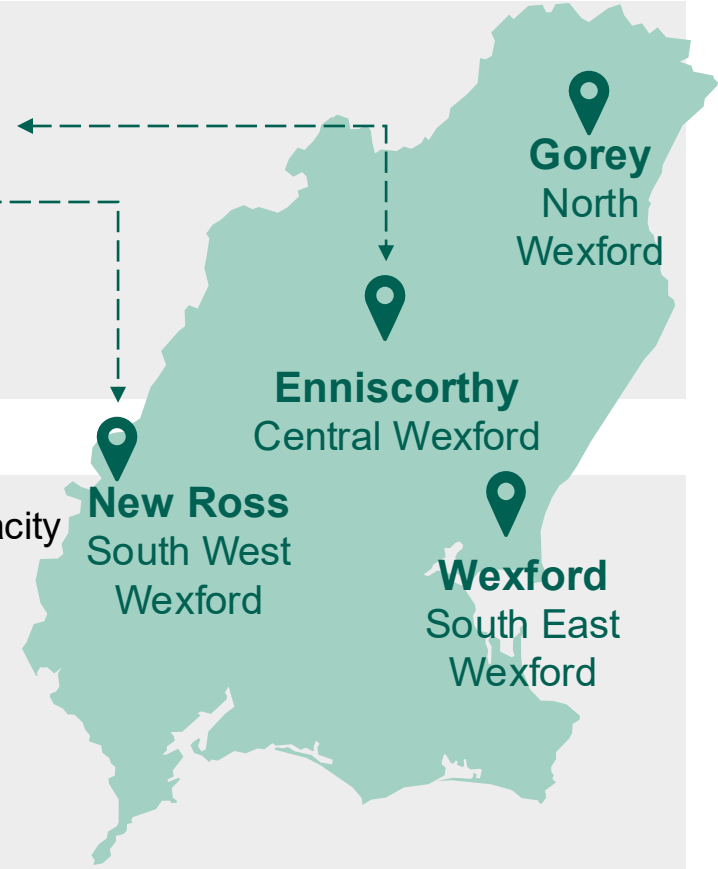
Overview of Wexford Population and Service Demands

County Wexford, with a population of over 163,000, includes communities with higher social and health needs, reflected in comparatively higher levels of disability, health challenges and educational disadvantage when viewed

Wexford Population Overview

- Population increased by 9% between 2016 and 2022.
- Central Wexford has the highest deprivation score in Dublin South East REO at 14.4%
- South West Wexford also has high deprivation score at 12.5%
- Traveller population represent 1.4% of the population, double the national average (0.6%)
- High representation Roma and Ukrainian populations compared to national averages



Speech & Language Therapy (SLT) in Wexford

- Growing population and increase in demand put pressure on waiting times and service capacity
- Large case load for paediatric patients leading to a need for quicker access to care
- 12% increase between 2023 and 2025 in referrals for children < 4 years of age
- 70% of total Wexford SLT referrals in 2025 were for children < 5 years of age
- 27 % increase in Wexford SLT referral between 2023 and 2025

Overview of Digital Platform for Paediatric SLT Services

SHARE App

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The SHARE App enables SLTs to develop a more accurate, holistic picture of each child's needs closer to the point of referral, supporting earlier clinical prioritisation, access to targeted home-based intervention and more effective waiting-list management.

For Families and Children

- Submit pre-assessment questions / forms digitally
- Securely upload video and audio examples of their child's needs or areas of concern
- Access targeted home-based activities

- Share progress recordings for SLT review and feedback
- Access summary reports through app

For Speech and Language Therapists (SLT)

- Clinician portal to review case files and audio/video submissions.
- Share tailored home-based activities and resources with families.

- Access enhanced data and reporting to monitor service performance and family engagement with therapy.

Scaling Digital Innovation Across Wexford SLT Services

Enhancing the patient experience and access by delivering care at home

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Nationally, demand for paediatric SLT services continue to grow, with children accounting for approximately **62% of accepted referrals** between January and October 2025. This challenge is reflected in Wexford, where around **70% of referrals were for children under five**, highlighting the need to better support this cohort with timely, needs-based support.

Journey to Date

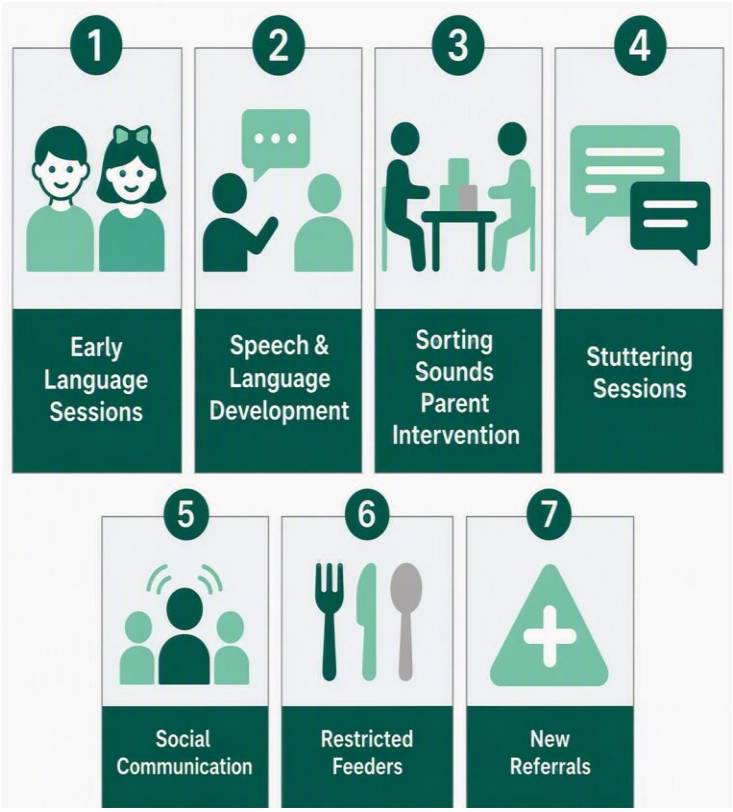
2023 Wexford SLT services trialled the SHARE App across four clinical pathways for children aged 2–11 following initial assessment.

- Children and families where given targeted content based on the 4 pathways which was shared via the app.
- SLT can review and see if families had engaged with the content
- Families could upload audio / video samples of child progress

2026 Scaled the app to all referrals for children <5, enabling earlier holistic view of child and rapid triage to digital or face-to-face pathways based on clinical need and complexity.

- Introduction of the 'Additional Information Form' families submit directly via the app

Overview of Digital Pathways



Productivity Benefits

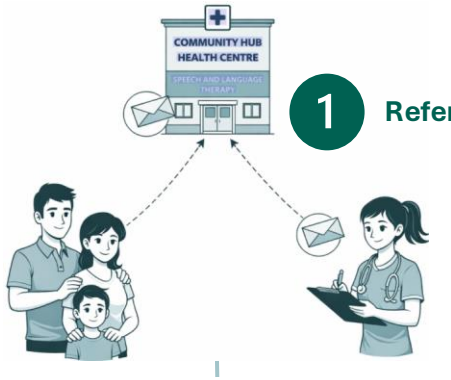
Increases patient contacts within same staffing model whilst enhancing patient satisfaction and access.

Enables SLTs to prioritise referrals more effectively and reserve in-person care for appropriate / complex needs cohort

Significant reduction in admin / postal costs, through digital pre assessment forms, with higher return rate.

Paedatric Patient Journey through Wexford Community SLT Services

New patient journey, enabling greater patient access to services



1 Referral Submitted

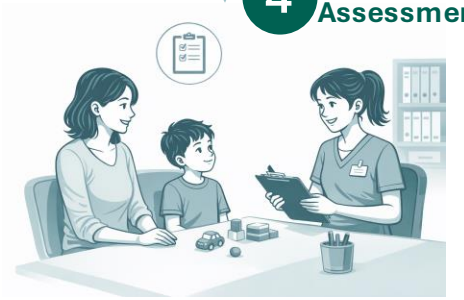
2 Administrative Staff will add the patient details on SHARE App

A welcome / confirmation email will be sent to parents with information on SHARE App and instructions

3 Additional Information Form Completed by parents via SHARE App

Universal content shared via App for parents to work with children

4 Initial Assessment



5 SLT will share targeted content to patients via the SHARE App

Parents will be given a schedule with targeted content for them to work through with their children

6 Pre-Initial Therapy

Parents work through targeted content chosen by SLTs but delivered via the SHARE App. Parents can submit video and audio clips of their child to be assessed by SLT

Email reminders

There will be automated reminders via email to complete content

7 SLT Review

SLT can review case notes / review whether family engaged with resources. This assists in supporting early discharge and / or tailored initial therapy sessions

Initial Therapy

Integrating SHARE App into Service Delivery

Outcomes and Benefits

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Integrating the SHARE App into Wexford SLT services has delivered measurable improvements in access, engagement and service efficiency, with a static resourcing model since 2023.

