



Integrated Healthcare Conference

Delivering Integrated Care Together

Delivering Impact through Integrated Care

The Auditorium, Convention Centre Dublin

3 September, 11:30 – 12:55



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IRELAND2026.EU
Imeacht Gaolmhar | Associated Event



Welcome and Introduction

Dr Sarah O' Brien
NCAGL for Chronic Disease



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Opening Address

Delivering Impact through Integrated Care

Martina Queally

REO, HSE Dublin & South East



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Why Integrated Care must be our default

The health needs of Ireland's population are changing, and our health services must change too



Population growth

Growth is exceeding projections



Rapid ageing

Ireland is ageing at one of the fastest rates in the EU-27



Chronic disease driving healthcare demand

39% of the population is living with at least one chronic condition

Sláintecare sets the direction: move from reactive treatment to a full continuum of care as close to home as possible



A fundamental change in how we plan, prioritise and resource healthcare services



From “hospital first” to “community first”

Use existing capacity better, join up pathways and scale what works



1

Deliver care at lowest clinically appropriate level of complexity

Strengthen CDM in General Practice supported by direct access to diagnostics & community-based specialist services.

2

Integrate across the acute-community shared system

Use shared pathways and posts spanning hospital and community to improve care continuity and flow.

3

Scale proven models across Health Regions

Resource what works: build on **digital, specialist nurse-led and HSCP-led interventions** already delivering impact.

TODAY'S SESSION: Patient Voice • National & Regional Clinical Leadership • General Practice • Public Health

Panel Discussion: Focus on how we move beyond pockets of good practice to consistent, person-centred integrated care within and across Health Regions



The Clinical Effectiveness and Return on Investment of Shifting Care to the Left:

The impact of the Respiratory Community Specialist Teams on acute hospital admissions and budget impact of national scale-up

Prof. Breda Cushen

Clinical Lead , National Clinical Programme Respiratory



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COPD is a leading cause of morbidity and mortality

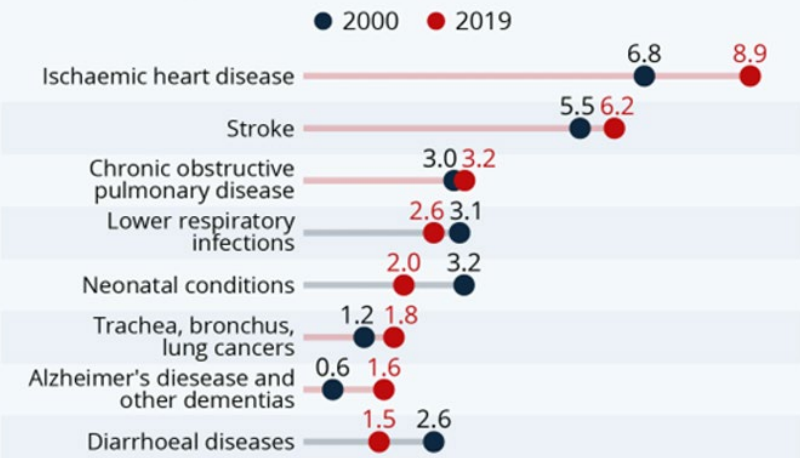
- Chronic Obstructive Pulmonary Disease (COPD) is a chronic lung condition which results from abnormalities of the airways and/or alveoli and causes persistent, often progressive, impairment of airflow and chronic respiratory symptoms.
- COPD is the most common chronic respiratory condition (200-300 million people worldwide)

Ireland has no accurate prevalence data

- Estimated ~400,000 carry a diagnosis
- 12% enrolled in GP Chronic Disease Management Programme
- Leading cause of death from non-communicable disease
 - Exceeded by IHD and Stroke
- 40% of respiratory deaths across the EU (likely more)

The World's Leading Causes Of Death

Total number of people who died from the following conditions (in millions)

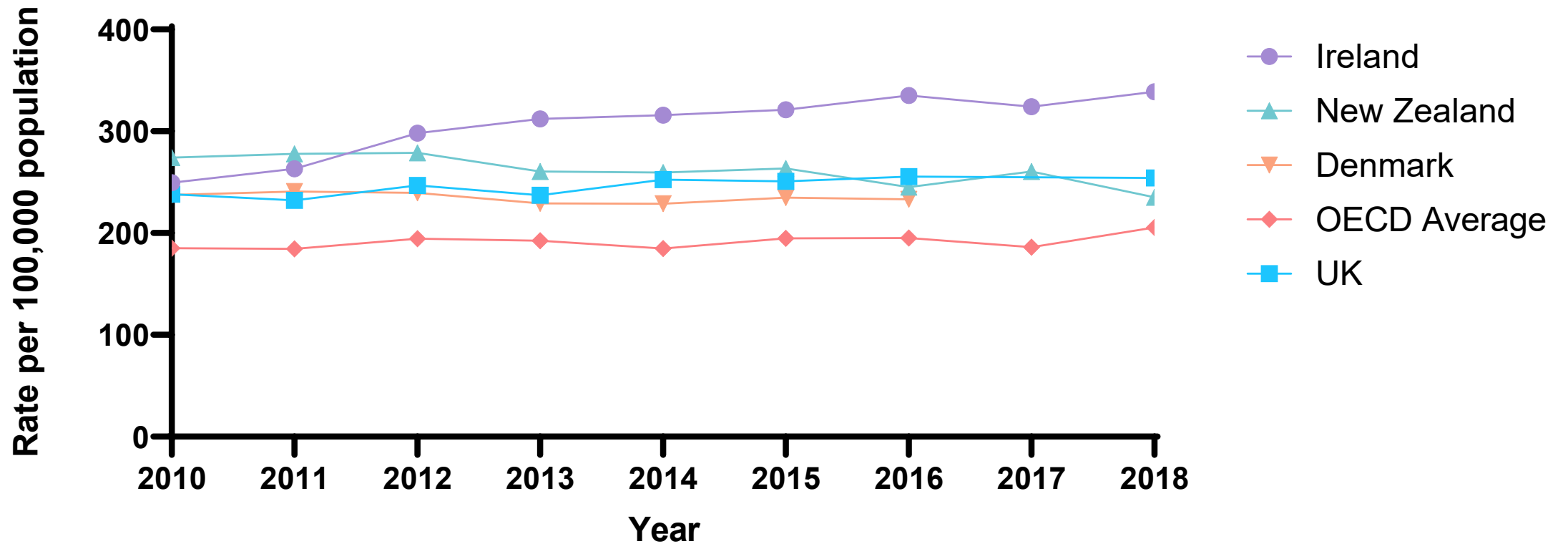


Source: World Health Organization



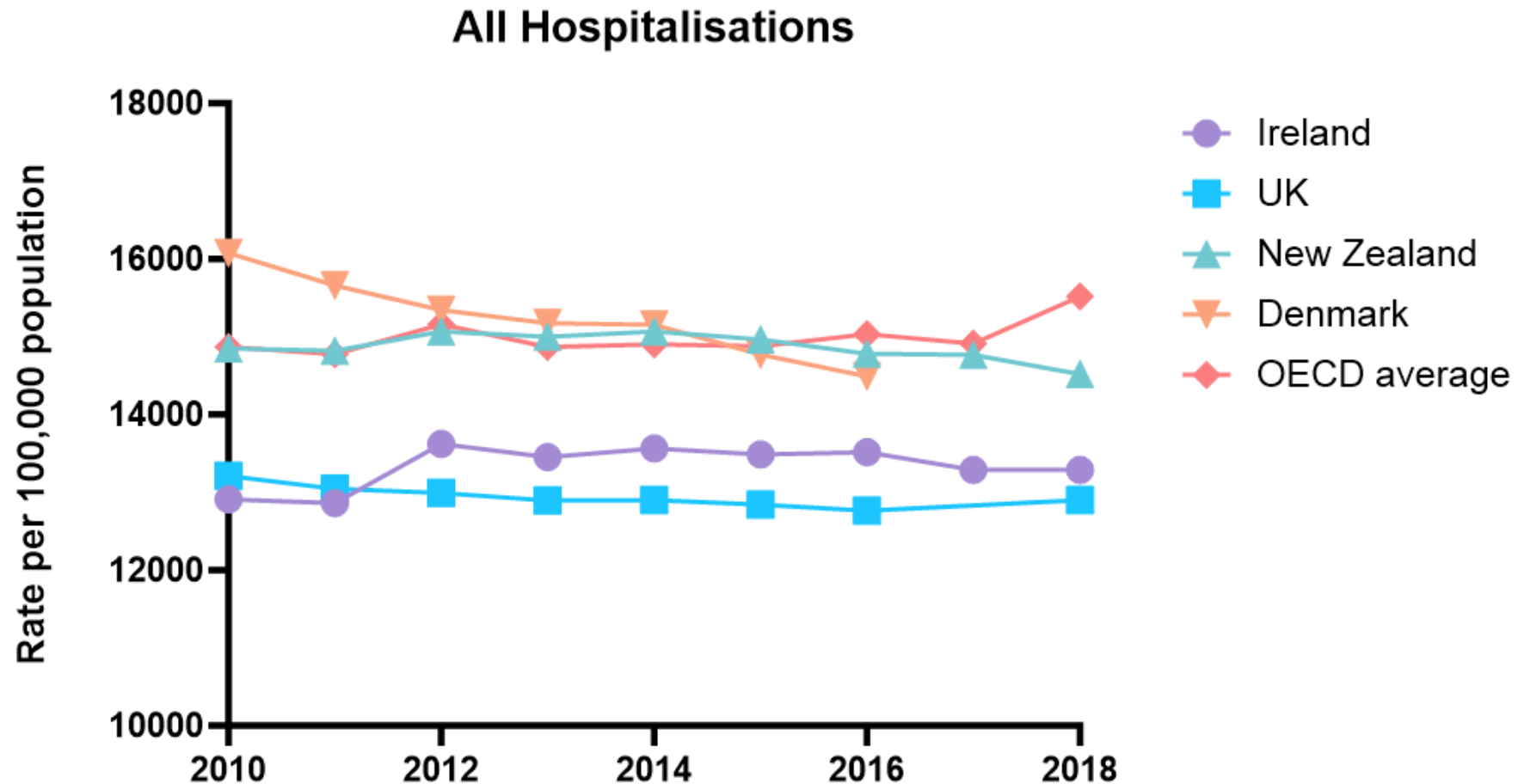
Ireland's COPD hospitalisation rate far exceeds OECD average