Key Outcomes

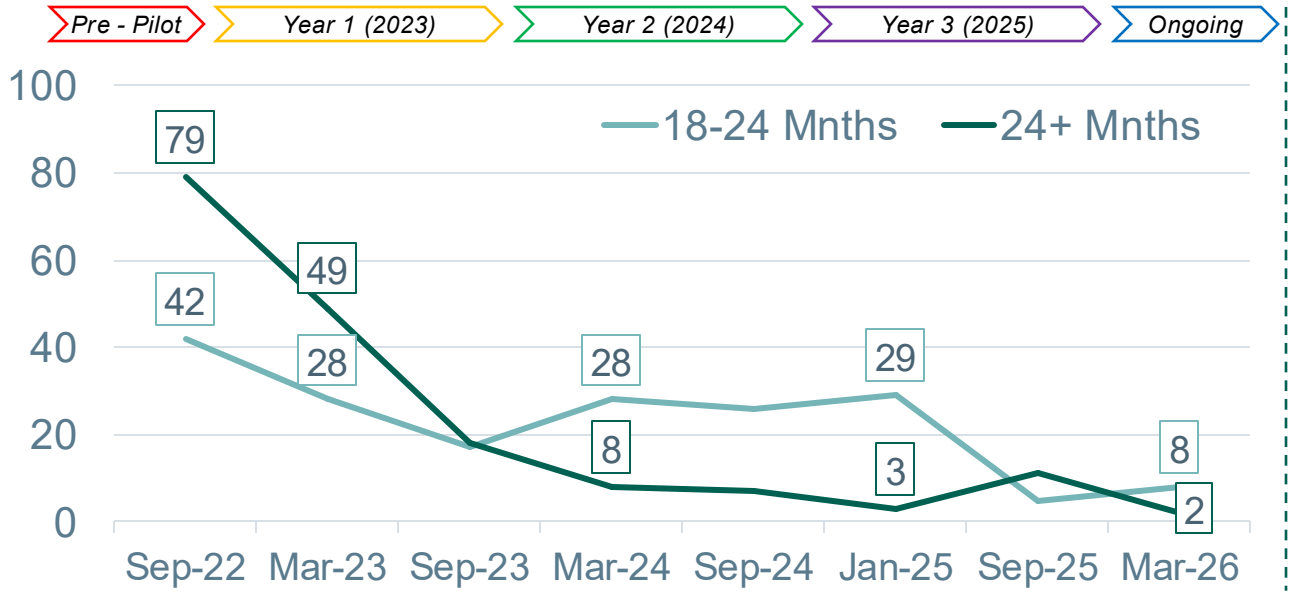
96% reduction in those waiting 24+ months

71% reduction in those waiting 18-24 months.

49% reduction in those waiting 0-4 months

1 in 3 patients supported via app were removed from waitlist

Wexford SLT Service: Decrease in Longest Waiters for Initial Therapy Waitlist *

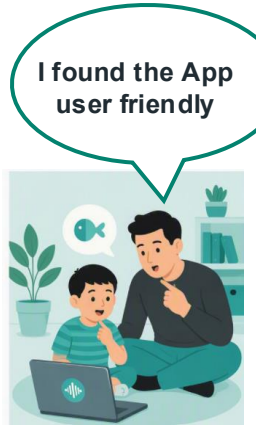


Overview of Benefits

Improved clinical and service productivity; enables SLTs to have a clear picture of child's need and triage more effectively closer to the point of referral

Higher engagement and compliance, such as 98% attendance via the SHARE App for the Stammer Programme (vs 67% for scheduled online education)

Greater service efficiency, reducing prolonged waits while maintaining stable SLT staffing levels from 2023 – 2025.



SLT SHARE App Pilot

Lessons Learned

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This digitally enhanced service model has the potential to scale across ECC SLT services, with the key lessons below supporting its successful adoption and sustainable implementation.

Clinical Leadership & Champions

- Early resistance driven by capacity concerns
- Clinical leadership and clear roles were critical
- Identifying early adopters and positioning them as clinical champions will drive service wide adoption.

Enhancing Service Productivity with Technology

- Technology can be safely embedded within healthcare pathways to expand access to services.
- Virtual care can reduce waiting lists while enhancing the patient and family experience.

Families Will Engage with Digital Care

- Clinician concerns about patient and family engagement were not realised.
- High engagement with digital questionnaires, media uploads and reminders.

Data Enables Better Clinical Decision-Making

- Digital triage helped manage rising paediatric SLT demand in referrals
- Lower-complexity patients supported remotely
- Face-to-face SLT reserved for higher-needs patients

Staff Training and Support Are Critical

- Protected time was essential for adoption
- Training built confidence and consistency
- People support mattered as much as technology

Creating a Culture of Innovation

- Creating a culture of innovation drives service improvement and technology adoption.
- As staff become more confident using digital tools, they identify further opportunities to leverage technology to enhance service delivery.

Maximising Capacity to Meet Demand

Speech Drives and Advice Clinics in North Dublin

Elizabeth O'Shee

Speech and Language Therapy Manager, Dublin North County,
HSE Dublin and North East

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Overview of Dublin North County SLT Service Demands

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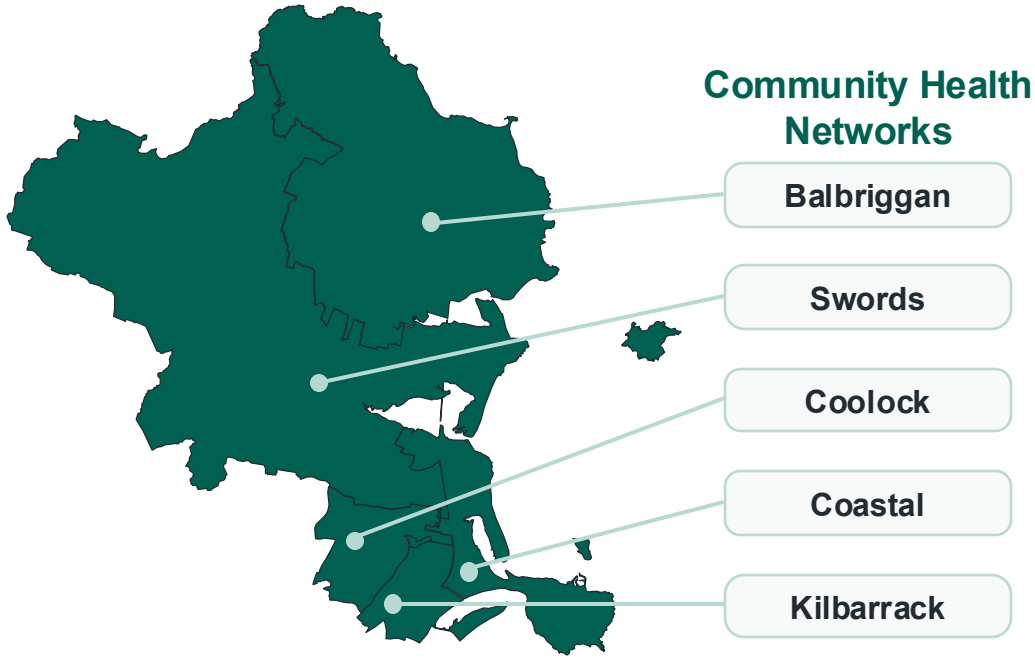
Dublin North County IHA has a large, growing and relatively young population, characterised by strong workforce participation, high educational attainment, significant diversity and a high proportion of family households, creating sustained demand for primary care and community services.

Dublin North County

Total Population: **284,727**



Community Health Networks

- Balbriggan
- Swords
- Coolock
- Coastal
- Kilbarrack

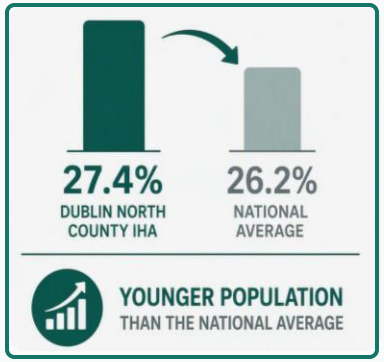
Population Profiles

27.4%
Children and young people (0-19 years)

58.4%
Working age population (20-64 years)

13.9%
Older population (65+ years)

Key Takeaway



Speech and Language Therapy in Dublin North County

- Primary Care SLT in North Dublin supports children and young people aged 0-18 years, and their families, who are looking for support related to speech, language, voice, stammering and communication.
- **35% increase in referral rate** to SLT services since 2021, with **~4k children and young people** on SLT caseloads in North Dublin.
- **Scope has also increased**, requiring the service and SLTs to work in different ways, and to learn new skill sets to support more diverse range of needs, alongside managing higher levels of risk and complexity

Source: Census Data, 2022

New Approaches to Managing SLT Demand

Growing demand and varying levels of speech needs require more targeted approaches to improve access and make best use of available SLT capacity. Speech Drives and Advice Clinics are two examples of targeted, early support for children with varying needs.

Clinical Need and Waiting-List Challenge

20–30% of all children referred locally for SLT have speech needs, with variation by Network.

Speech sound needs range from difficulty with one specific sound to significant needs requiring individualised, extended therapy.

Speech Drives target children in the moderate-to-mild range; severe speech needs are pathwayed separately and unnecessary referrals are avoided.

Access Levers Working Together

Supporting Referrals

Periodic PHN training on SLT service scope, fostering closer working relationships.

Advice First

Advice Clinics used to signpost families, PHNs, and educators on SLT-related queries

Quick Access

Where the likely need is clear, screening can place the child directly on the relevant therapy pathway.

Speech Drive

Protected, high-volume appointments reassess long waiters and create an immediate next-step decision.

Design Principle

Offer timely support without removing children from waiting lists or established care pathways, by acting as a mechanism to match support to need as soon as possible.

Speech Drives: Earlier Review, Clearer Pathways

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25% | Speech Drives provide focused pathways to reassess need, release assessment and therapy capacity and ensure each child receives the right next step, with a model previously run in the Coastal Network achieving discharge for **25%** of attendees.

2023 database analysis showed that:

37%
of parents had referred their child due to speech difficulties*

30%
of this cohort were discharged at the first therapy session because difficulties had resolved*

Operational Insight
Time and resources had been invested in initial appointments that were no longer necessary

8 Assessments
per day via Speech Drive vs
3 assessments in a standard clinic day

Speech Drives can support in:

Identifying
children who no longer require intervention

Releasing
assessment and therapy spaces for ongoing needs

Supporting
children awaiting intervention through home programmes

*Source: Coastal Network SLT internal database analysis, 2023

Speech Drives in Practice and Outcomes

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The Speech Drive model follows a structured process to assess patient need and determine next steps, with previous implementation showing significant capacity and pathway benefits.

Speech Drive Methodology

1. **Analyse** — Identify children whose primary area of need was speech.

2. **Triage** — Severe speech sound cases (2-3%) for alternative pathway.

3. **Invite** — Offer the remaining candidates a focused assessment.

4. **Assess** — Assess speech production and stimulability.

5. **Decide** — Discharge if no further need; retain and support where need remained.

Speech Drive Outcomes

8 — **Assessments Per Therapist/Day**
Delivered in the first Drive, compared to 3 assessments in a standard clinic day.

109 — **Appointments Offered**
To children in the Coastal Network

76 — **Appointment Attendances**
Out of 109 appointments offered.

7% — **DNA Rate Reduction**
7% DNA rate to the Speech Drive, when compared to 14% for typical assessment.

25% — **Of Children Discharged**
No further need identified at the focused assessment.

75% — **Of Children Supported**
Home programme plus therapy or review for children with continuing needs.

Key Workforce Conditions | **Protected Clinical Time, Clearly Defined Cohort, Visible Pathway Decisions, and Planned Capacity for Therapy**

Advice Clinics: Managing Demand at the ‘Front Door’

Advice Clinics provide early access to SLT expertise, helping families and professionals identify the right next step without automatically entering a standard referral pathway.

Advice Clinic Methodology

Signpost

Advice Clinic is available to families, PHNs, and teachers

Book

An administrator arranges a telephone slot with an SLT.

Discuss

Clinician explores concerns and provides advice and resources.

Direct

Child is signposted, referred or routed to most appropriate pathway.

Respond

Clinics held ~6 weeks, increasing where demand requires.

Advice Clinics Enable:

Advice Before Referral

Families can receive SLT guidance even where the child has not yet been referred.

A Clearer Next Step

Advice, resources and signposting help match the child to the appropriate response.

More Targeted Referrals

Point of contact with an SLT for early and pre-referral advice

Flexible Access

The clinic can scale up to respond to demand where required.

Design Principle | **Provide advice early to a defined cohort, and connect each child to the clearest next step**

Scaling What Works: A Replicable Model for SLT Access

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Why Replicate across other areas?

1 Improve Access
Reassess defined waiting-list cohorts and provide advice before a formal referral is automatically made. 114 appointments to date in 2026, across 5 CHNs with 85% attendance.

2 Improve Use of Clinician Time
Discharge children whose needs have resolved and direct clinical time towards children who continue to need support.

3 Create Clearer Pathways
Give each child a defined next step: advice, home support, discharge, review or onward therapy pathway.

How to Replicate Speech Drive and Advice Clinic Models

1. Define the priority cohort using waiting-list, referral and caseload information.
2. Speech Drive for a defined cohort.
3. Set clear eligibility criteria, ring-fence clinical and administrative capacity, and confirm onward pathways.
4. Track attendance, discharge and pathway outcomes, then adjust the model to local demand.

Future Improvement to Models

Speech Drives & SLT SHARE App
Extend support beyond the appointment by sending tailored resources, activities and advice.

- Supports home practice
- Reinforces therapist advice
- Improves family engagement

Advice Clinics & Attend Anywhere
Use telehealth to schedule and manage telephone or video advice calls more efficiently..

- Simpler scheduling
- Clearer access for families
- Improved use of admin time

Testing a National Integrated Care Pathway for Hip and Knee Osteoarthritis (OA)

Ruth Kiely
Programme Manager, National Clinical Programme for Trauma & Orthopaedic Surgery

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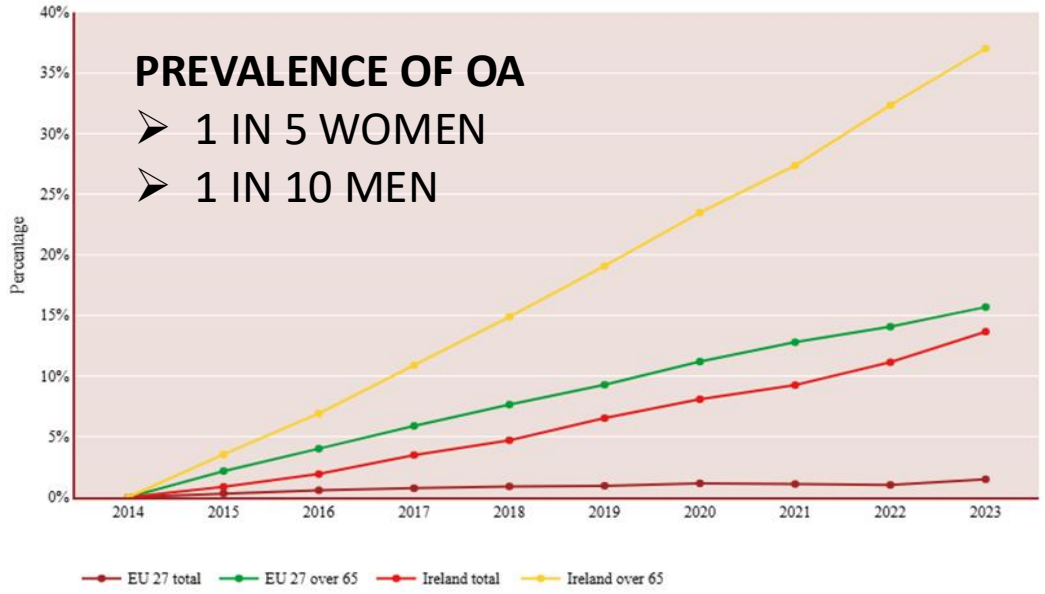
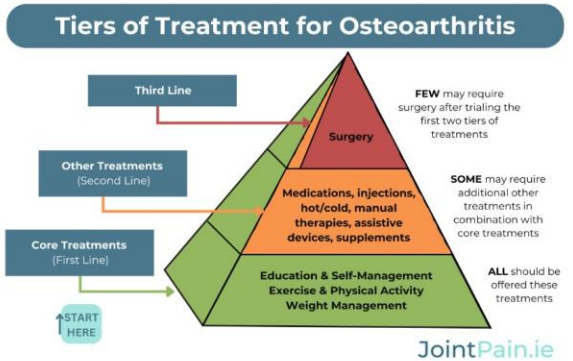
The Wicked Problem

- Ireland has a growing and ageing population
- Osteoarthritis is a chronic condition affecting ~ 400,000 people
- Most prevalent in people aged > 50 years
- Symptoms include:
- Pain, swelling & joint stiffness
  - Muscle weakness
    - Reduced mobility and function
- At the end of July 2026, 81,565 adults waiting for an initial Orthopaedic OPD Appointment (NTPF)
- Poor access to conservative management in the primary care setting for OA





Co-design and Collaborative Process 2021 – 2025

Integrated Care

Collaboration and Co-design

- Patients, clinicians (GP's, consultants, Physio, Dietetics) HSE, Spark Innovation, App developers, primary & secondary care managers, clinical programmes, Department of Health, RCSI, Arthritis Ireland

Coordination

- Patients managed through their patient journey in a timely manner by a dedicated team of health and social care professionals (physiotherapy & dietitian)

Continuity

- Sustainability post Sláintecare Integration Innovation Fund (SIIF) June 2025 onwards