COPD Hospitalisations



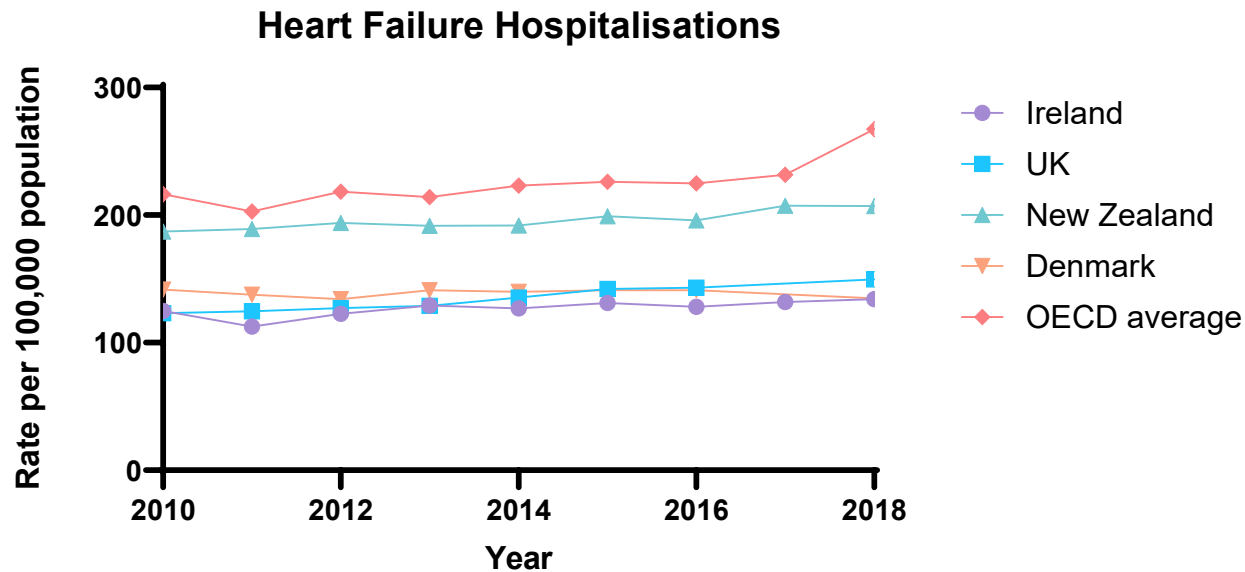


All-cause hospitalisations are below average





COPD is more prevalent than other chronic disease admissions



Source: OECD

Breakdown of Ambulatory Care-Sensitive (ACS) Hospitalisations, 2019-2024		
ACS Condition	Hospitalisations (Count)	Hospitalisations (% ACSs)
COPD	92616	16.6%
Diabetes complications	59281	10.6%
Iron deficiency anaemia	54049	9.7%
Convulsions and epilepsy	53557	9.6%
Asthma	51901	9.3%
ENT infections	42935	7.7%
CHF	41861	7.5%
Cellulitis	31493	5.6%
Dental conditions	31321	5.6%
Influenza and pneumonia	21540	3.9%
Angina	19853	3.6%
Dehydration and gastroenteritis	19246	3.4%
Hypertension	18712	3.3%
Pyelonephritis	12509	2.2%
Perforated/bleeding ulcer	3030	0.5%
Pelvic inflammatory disease	2662	0.5%
Other vaccine preventable	1466	0.3%
Gangrene	555	0.1%
Total	558587	100.0%

Source: Department of Health



The multidimensional ECC model for COPD supports shift left



Designed to meet the needs of all with this heterogenous condition (variable needs, variable clinical trajectories)



The implementation of ECC has been variable



In 2024, of 27 model 3 & 4 hospitals linked with ECC:

- **12** were able to deliver **to some degree** all components of the ECC quality COPD care model **“Complete ECC model”***
- **15** were unable to deliver **in any form** some components of ECC quality COPD care **“Partial ECC Model”**
 - No GP access Spirometry
 - No Consultant oversight
 - No COPD Outreach

*Site to site variability exists in the level of each service that individual sites can provide



The impact of ECC on COPD hospitalisation

Aim

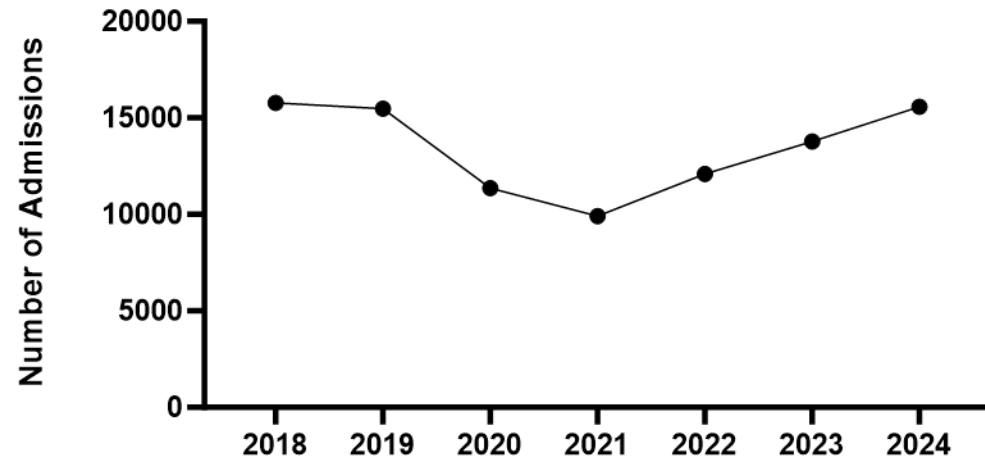
- To determine the impact of the implementation of the ECC model of quality COPD care on National COPD admission and readmission rates.
 - Determine change in these metrics in 2024 compared to pre-COVID (2018)
 - Examine if there are differences between ECC sites
 - Examine the impact of components of ECC care on COPD hospitalisations

Data Source

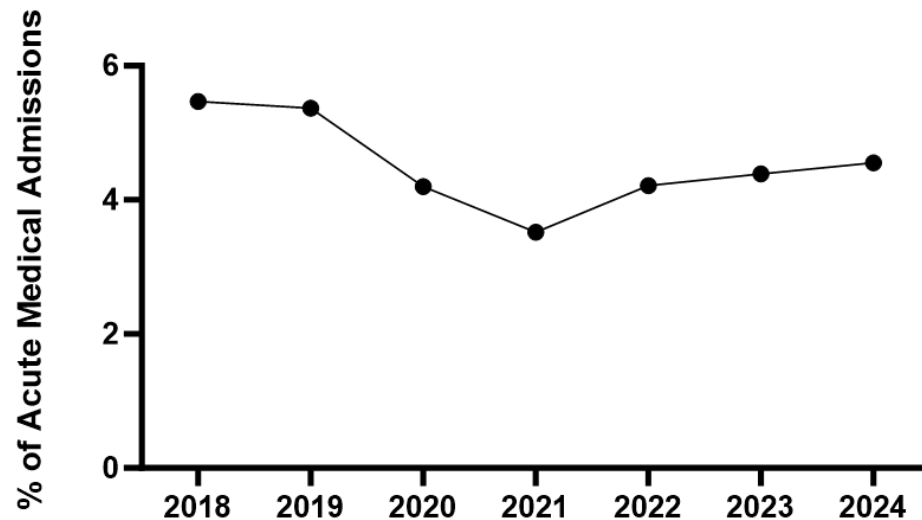
- Components of ECC care delivery nationally
 - ECC data, and local knowledge of site structures
- COPD admission and 90-day readmission rates per hospital site
 - HIPE data from 2018 to 2024
 - COPD discharges based on principal diagnosis of COPD
 - Age ≥ 15
 - Inpatients
 - Virtual wards excluded
- Total acute medical emergency admission activity
 - HIPE data from 2018 to 2024
- COPD Outreach Activity
 - NCP Respiratory National data 2017-2023