Hip & Knee Pathway

Project Aims and Objectives

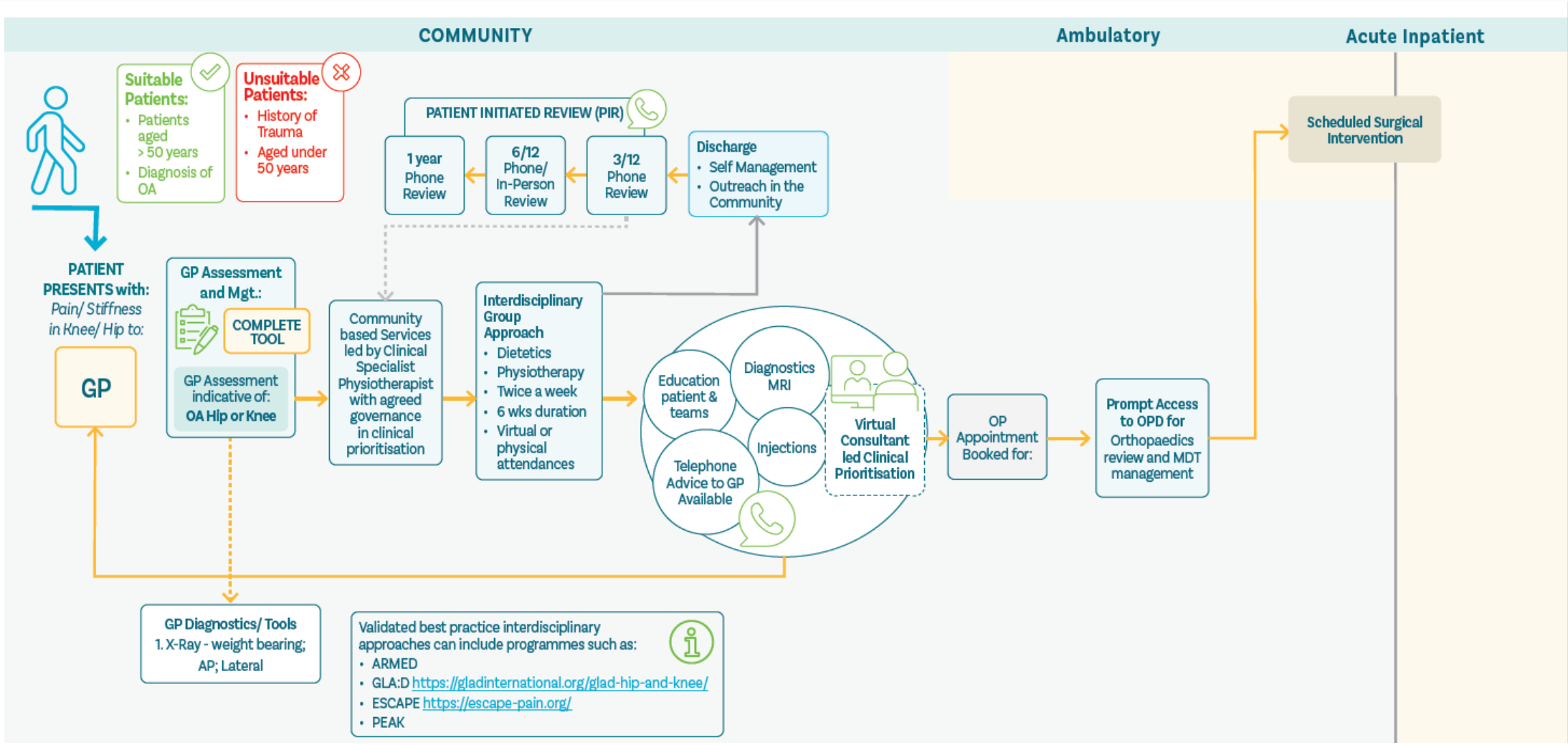
Aims

- To implement, test and evaluate the National OA Hip and Knee Pathway on two pilot sites – Our Lady's Hospital, Navan/Meath; Carlow Kilkenny/University Hospital Waterford
- To develop a patient app which would enable patients to self-manage their symptoms both during and after the programme

Objectives

- To demonstrate the efficacy of this integrated care pathway by improving timely access for patients with OA hip and knee to a community evidence based exercise and education programme that included weight management
- To improve functional outcomes and reduce pain for patients participating in the programme
- To reduce the number of unnecessary radiological investigations being completed in the primary care setting.
- Evaluate the implementation of the pathway & apply lessons learned for national implementation

National OA Hip and Knee Pathway



Pilot Project Results

April 2023 – June 2025

- 2,074 referrals were received between the two pilot sites
- 1,059 (51%) were direct GP referrals
- 1,197 patients were referred for interdisciplinary group interventions
- 130 groups delivered over 7 locations
- 58 (5.5%) of patients were referred for an orthopaedic OPD appointment (within 8 -10 weeks of referral)
- 25 (2.36%) patients converted to surgery
- 1,001 OPD appointments saved (€ 220,220)

Radiological Investigations

	January 2024 – May 2025		
	Kilkenny	Meath	Total
MRI	6,453	3,625	**10,078**
X-Ray	1,271		**1,271**

	MRI Hip	MRI Knee	X-Ray Hip	X-Ray Knee	Total
MRI	195	1,625			**1,820 (88%)**
X-Ray			36	201	**237 (12%)**
Total	195	1,625	36	201	**2,057**

This data highlights a disproportionate reliance on MRI within this patient cohort and identifies a potential for reducing costs through greater utilisation of X-Ray.

Learnings and Recommendations

Learnings

- Collaborative working and optimisation of current HSCP resources across both primary and secondary care to ensure long term sustainability of the pathway & improve patients access to conservative management.
- Suitable referrals should be sourced from various services (Primary Care Physio WL, MSK Triage) until a steady flow of GP referrals is embedded within the pathway.
- Early identification of key stakeholders including sports partnerships & regular communication is essential for successful implementation

Recommendations

- Inappropriate utilisation of MRI within this patient cohort is resulting in an increased demand for specialist orthopaedic opinions (3.4% increase OPD referrals HSE 2025)
- The Programme recommends the national implementation of this and other condition specific MSK integrated care pathways to help address the increasing demand and ensure earlier access for patients to conservative management.
- Patients need to have access to high quality evidence based information via websites e.g. www.jointpain.ie & the HSE Hip and Knee Pathway App

Acknowledgements

Our Collaborators

- All our patients that participated in this pathway
- Department of Health Sláintecare Integration Innovation Fund (SIIF)
- Mr Alan Walsh, Consultant Orthopaedic Surgeon and clinical advisor
- Mr Finbarr Condon, Mr Tom McCarthy Joint National Clinical Leads
- All GP's that participated in this project
- **Our Lady's Hospital Navan / Meath**
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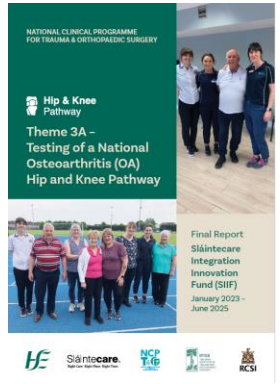
- **Carlow / Kilkenny / University Hospital Waterford**
- Grace Rothwell / Ben O'Sullivan, Mr Terence Murphy, Sinead Gavin, Helen Fitzgerald, Ruth Loughlin, Paul Bolger, Eileen Long, Siobhan Corcoran, Sarah Kennedy, Amanda Challoner
- HSE Spark Innovation Programme, Lorraine Smyth
- Local Sports Partnerships
- Pobal, Zendra



[Final Evaluation Report (2026)]

Virtual Physiotherapy Pathway

Technology Enabled Waitlist Management for P2 Patients

Sam Hancock

Senior Physiotherapist, South Kilkenny

CHN 2 Central Kilkenny and South Carlow

HSE Dublin & South East

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Carlow and Kilkenny Population Health Demographics

IHA Carlow Kilkenny serves a growing and ageing population across a widely dispersed rural catchment, driving greater demand for physiotherapy services and increasing pressure on services and waiting lists.

Growing Population

- Carlow population grew by 9%
- Kilkenny population grew 5%

(From 2016 to 2022)

Ageing Population (65+)

- Growth of 26% in population aged 65+ in Carlow
- Growth of 21% in population aged 65+ in Kilkenny

(From 2016 to 2022)

Rural Catchment Areas

Significant rural and dispersed populations result in longer journeys to access healthcare.

Waitlist Pressures

7% increase in physiotherapy waiting list across IHA since Jan 25

Reduced access to timely care

Delayed access to care may lead to deconditioning and greater healthcare needs.

Staffing Constraints

Within current staffing constraints, the existing service delivery model may not meet the population's needs in a timely manner.

Overview of the P2 Virtual Physiotherapy Trial

This Quality Improvement and Wait List Initiative aims to provide patients on the P2 physiotherapy waitlist with a **virtual education focused appointment** via Attend Anywhere closer to the point of referral.

Approach & Aims:

A dedicated weekly virtual education clinic delivered via Attend Anywhere, designed to:

- Provide accurate, condition-specific information to rectify misconceptions and help prevent further deconditioning.
- Provide early, targeted movement and strengthening exercises to help reduce future physiotherapy intervention.
- Provide reassurance to reduce fear avoidance or pain related anxiety of appropriate exercises

< 1 months post initial referral

6 – 8 months post initial referral

Triaged by Physiotherapist:
Triages and identify P2's that are clinically suitable for Attend Anywhere Contact using the inclusion and exclusion criteria

Admin Contacts Patient:
Contacts patient via telephone to inform them of service and schedules their appointment on DiaryBook

Telehealth Appointment:
Physiotherapist gives exercise advise and condition education to patient via Attend Anywhere

Removed from Waitlist or Face to Face Appointment
Once eligible for a face-to-face appointment, patients are re-contacted to confirm whether physiotherapy service still required.

Patient Suitability for Telehealth:

✓ Inclusion Criteria

- P2 Referrals within 1 month of receipt
- Persistent Non Specific Lower Back Pain (<3 months)
- Peripheral Joint Conditions incl. tendinopathy or arthritis of joints
- Peripheral Joint Issues

✗ Exclusion Criteria

- P1 referrals or patients requiring home visits
- Patients requiring > 1 immediate session
- Chronic pain presentations i.e. fibromyalgia
- Recent hospital discharge
- Lower back pain with complex etiology
- Orthopaedic, respiratory & rheumatology referrals

P2 Physiotherapy Patient – Current Journey

How Waiting Can Increase Pain and Disability

This journey illustrates how delayed access to early education can worsen patient outcomes and increase the need for healthcare support that timely intervention may have prevented.

1 Getting Active

Mary (65) decides to become more active and joins an exercise class.

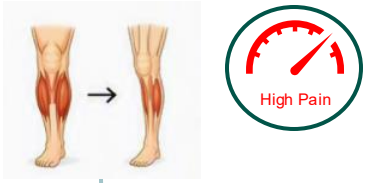
Two weeks in, she experiences pain in her right knee.

2 GP Appointment & Referral

Pain persists even after stopping classes.
She visits her GP and is told she has osteoarthritis and refers her to ECC Physiotherapy.

3 Activity Avoidance & Deconditioning

In the **6 month waiting period**, pain and fear lead Mary to avoiding the activities she enjoys resulting in weakening muscles and increased pain.



4 Initial Assessment with Physiotherapist

By the time Mary sees the Physiotherapist, she has developed an association between movement and pain.
The Physiotherapist reassures Mary and advises her how to gradually return to activity.

5 Ongoing Treatment & Recovery

After attending multiple appointments and carrying out her exercises from the Physiotherapist, Mary regains confidence and returns back to doing activities she loves.

P2 Physiotherapy Patient – Future Journey

A Proactive Approach That Leads to Better Outcomes

The early intervention virtual physiotherapy journey provides confidence and education to the patient to manage their condition and prevent avoidable deconditioning

1 Getting Active

Mary (65) decides to become more active and joins an exercise class.

Two weeks in, she experiences pain in her right knee.

2 GP Appointment & Referral

Pain persists even after stopping classes.
She visits her GP and is told she has osteoarthritis and refers her to ECC Physiotherapy.

3 Early intervention Telehealth Appointment

Within **2-3 weeks,** Mary has a **video call** with the Physiotherapist who provides advice and education on her condition.

4 Keeping Active & Building Strength

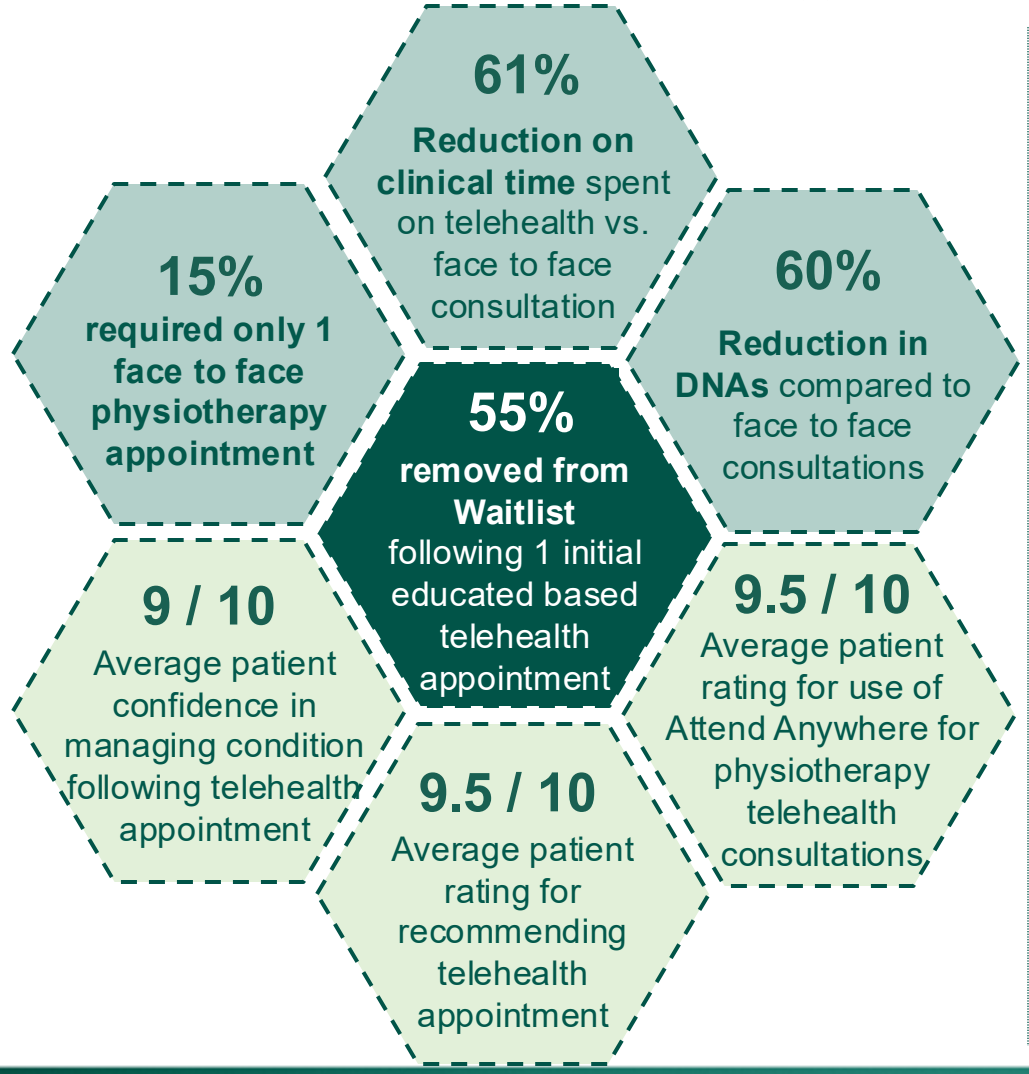
With the advise and exercise plan, Mary starts to build up muscle and takes control of her knee health.

5 Removed from Waitlist or Face to Face Appointment Offered

6 months later, Mary is offered a F2F appointment. At this point, Mary's knee has much improved and she decides to decline the physiotherapy appointment and is removed from the waiting list

Post Virtual Physiotherapy Trial - Outcomes and Benefits

The trial to date indicates that an early video enabled telehealth education session with the physiotherapist can reduce demand for face-to-face appointments, improve patient flow and help alleviate P2 physiotherapy waiting lists.



Benefits:

- Timely physiotherapy advice for appropriate conditions can correct misconceptions, promote safe activity and **prevent avoidable deconditioning** for long waiters.
- Leverage telehealth to optimise service efficiency and productivity within current staffing levels.
- Reduce demand for in-person appointments, preserving capacity for patients who require face to face care.
- Telehealth has enabled timely, efficient access to care at home, closer to the point of referral whilst reducing unnecessary travel for patients.

Lessons Learned

This model has the potential to scale across ECC physiotherapy services, with the key lessons below supporting its successful adoption and sustainable implementation.

Efficient Early Intervention

Timely education, reassurance and exercise guidance, helps prevent deconditioning while patients await care and this can be delivered more efficiently when conducted through video enabled telehealth pathways.

Value of Video Enabled Care

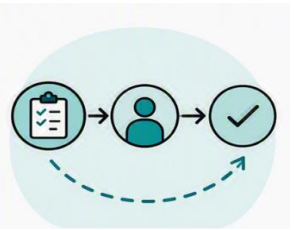
Visual assessment provides richer clinical information, supports greater patient engagement and enables clinicians to incorporate visual cues into decision-making compared with telephone consultations.

Inclusive Digital Access

Family or carer assistance, alongside administrative support for basic queries, helps patients with lower digital literacy engage confidently and successfully with virtual care platforms.

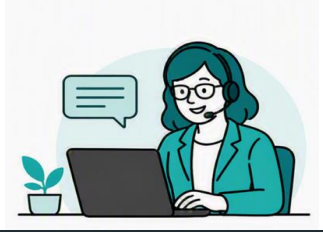
Enhancing Patient Experience

Patients view the early advice clinic as an additional service, supporting high satisfaction whilst ultimately demonstrating reducing demand for further physiotherapy services and easing waiting-list pressure



Digital & Process Enhancement

Optimising digital tools and adapting workflows to support efficient virtual service delivery is key to streamline and embed telehealth within the service.



Administrative Support

Administrative staff are required to support the initiative; for patient communication, scheduling and explaining the virtual consultation process / Attend Anywhere platform.