First appearances can be misleading



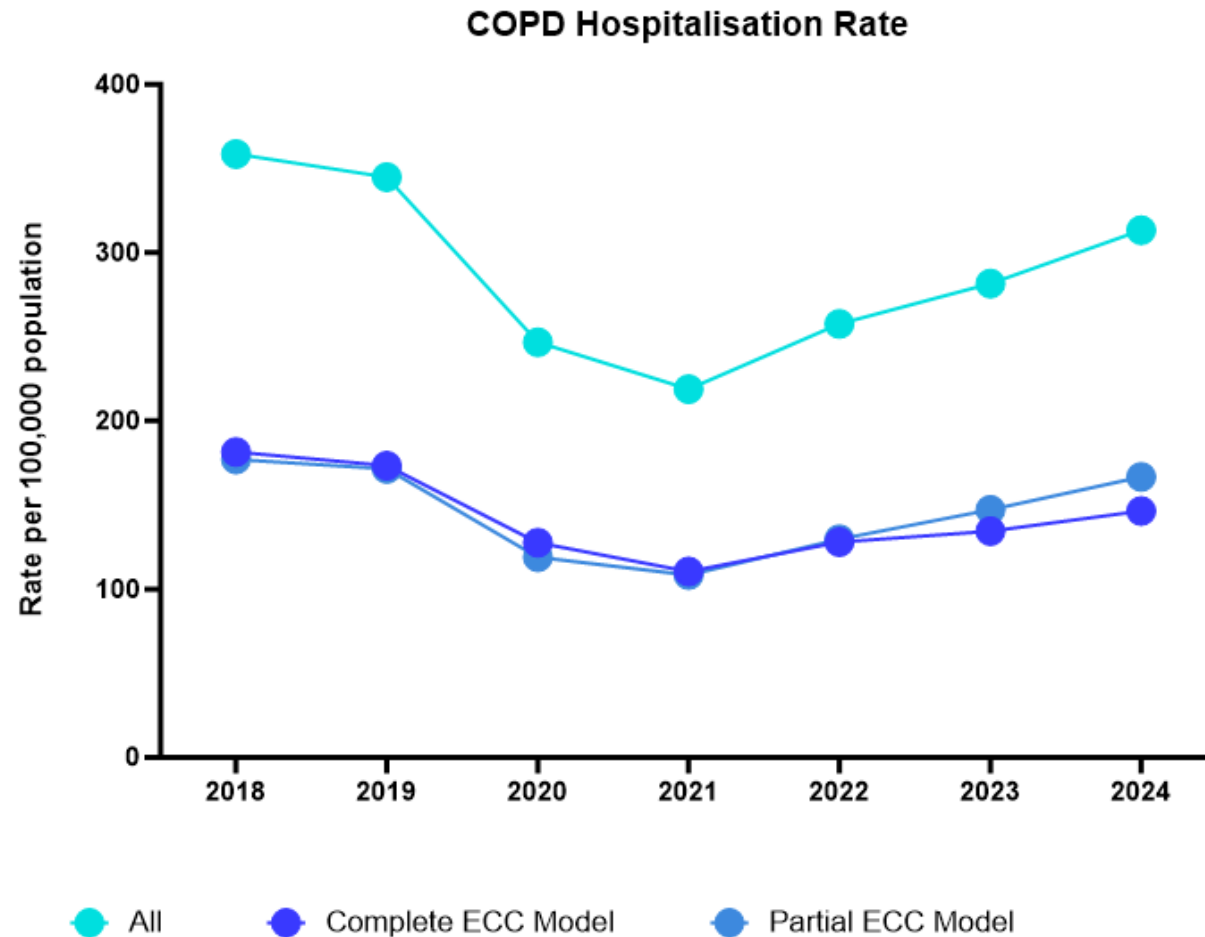
Nationally number of COPD hospitalisations reverted to pre-COVID levels



COPD accounted for a smaller proportion of acute hospital admissions in 2024 vs 2018



Complete ECC model sites account for fewer hospitalisations



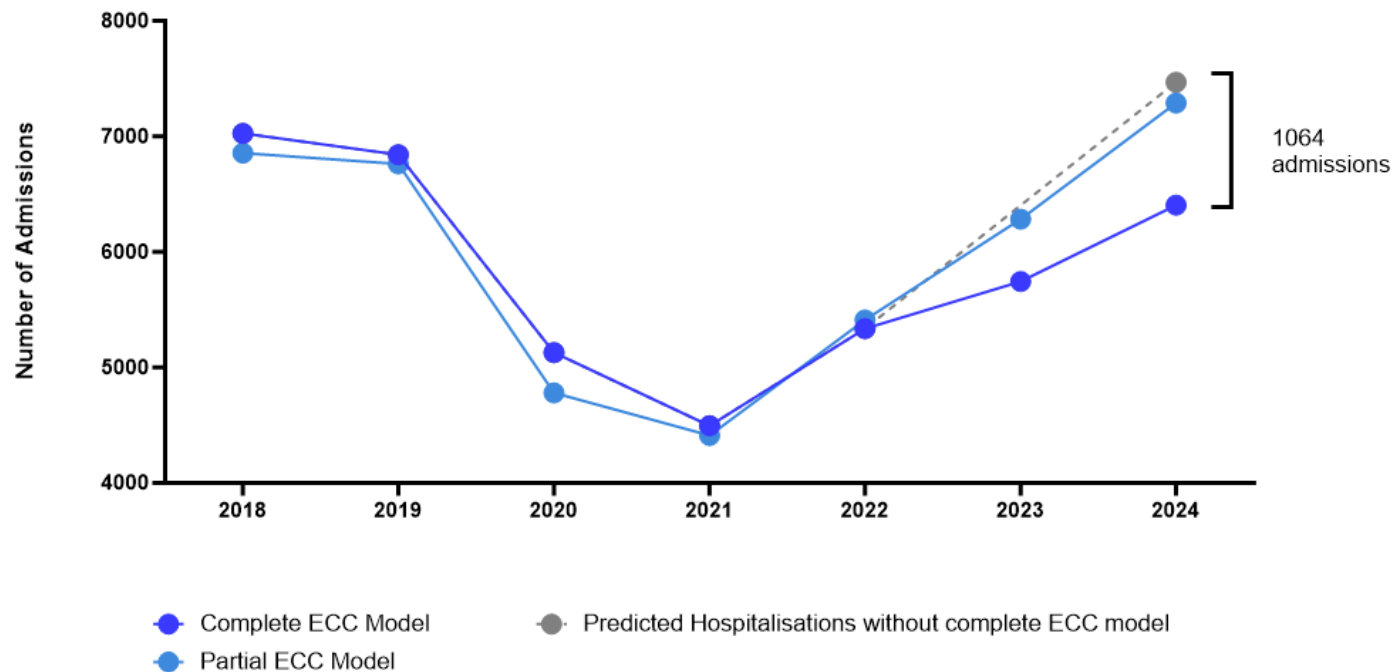
Rate per 100,000 population 2024
All sites: 313.39

Partial ECC Model: 166.80
Complete ECC Model: 146.59



COPD care under the ECC model

Delivering all components of quality COPD care under ECC model altered the trajectory of COPD admissions.

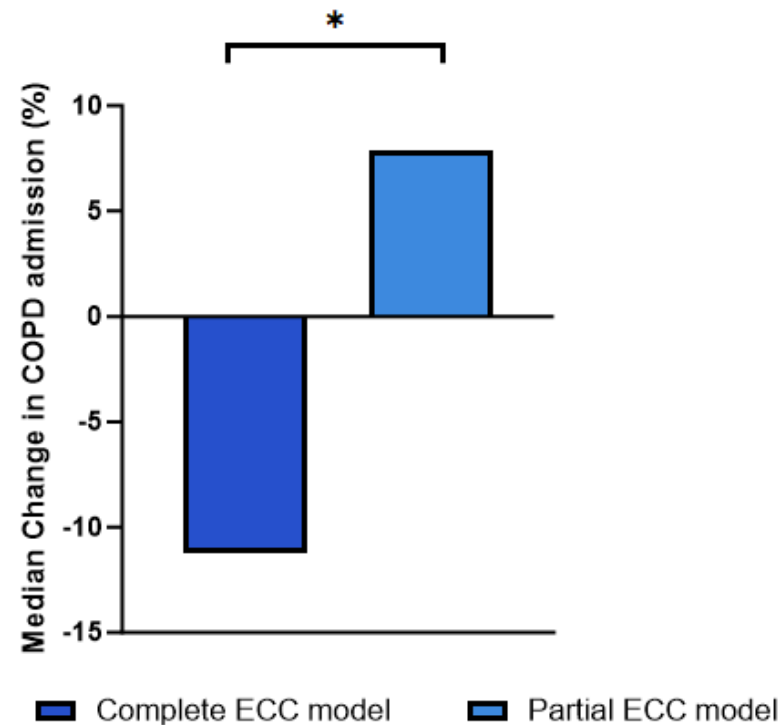


- **1064 potential admissions saved** at Complete ECC model sites
- **7,874 bed days saved**
(based on national avLOS 7.4days)
- **€6m - €10m saved**
(based on average cost inpatient COPD admission)



Delivery of COPD care

Sites delivering all components of quality COPD care have greater admission reduction 2018-2024.



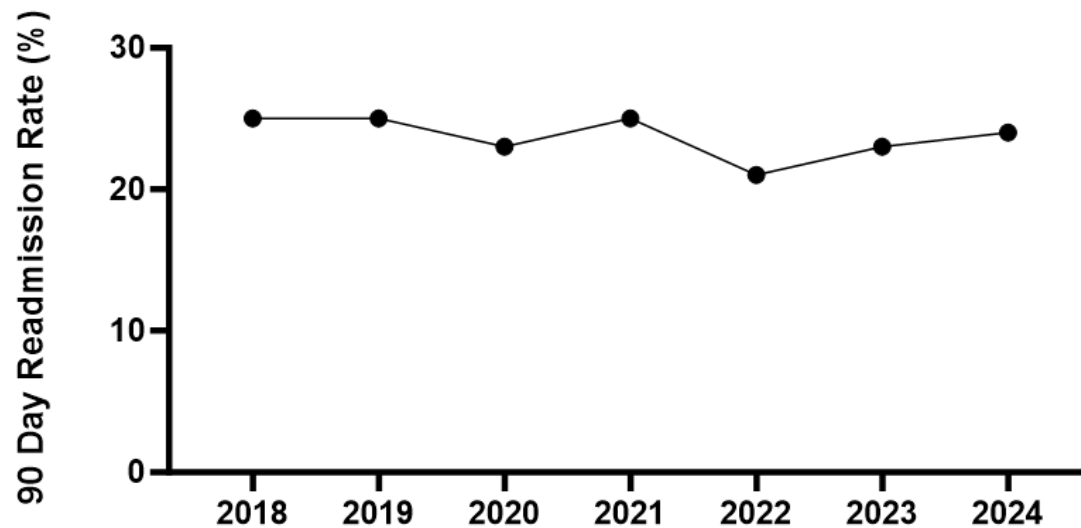
* $p < 0.05$

Site to site variability exists in the level of each service that individual sites can provide

HIPE data shared with NCP Respiratory

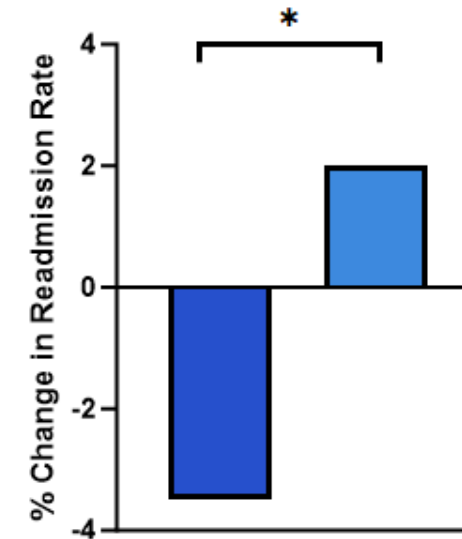
HF COPD readmission rates

90-day COPD readmission rates are reducing at complete ECC model sites.



National 90-day readmission rate is static at 25%

2024: Complete ECC model - 23%; Partial ECC model - 26%



Complete ECC model Partial ECC model

* $p < 0.05$

*Site to site variability exists in the level of each service that individual sites can provide

HIPE data shared with NCP Respiratory



Access to diagnostic Spirometry

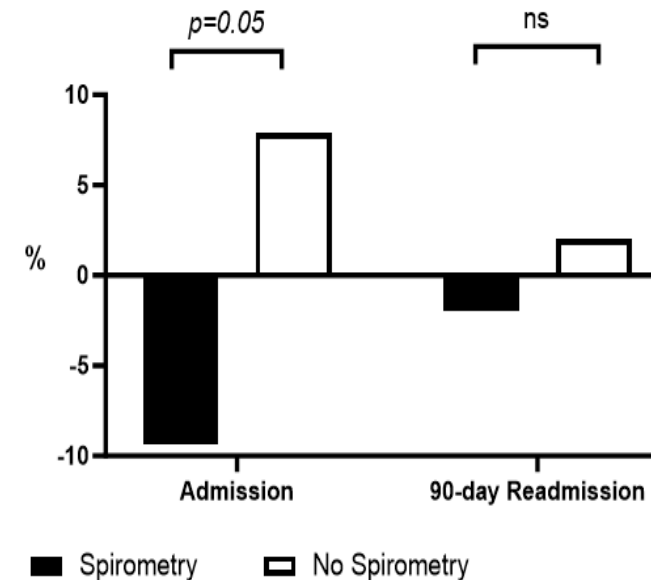
Sites who can provide Diagnostic Spirometry have reductions in COPD hospitalisation and Readmission Rates

In 2024, of 27 hospitals linked to ECC:

- 13 offered direct GP access spirometry
- 1 facilitated GP access through acute services only
(no additional staffing through ECC)
- 13 did not offer GP access spirometry

Having a diagnosis of COPD is required to access all ECC-funded services

Change in COPD admission and 90-day admission rate 2018-2024 stratified by availability of GP access spirometry

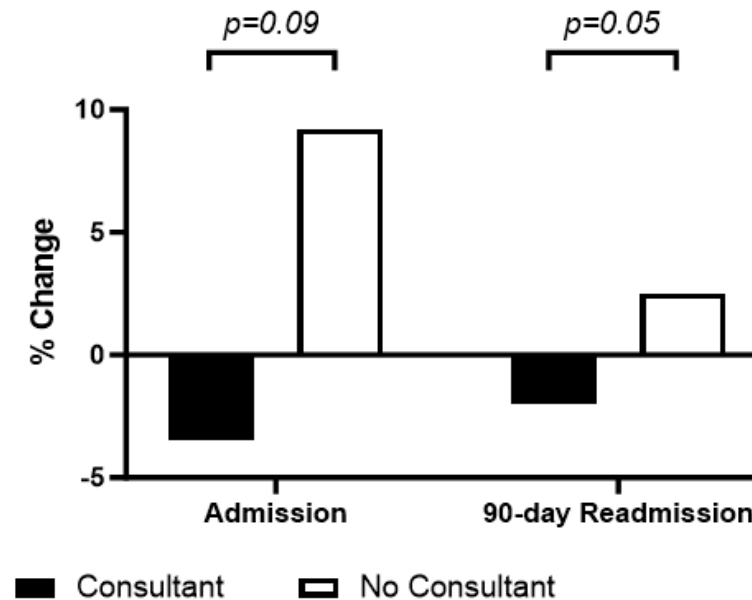




Consultant Leadership supporting outcomes

The presence of consultant leadership improves COPD hospitalisation and Readmission Rates.

Change in COPD admission and 90-day admission rate
2018-2024 stratified by availability of Consultant



In 2024, 13 consultants were fully established in post.

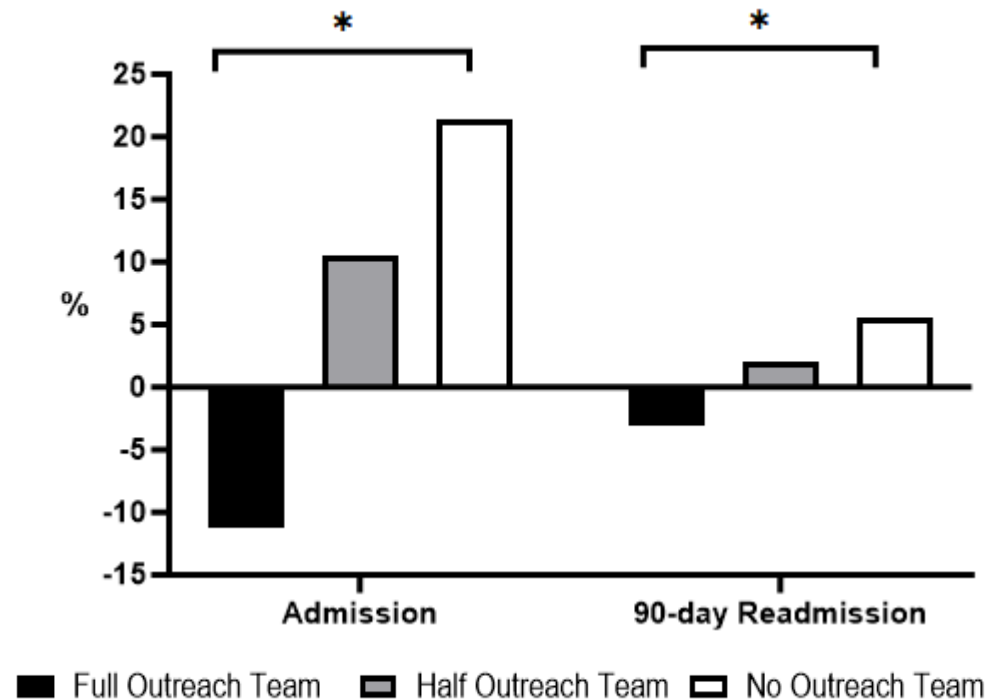
Capacity of COPD outreach services is related to COPD hospitalisation and readmission rates

In 2024, of hospitals linked to ECC.
COPD outreach teams:

- Full teams (2WTE): 14
- Partial teams (1WTE): 11
- No team (0WTE): 2

Admission avoidance activity has doubled with expansion of COPD outreach teams under ECC.

Change in COPD admission and 90-day admission rate 2018-2024 stratified by capacity of COPD



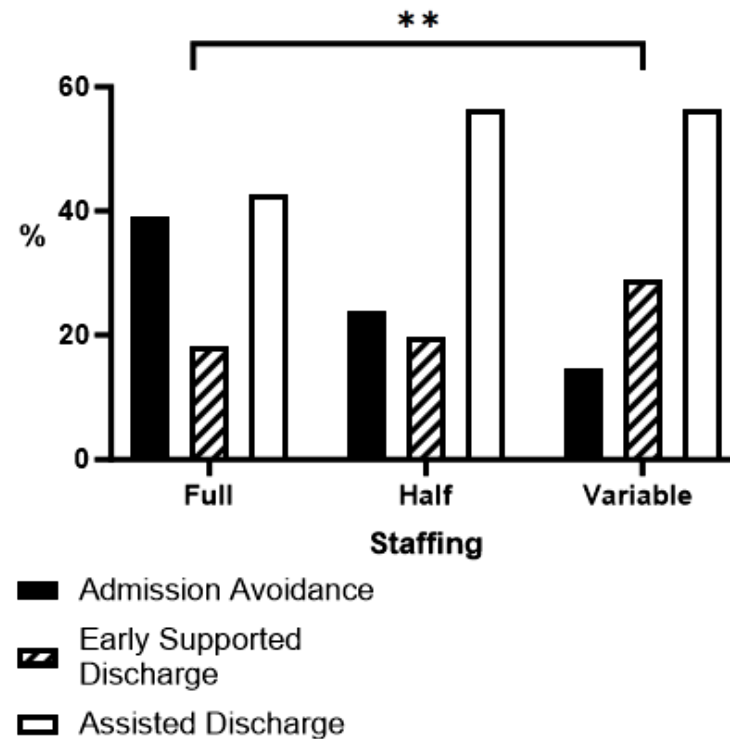
* $p < 0.05$

HIPE data shared with NCP Respiratory



The centrality of staffing

More staff means more admission avoidance



Relationship between Outreach pathway recruitment and COPD outreach Staffing.