Virtual Care in the Community

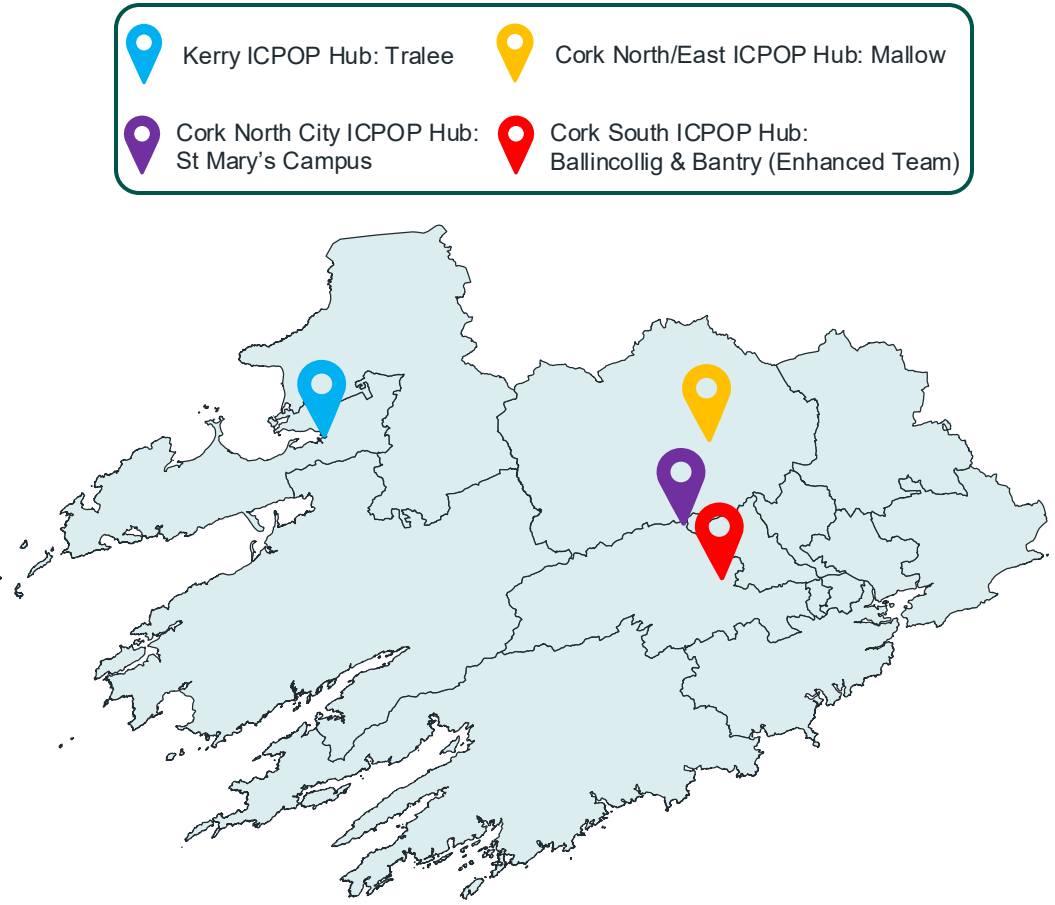
ICPOP Cork South City and West Cork

Dr Bart Daly

Consultant Older Adult, Cork South ICPOP

Overview of Cork Population and Service Demands

Cork/ Cork West CST covers a large and growing population, with an ageing demographic and dispersed communities driving increased demand for timely, accessible care.



Population Profile

8%

Cork population grew by 8% (From 2016 to 2022)

Combination of urban, rural and dispersed populations result in significant journeys to access healthcare

21%

The 65+ age group increased by 21% to 89,461 in Cork since 2016. (From 2016 to 2022)

ICPOP Performance Indicators in Cork/ West Cork

- 13% seen same/next day - above 10% national target;
- 100% specialist assessments completed - meeting target
- Achieved a 3% increase in patient contacts by June 2026 YTD compared with June 2025 YTD, while maintaining performance above key quality benchmarks,
- 12.9k patient contacts YTD, 12% ahead of target and 3% above Same point last year PLY

Older Person / Chronic Disease Service Model

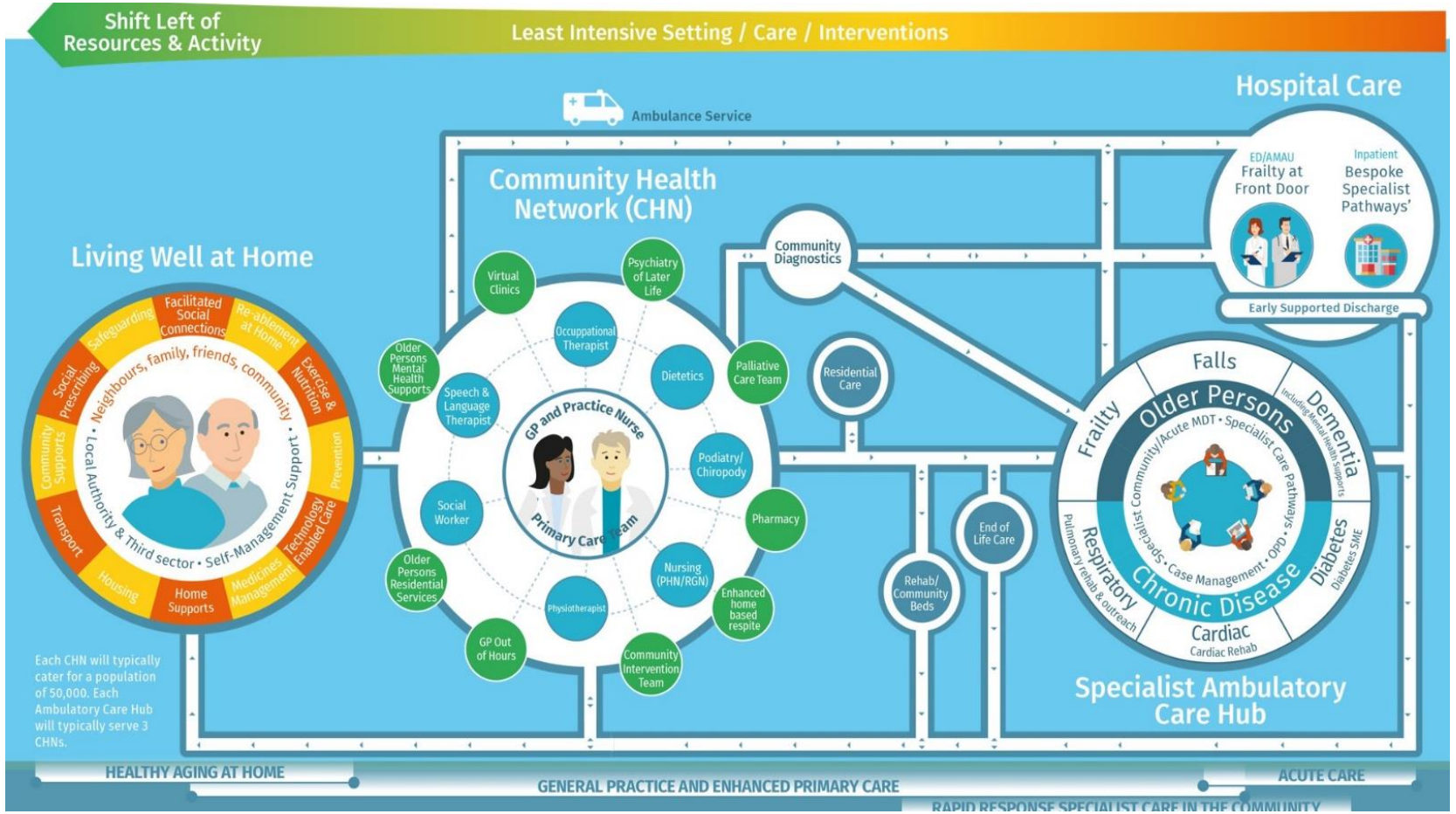
The Cork/Cork West ICPOP team have implemented the Older person Service Delivery Model. The increasing population requires continuous evolution while continuing to shift care as close to the persons home as is appropriate

Building Blocks

- Older person teams across care settings
- Utilising existing structures & pathways
- Virtual care infrastructure
- Specialist support virtually

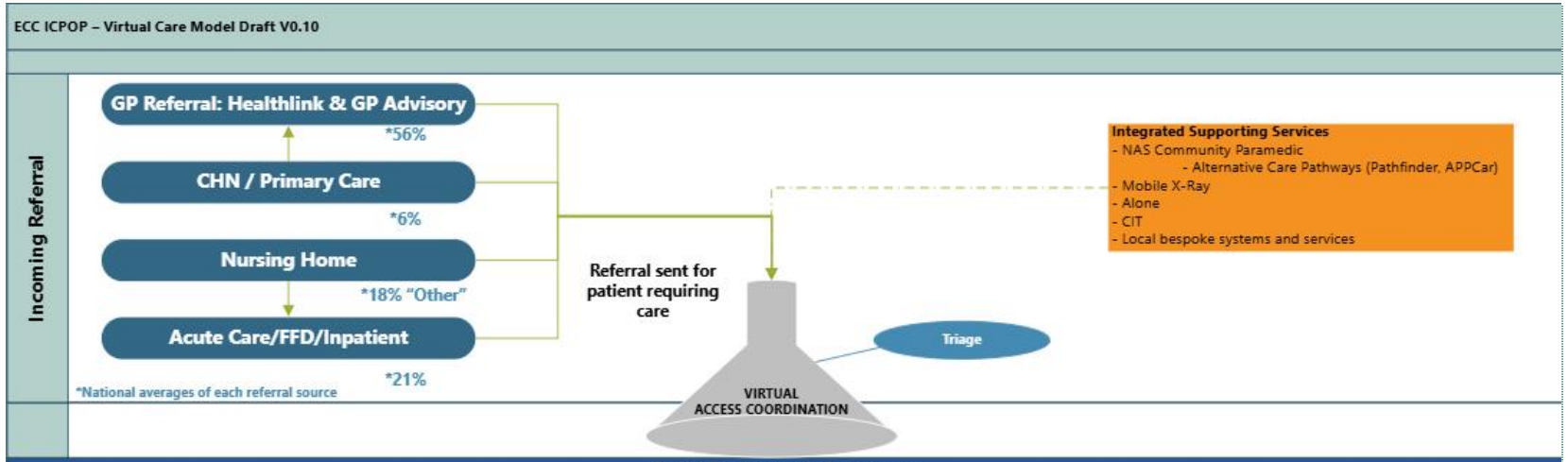
Reflections

- We are all ICPOP
- Each care setting is interdependent
- We have the necessary components but functionally not one team
- Age Friendly model can be the engine
- There isn't a Plan B