Full- 2WTE. Half- 1Wte, Variable – 1-2 WTE intermittently throughout data collection period

Data from COPD Outreach services shared with NCP Respiratory

- The “shift left” is happening
 - More scheduled care delivered closer to home
 - Reduction in unscheduled emergency care
-but implementation of the ECC model for COPD has been inconsistent
- Sites delivering a complete ECC model are outperforming others

Is there return on investment?

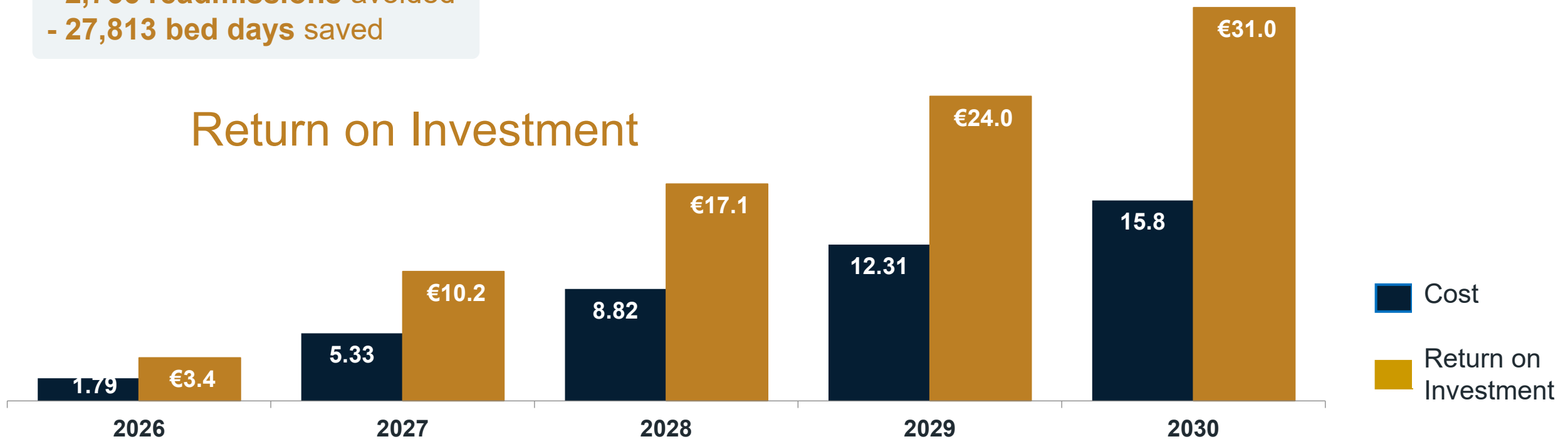


What completing the model costs

Returns over 5 years – Budget Impact and Return on Investment

+€ 15.5m net savings
- 5,080 admissions avoided
- 2,766 readmissions avoided
- 27,813 bed days saved

Return on Investment





What drives the return on investment?



Incremental ROI with 3 significant components

- Outreach Teams
 - strongest value;
 - increasing impact with increasing staffing from 0 to 2 WTEs
- GP access spirometry
 - access to diagnosis and ECC services
- Consultant leadership
 - Governance and pathway leadership

- COPD is a big driver of unscheduled care
- The ECC COPD model is clinically effective when appropriately resourced
- Finishing the model is good value for money (ROI 2:1)
 - Cost: €15.8m
 - Savings: €31m
 - Admissions prevented: 5,080
 - Bed days saved: 27,813

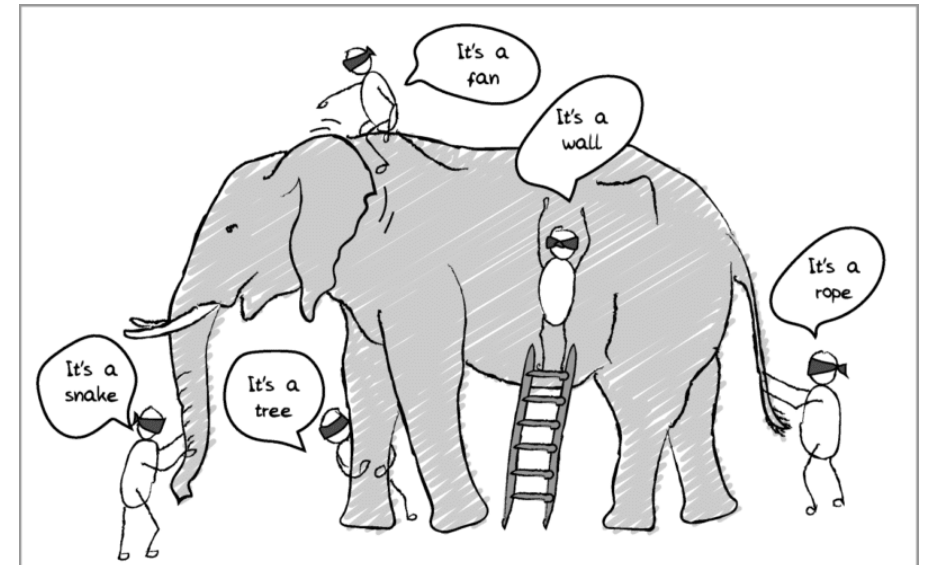


There's a lot more to do

National, Regional and Local picture

Nationally and Regionally

- Support full implementation of COPD MoC
 - fill the gaps
- Protect and uplift COPD outreach services
 - increase admission avoidance and ability to manage more COPD patients at home
- Increase access to diagnostics
 - can't access services. Can't manage appropriately
- Innovate
 - Explore novel ways of working
 - Incorporate digital solutions into clinical practice



Locally

- Break down barriers
 - Most successful sites are those with greatest collaboration across acute and community interface
- Patient-first approach

NCP Respiratory Team

Ms Susan Curtis Programme Manager
Dr Shane McKeogh

ICPCD Team

Dr Sarah O'Brien NCAGL
Mairead Gleeson Programme Manager

Acknowledgements

Respiratory CD-CSTs
Respiratory Acute Hospital Teams
ECC team
HIPE data office

Public Health Economics Network

Dr Geraldine McDarby
Dr Milton Valdez

[PHEconomicnetwork@hse.ie](mailto:PHEconomiconetwork@hse.ie)





The Impact of the One-Stop Shop Respiratory Clinic on Scheduled and Unscheduled Care in GUH

Prof. Sinead Walsh

Integrated Care Consultant Respiratory Physician, GUH & Galway City Hub

On behalf of Respiratory Team, Galway City Integrated Care Hub

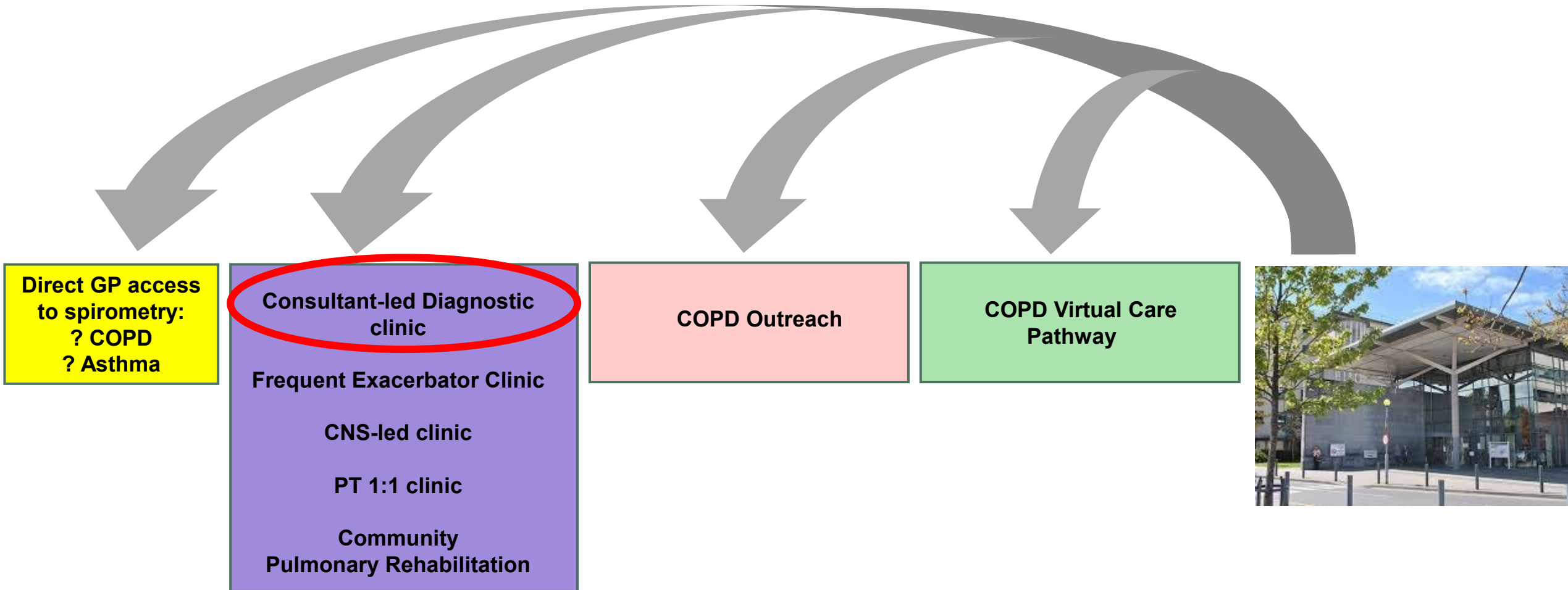


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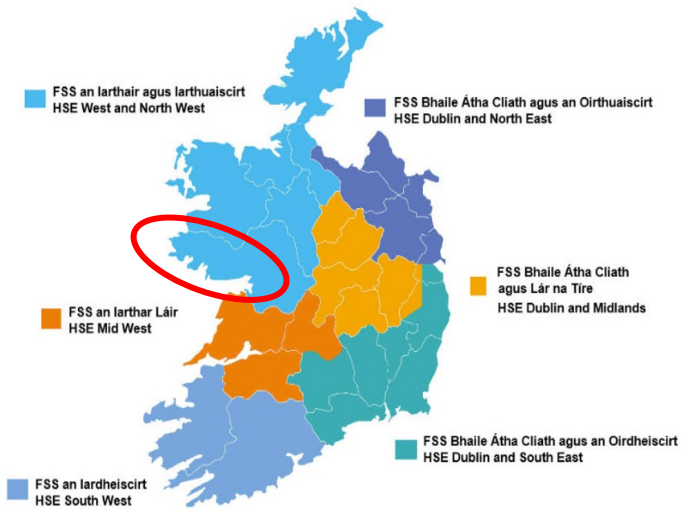
Respiratory Integrated Care Service Galway City Integrated Care Hub

Shifting Patient Care Left





Consultant-Led Diagnostic Clinic ('One Stop Shop')



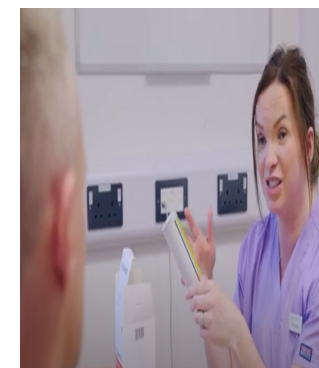
FOUR CLINICAL ENCOUNTERS AT THE ONE VISIT:



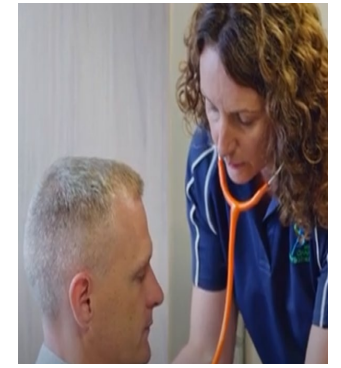
Diagnostic Spirometry



Consultant review



Respiratory CNS



Resp Physiotherapy

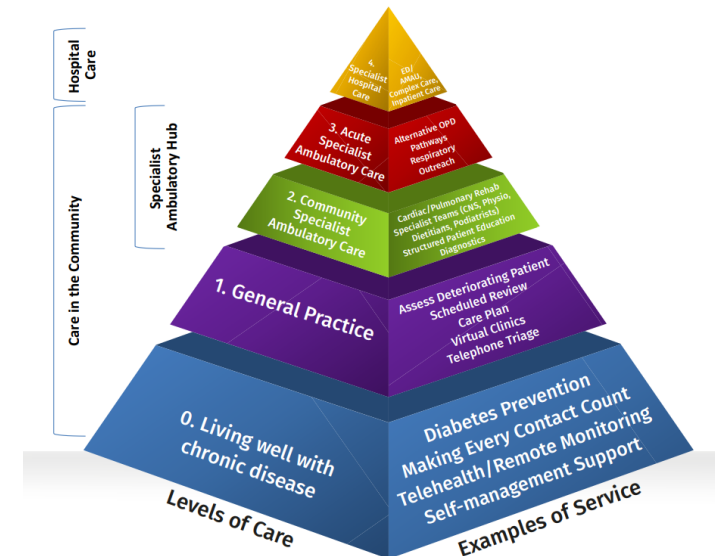


Clinic in operation: April 2023 – To Date

- **1200 new patients seen**
- **Referral sources:**
 - GP directly to hub (64%)
 - Redirected from hospital wait list (32%)
 - Other (ICPOP, ICPCD teams) (4%)
- **Average wait time:** 6 weeks
- **88% discharged medically** after one visit with CNS & PT follow up
- **12% further investigations (Acute Specialist Ambulatory Care)**
 - Discharged
 - Onwards referral to specialist services in hospital
 - Severe COPD clinic
 - Severe Asthma clinic
 - Bronchiectasis
 - Lung cancer service
 - ILD service
 - Sleep service



Diagnosis	% of patients
Asthma	45.2
COPD	22.6
Asthma-COPD overlap	10.5
Bronchiectasis	2.54
Lung cancer	0.4
Idiopathic pulmonary fibrosis	0.15
Alternative non-respiratory diagnosis (GORD, sinusitis, obesity, normal)	18.6





Service User Perspective: Your Voice Matters

- **WHAT WORKS WELL**

- 100% satisfied with wait time
- 99% rate experience as positive
- 98% report care received directly contributed to measurable benefits to health & lifestyle
- 96% describe convenient clinic location

- **AREAS FOR IMPROVEMENT**

- 6% requested clearer advance details about their appointment to reduce anxiety and information overload
- Appointment letters updated accordingly





Impact on Scheduled Care

General Respiratory Hospital Wait List



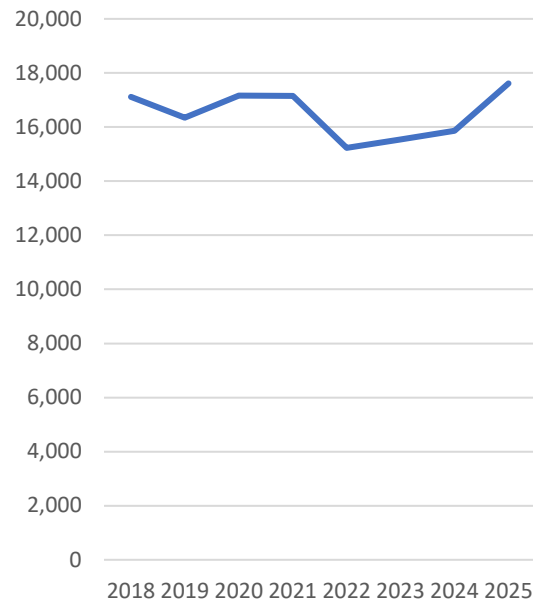
Wait-list	May 2022	August 2026
Total number waiting	1800	544
Number waiting over 18 months	600	0
Number waiting over 24 months	480	0



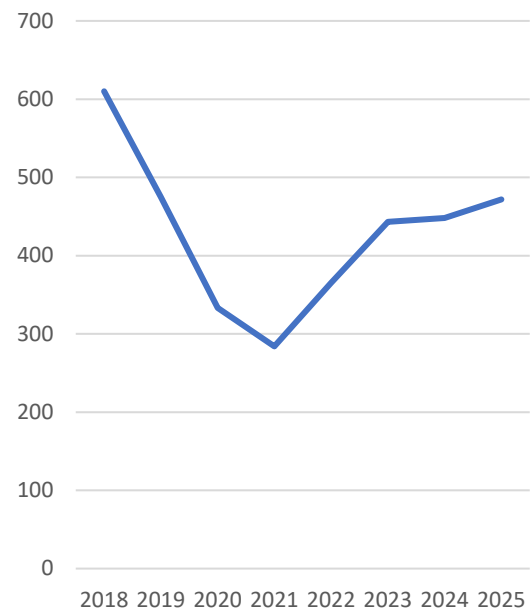
Impact on Unscheduled Care

COPD & Asthma HIPE Data for GUH 2018 - 2025

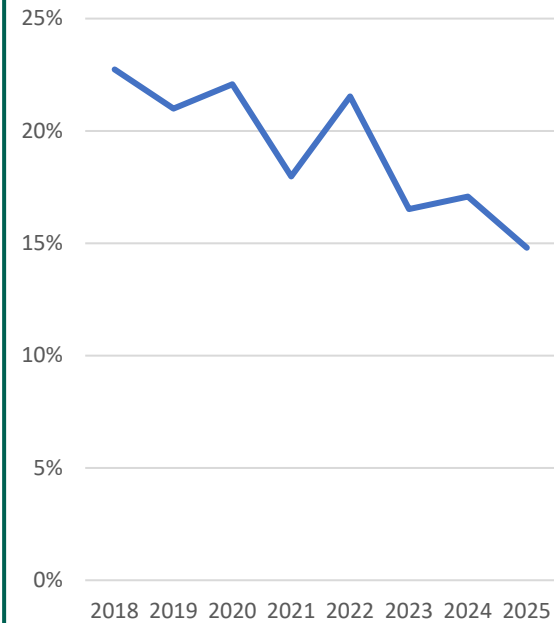
**Total inpatient discharges
GUH**



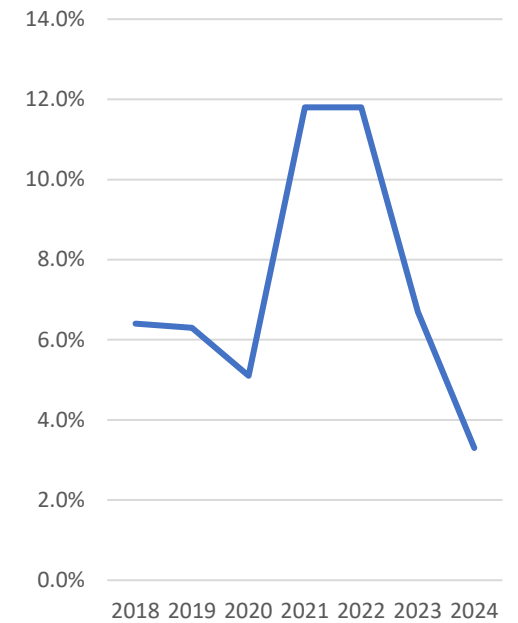
COPD Admissions



**COPD 90-Day Readmission
Rate (%)**



**Asthma 90-Day
Readmission Rate (%)**



ENABLERS

- Governance Structures
- Senior leadership
- People
- Working relationships
- Clinical space



WISH LIST!