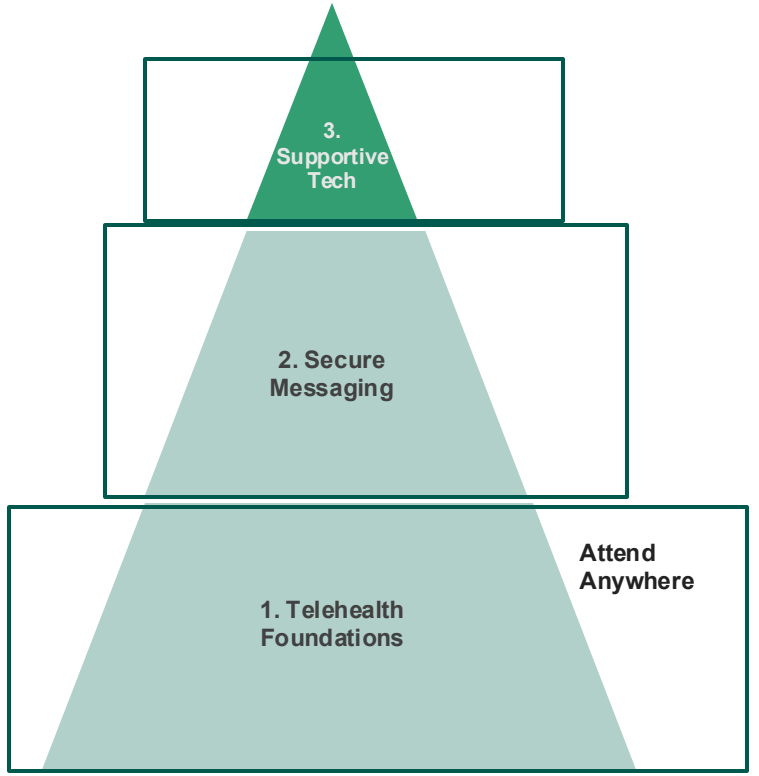
Virtual Care in the Community Initiative

The VCIC model creates a scalable framework for delivering integrated virtual care across community services, ensuring patients receive timely, appropriate interventions in the most suitable setting, streamlining referral management, triage and digitally enabled care.



Service	1. GP Virtual Clinic	2. Unscheduled Callout/Review (Crisis Care)	3. Virtual Domiciliary Care (Outreach)	4. Virtual ICPOP Pathway	5. CGA Pre-assessment	6. Early Supported Discharge (Rehab at Home)	7. Group Scheduled Meetings (Complex care)	8. Nursing Home Inreach
Service Description	Empowering the GP through the access to specialist advice	Crisis Care patient/family can contact staff (within the appropriate hours) and engage as appropriate	Clinical staff conducts home visit and engages with staff in hub via video	Face to face appointment conducted via video consultation	Initial Information gathering and pre-assessment for a formal CGA to be conducted	Outreach support for patients who requires interventions but not acute care. Eg those that require follow on MDT activity but can do not require an acute bed	Virtual meetings to support engagement between ECC CHN / ICPOP / MDT or Care planning meetings. Delayed transfer of care meetings	Supporting patients within nursing homes who require interventions but not acute care. Eg those that require follow on MDT activity but can do not require an acute bed
Service Users	GPs Local processes/ consultant to dictate cadence of slots	Case management patients & family	Patients with limited mobility or unable to travel	Patients who have been screened as suitable for virtual consultations	Patients who have been screened as suitable for virtual consultations and appropriate for virtual CGA element	Patients who require further therapy but no additional acute treatment	ICPOP clinicians and staff. CHN team members External providers	Nursing Home patients that have been screened as suitable for virtual consultations

Digital Enablers:



Virtual Access Coordination

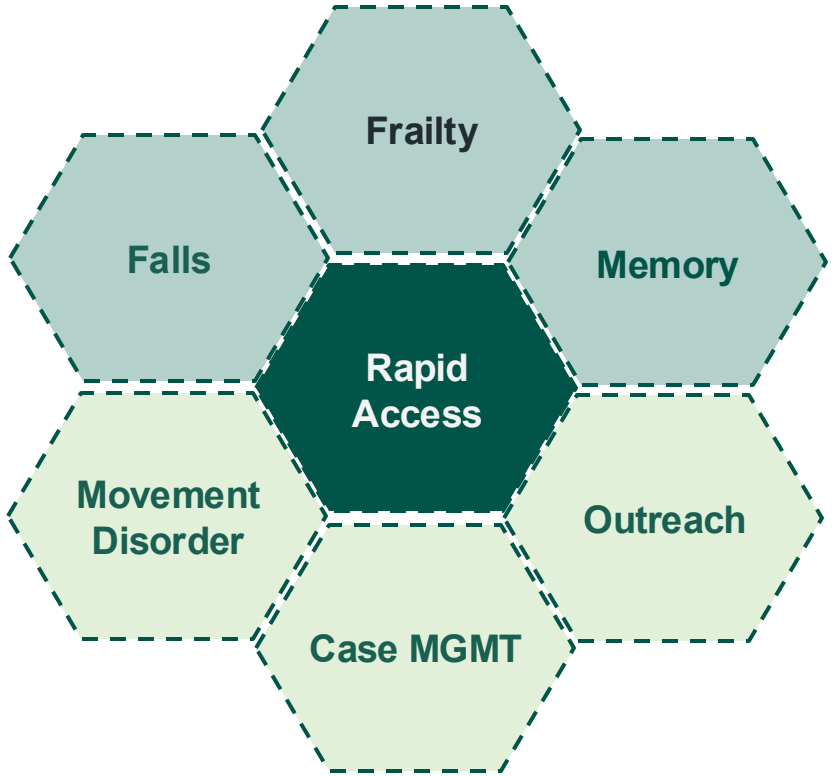
Learnings and Breakdown

The availability of a coordination function is critical to managing rising demand and enabling timely access across care settings. The Cork/West Cork ICPOP team provide a variety of services to the local older population. This service has developed in response to the evolving needs using the resources available to the team

Lessons Leaned from Original Model

- Consistency of model and service delivery
- Vulnerability of isolated services
- Rising demand ~15% annually
- Active coordination between care settings
- CUH regional role and demand

Type



Breakdown by Area/Type

5500 patients annually (1:1 new/return)

Demand in coordinating care across settings

Rapid access 20-25% (<2/52 – majority same week):

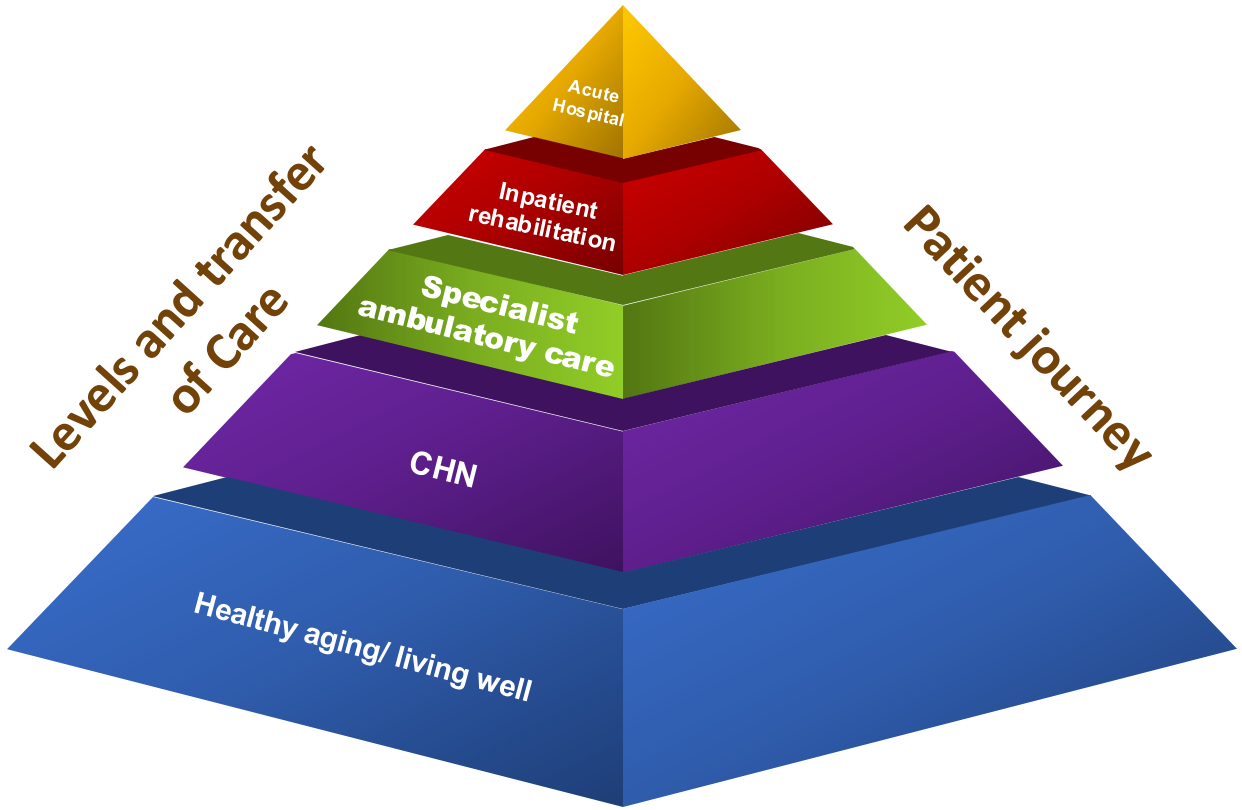
- GP
- APP Car/ED/FIT/UVC
- Inpatient Geriatric teams
- Case management/CHN teams expediting GP referrals

Virtual Access Coordination

Coordination of Care and team priorities

Virtual Access Coordination enables teams to work closer together, improving care coordination, pathway visibility and transitions across settings.