- Community diagnostics
- Point of care testing
- Widespread implementation of complete model of integrated care
(Nearby hubs → further reduction in GUH OPD wait times)



FUTURE PLANS

- Homelessness clinic
- Other outreach clinics to support vulnerable groups





Hospital Admission Avoidance Through Delivery of Urgent Care for Deteriorating Heart Failure in the Ambulatory Care Setting

Prof. Ken Mc Donald

National Clinical Co-Lead for National Heart Office, Consultant Cardiologist



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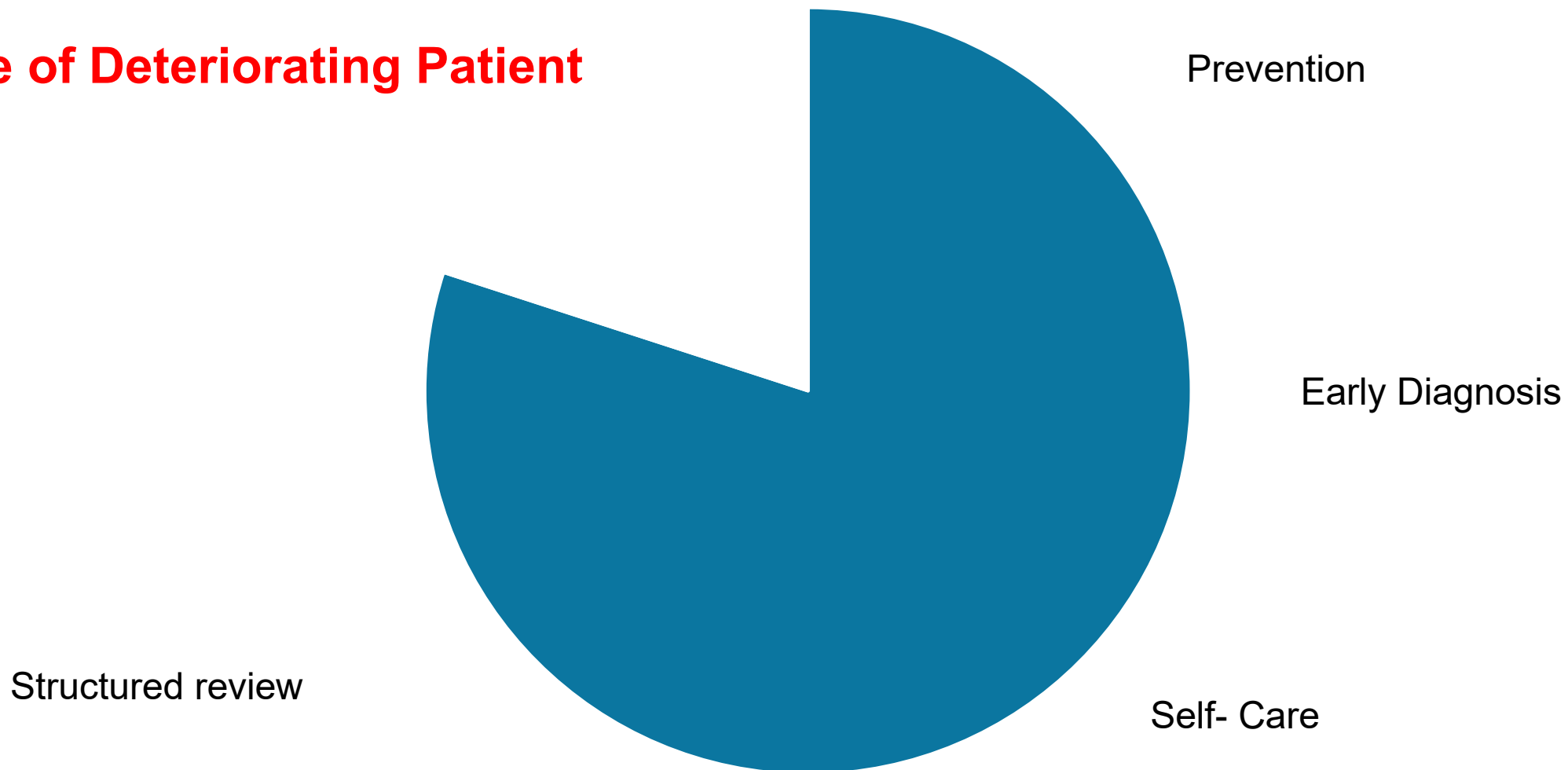


Urgent Care of Clinical Deterioration in the Community

Completing the Cycle of End-to-End Care of Chronic Disease



Urgent Care of Deteriorating Patient





Essential Features of a Condition suitable for Urgent Community Care



Common development	Needs to be commonly seen to establish familiarity with community approach
Early warning of deterioration	Deterioration needs to be characterised by early warning features that alerts patients and health care providers to need for intervention
Capacity to treat in community	Interventions need to be simple and not requiring of complex support systems
Service can be integrated	Service should be integrated into wider community care systems delivered by the same staff
Safe and cost effective	Proven to be effective in treating deterioration, avoiding ED and hospital admission and returning patient to routine community follow up



Deteriorating Heart Failure Fulfils these Criteria

A. Prevalent Problem

Greatest Cardiovascular
Consumer of Emergency Beds

~300 beds / yr occupied by HF

Most concerning trajectory of
Growth in bed need in CV medicine

B. Early warning signs are a feature.

~50% 3 day warning
~30% 7 day warning



Opportunity to intervene



Worsening Heart Failure Can be Effectively Treated in the Community



Setting

- Pilot Service SVUH
- Using HF Unit
- Experience over 3 yrs
- No direct GP referral
- Consultant-delivered

Effectiveness

- ~550 patients to date
- 75% admission prevented
- 3-4 opd visits/ per patient
- Intravenous Rx ~30-40%
- Linked virtual follow-up

Impact

- ~4,000 bed days saved
- Morbidity of hospital stay avoided

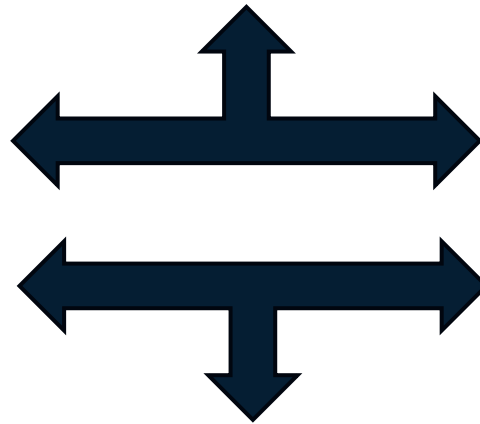


National Impact of Community Based Urgent Care for Heart Failure

Impact with 3 day warning

- ~5,000 appropriate
- ~3,750 admissions prevented
- ~37,000 bed days saved

Primary HF Admissions
~10,000 (conservative)



Impact with 7 day warning

- ~3,000 appropriate
- ~2,250 admissions prevented
- ~22,000 bed days saved

Benefits to Patient

- Avoid Exposure to sequelae of Hospital Admission
- Care continuum with Routine Team

~100 “new beds” in the system

~60 “new beds” in the system

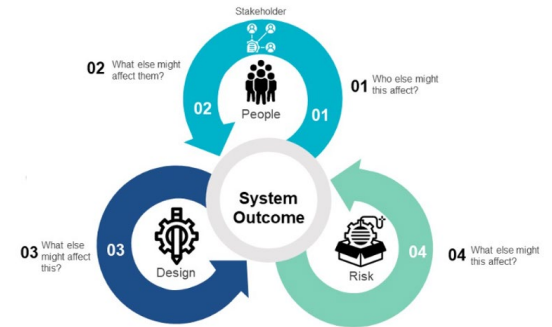


Whole System Outcomes and Integrated Care Programme for Older People (ICPOP)

Dr John Butler

Consultant Geriatrician

Sligo University Hospital and Sligo/Leitrim/West Cavan/South Donegal
Integrated Care Team for Older People



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SUH, ICPOP and Community Hospitals/Clinics

- **Sligo University Hospital:** 9000 >75yrs ED presentations, 30 per day and 10-15 admitted. **FFD Team and Frailty In-reach Service**
- **Community hospitals** in Sligo, Ballyshannon, Carrick-on-Shannon and Manorhamilton
- **Large geographical reach:** **90km** from Sligo base to Leitrim/Longford border and **70km** to Sligo- Mayo Border. Approx 7350 square kilometres
- **ICPOP Ambulatory Hub** Woodhaven, First Sea Rd, Sligo
- **Satellite** St Patricks Hospital, Carrick on Shannon, Co. Leitrim
- **ANP, CNS-Led Outreach Clinics** – Ballyshannon, Ballymote & Manorhamilton



L CHO 1. Health Service Executive



What are Whole System Outcomes that matter?

Stage	Acute-hospital contribution	ICPOP contribution	Shared desired outcome
Before crisis	Receives and advises on escalating risk where required.	Proactive frailty, falls, cognition, medicines and carer support; rapid community assessment.	Fewer preventable crises and appropriate use of ED.
ED/front door	Rapid diagnosis, early senior decision-making, frailty identification and CGA.	Direct access to community specialist assessment, rapid response, supported discharge or direct rehabilitation where safe.	The right person receives the right care in the right setting.
During admission	Treats acute illness; prevents delirium, immobility, deconditioning, medication harm and loss of function.	Maintains communication with community teams and carers; begins discharge planning early.	Recovery without avoidable functional decline.
At discharge	Safe, timely discharge with clear clinical plan, medicines reconciliation and escalation advice.	Home support, rehabilitation, case management and early review.	A stable transition home rather than a delayed or unsafe discharge.
After discharge	Receives people who genuinely need acute reassessment or treatment.	Monitors recovery, responds early to deterioration and adjusts supports.	More days alive and well at home; fewer avoidable readmissions.