GP Fellow – Dr Andrea Fitzgerald / Professor Tony Foley



Considerations

- Expansion of ICPOP – multiple care settings input
- Demand associated with transfer of care/information
- Duplication of work/assessment
- Telehealth options (Attend anywhere)
- Real time pathway visibility and decision making for referrers
- Act as one team

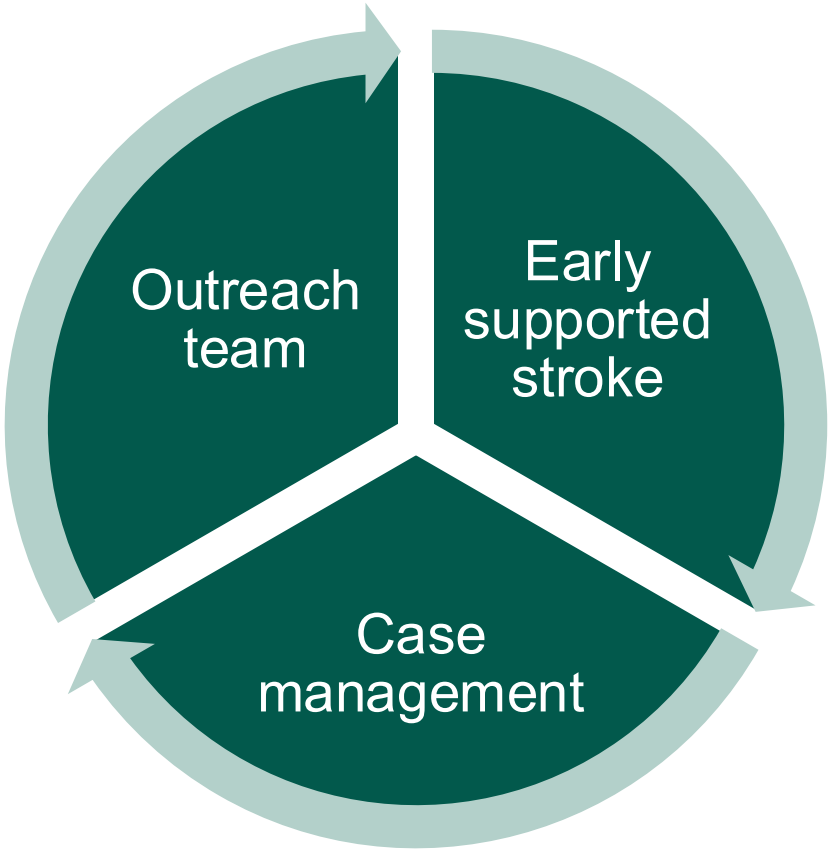
Team Roles and Priorities

- Work with existing team and structures
- Improved coordination of care
- Case management development and support
- Embedding telehealth options within existing pathways

Domiciliary specialist care

The Cork/Cork West team has developed several virtually enabled pathways, including nursing home outreach, domiciliary in-reach and closer integration with MDTs and supporting services. The domiciliary in-reach pathway is particularly noteworthy, enabling older people to receive support in their own homes.

Domiciliary Care uses



Enablers and Outcomes

Enablers
- End to end pathways
- Rapid access support
- Coordination of care and access

>800 patients annually

Crisis

Rehab

Supported Discharge

Assessment

Use Case: Nursing Home Inreach Telehealth Example

How Telehealth enables early supported discharge. This journey illustrates how Telehealth was used to support a ICPOP care of an ED discharge of a Nursing Home resident

1 Presentation

86 year old NH resident seen in ED with hypoactive delirium on b/g recurrent aspirations

Supported by:
ED team
FIT team/ Fellow

2 Review

Discharged with telehealth review the following day and home visit within one week

Supported by:
NAS
Clerical team
CNS
Geriatrician
Fellow/ANP
DON NH

3 Future Planning

4M's plan and future care plan developed with patient, family and NH team

Supported by:
Patient
Case management
NH team
GP
Palliative care team

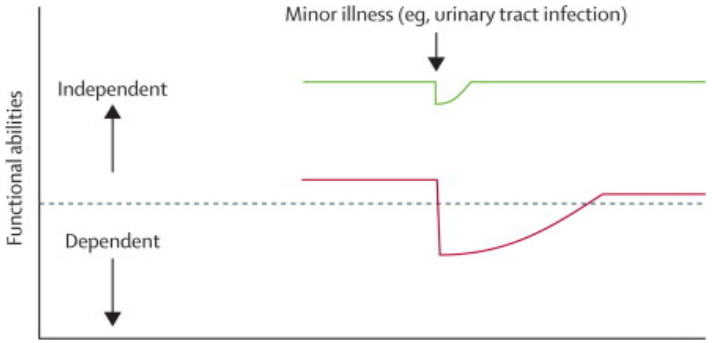
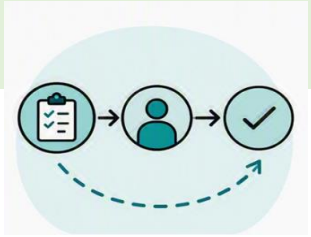


Figure 1 Vulnerability of frail elderly people to a sudden change in health status after a minor illness

Use Case: Rapid Access Telehealth Example

This journey illustrates how Telehealth was used to support a ICPOP care of a ED discharge of a Nursing Home resident

Presentation	Rapid Access	Extended CTM
77 year old known to service from previous home visit – contacted on death of partner/main carer Supported by: • Niece • Single point of contact – clinical and clerical • Frailty ANP	Rapid access home visit with telehealth discussion with Geriatrician 4M's plan and contacted CHN team Supported by: • Clerical team • CHN manager, GP and PHN • Frailty ANP • Geriatrician • Patient and family	Emergency respite sourced within 1/52 and onward transfer to Nursing home care directly Telehealth follow up 6/52 post admission Supported by: • Hub team • Placement coordinator • GP • CHN team • NH team



Telehealth Referrals

Attend Anywhere is now deeply ingrained in the Cork/Cork West Hub. Defined processes have been stood up and iterated upon, providing staff with the ability to offer virtual consultations when appropriate.

Telehealth Review Referrals:

- Referrals are predominantly from GP
- Some are crisis call from case management/Nursing Home for older adults previously seen ICPOP service
- 2024- Jan-Dec 39 virtual calls.
- 2025- present 243 Virtual Calls. Currently structured clinic in place and embedded within frailty pathway

Telehealth Challenges:

- Patient selection
- Dedicated staff role and resourcing
- Staff and patient confidence with technology and equipment
- Technical and process issues

Delivery Challenges:

- Governance
- Coordination
- Robustness of pathways
- Geography
- Demand is not static

Patient Suitability for Telehealth:

- Return patients/ Existing CGA
- Defined question
- Caregivers present
- Multiple care settings and providers– shared input and decision making
- Experienced staff who have worked together

Main Referral Themes:

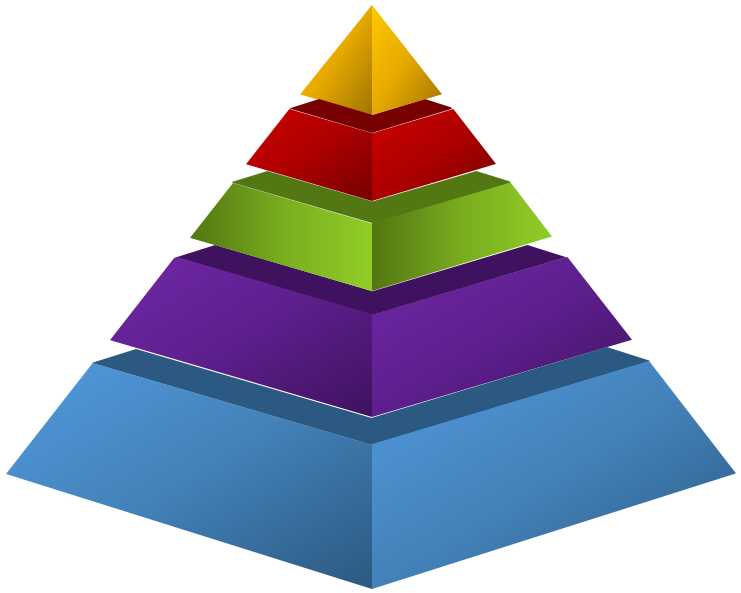
- Specialist review using 4m approach and advise
- Home review/Long term care
- Education and support
- Extended CTM/Complex case forum

End to end pathways

Virtual Care in the Community will continue to evolve as new opportunities and appropriate use cases emerge. These pathways will be developed collaboratively with wider older person support services, ensuring coordinated and integrated care.

Future planning

- Hub as structural anchor for further developments
- CUH pathways – rapid assessment / in-reach / supported discharge / complex case management
- Further CHN integration
  - shared planning within individual pathways



Next Steps

- Embed telehealth within each pathway supported by virtual team
- Expanded follow up – target additional 10% year ~ 250 appointments
- Coordination of care across settings (Siilo between teams/FIT/CHN's)
- Hub to host complex care meetings across care settings
- Developing pathways with other services e.g NAS

Simplicity does not precede complexity, but follows it

Alan Perlis

Panel Discussion

Moderator – Pat Healy, National Director, National Services and Schemes

- **Martina Queally**, REO, HSE Dublin and South East
- **Dr David Hanlon**, Clinical Lead Shared Care Record and National Clinical Advisor and Clinical Programme Group Lead Primary Care Clinical Design and Innovation
- **Ellen O'Dea**, Regional Director Health and Social Care Professions, HSE Dublin & Midlands
- **Niall Redmond**, Assistant Secretary, Department of Health

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Closing Remarks

Pat Healy

National Director, National Services and Schemes

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