Improving Whole System Outcomes

- Shift from Measuring activity to Outcome measurement
- Targeting intensity
- Making Integration Operational
- Addressing Constraints outside ICPOP
- Embed **4Ms assessment**



SUH Frailty Front Door Outcomes 2025



High-volume, self-referral–driven service:

In 2025, FFD at SUH assessed 828 frail older adults. 74% (613) arriving via emergency self-referral, 24% (198) from GPs, and 3% (26) from nursing homes

Strong direct discharge performance: 45% (373 patients) were discharged directly from ED, all supported by Primary Care and/or ICTOP to enable safe community management.

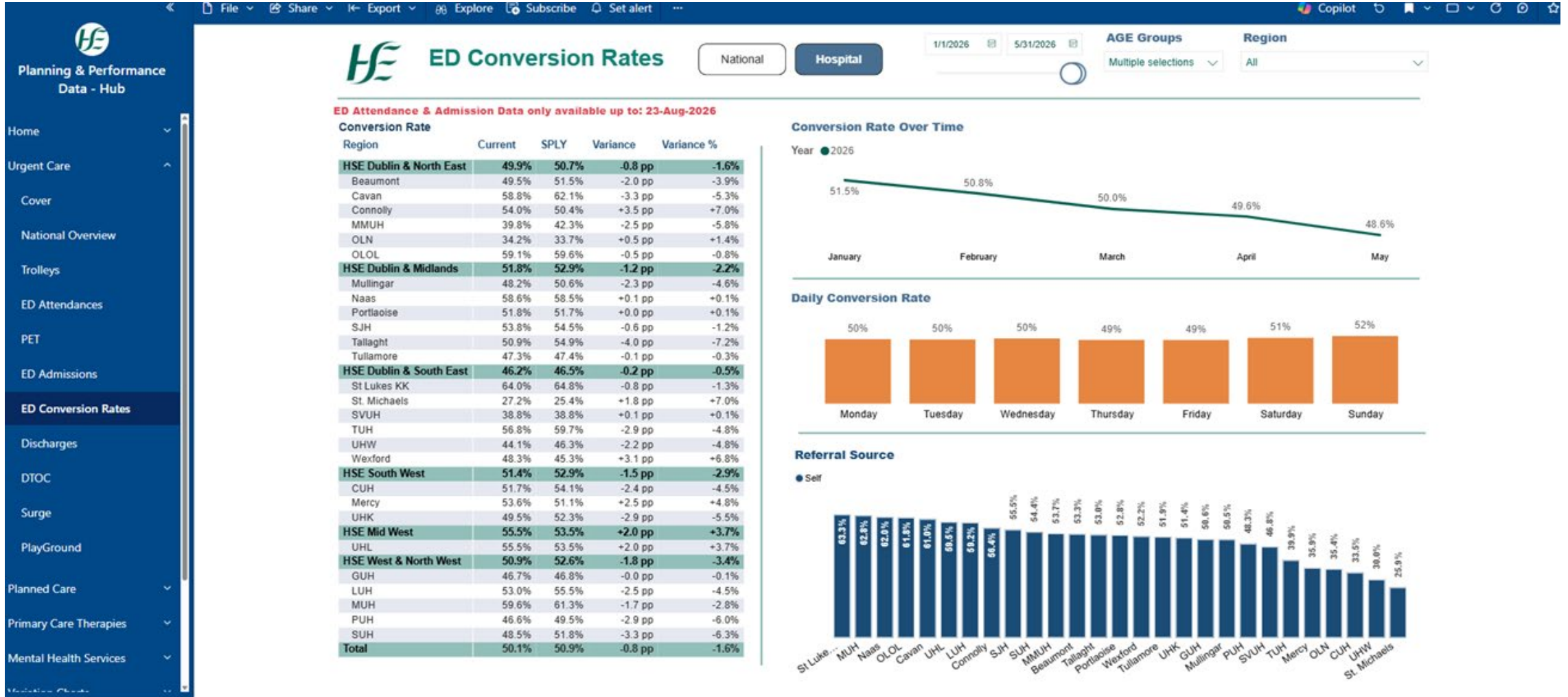
Low 30-day re-admission rate: With FFD input, the annual 30-day re-admission rate was just 2.8% (23 re-admissions). No significant month-to-month variation.

Reduced LOS for admitted patients: Average length of stay was 8.6 days, reflecting streamlined inpatient care following CGA and coordinated discharge planning.

Substantial cost avoidance: Using a conservative bed-day cost of €813, the FFD model avoided an estimated €2,607,941 in acute hospital admission costs in 2025.



ED Conversion Rates





Consultant Post-Take ward Round and WSO

PTWR Medical Consultant Review	
Date:	Time:
Consultant:	
Addressograph	
History and Examination Findings	
Review of Completed Investigations	
Differential Diagnosis	

PTWR Medical Consultant Review		
Highlighted areas must be completed		
Addressograph		
Management Plan	Acute Admission to SUH Clinically Indicated: Yes ☐ No ☐	
	VTE Prophylaxis indicated according to renal function and weight: Yes ☐ No ☐	
Discussion with Patient ☐ And Family ☐	(include ceiling of treatment decisions and establish if any advanced care plans are in place)	
Ceilings of Treatment	CPR Yes ☐ No ☐ DNAR form Completed Yes ☐ No ☐ ICU Yes ☐ No ☐	
Preferred Ward for Continuity of Care		
Acute Medicine/Short Stay Unit	Geriatric Medicine/Med 7	Stroke/Med 7
Diabetes and Endocrine/Med 5	Infectious Diseases/Med North	Neurology/Med 5
Respiratory/Med South	Renal/Med 5	Gastroenterology/Med North
Frailty Intervention Team/SSU	Suitable for transfer to Off-site bed Yes ☐ No ☐	
Criteria for Discharge		PDD
Completed By:		Bleep/Phone
Consultant Signature		



ICPOP Sligo / Leitrim / South Donegal / West Cavan Activity

Overview of Referrals



CHN	Population
Sligo South Donegal	81,114
Leitrim and West Cavan	33,345
Total Population	114,459

2025 ICPOP Referral Source by Month *Provided by local team

Source		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
GPs		34	41	43	47	37	32	45	29	52	39	38	38	475
CHN / Primary Care Team		5	1	5	6	5	1	8	6	4	5	4	4	55
NAS		-	-	-	-	-	-	-	-	-	-	-	-	0
(Early) Discharge Management	Frailty at Front Door	1	4	4	7	11	9	6	12	8	19	8	8	97
	ED	16	1	7	9	4	5	9	6	2	1	6	6	72
	Acute Impatient	31	21	14	15	11	19	9	13	17	12	15	15	71
Geriatric Medicine OPD		15	10	15	18	11	7	7	7	11	13	11	11	193
Other Sources		9	13	8	4	21	16	12	12	8	16	11	11	137
Grand Total		111	91	96	106	100	90	96	85	102	105	93	93	1168

- 18% of new referrals seen same day or next day of referral
- 55% of new referrals seen within 2 weeks of referral
- 26% of new referrals seen more than 2 weeks after referral

49

Associated IHA	SUH 2024 Conversion Rate	NH – Hospital Conveyance Rates	Projected Number of Referrals Accepted to ICPOP 2025	CGAs completed as a % of referrals accepted	Referrals discharged Home with Community Services	Number of Patient contacts for 2025
 F2 Sligo Leitrim W Cavan S Donegal	 52.0%	 287				



WSO - Functional and User Satisfaction



"WE COULDN'T HAVE DONE IT WITHOUT YOU", A SERVICE-USER'S PERSPECTIVE

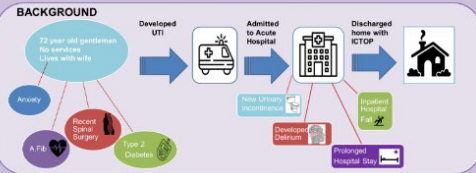
Laura Maguire, Dara Dardis, Maria Armstrong
Sligo Leitrim ICTOP. Email: laura.maguire2@hse.ie



INTRODUCTION

Key principles in the Enhanced Community Care Programme are supporting the transition from hospital to home and supporting care management at a local level (HSE, 2023). The following is a case study of a service-user who was referred to the Integrated care team of the older person (ICTOP) service. The purpose of this referral was to aid his transition from the acute setting to home by helping to address his resulting delirium and underlying cognitive concerns, mobility issues, incontinence & safety concerns. ICTOP supported both service-user and his family during this transition, while managing his medical and functional issues at home, preventing hospital readmission. On initial assessment a comprehensive geriatric assessment (CGA) was completed. It was identified he would require input from the following team members Clinical Nurse Specialist, Physiotherapist, Occupational Therapist and Therapy assistant under the clinical governance of the consultant geriatrician.

BACKGROUND



AIMS AND OBJECTIVES

- To provide patient-centred care in the patient's own home
- To promote independence and improve patient outcome measures
- To provide education to service-user and his wife so they can take an active role in managing their own health
- To prevent hospital re-admission

ICTOP INTERVENTIONS

- Education of service-user & wife about delirium recognition and management, medication management
- Sign-posting: Appointment co-ordination between GP, PHN, urologist and geriatrician
- ADL Rehab: strategies of personal care and domestic tasks
- Cognition: MCA 2000. Cognitive health strategies & Cognitive-Communication programme completed.
- Falls Prevention: Supported in organising grab rails and pendant alarm
- Mobility: Strength and balance exercise programme. New 4 wheel rickshaw provided

→ avoided another admission thanks to early UTI treatment with gentamicin

→ Integration of care and shared purpose, enhanced healthcare navigation

→ Increase patient's independence and thus reduced his wife's carer burn-out

→ Increased independent use of cognitive compensatory strategies and increased cognitive stimulation within routine.

→ reducing risk of and mitigating adverse outcomes from future falls

→ Improved Timed up and Go (TUG). Significant reduction in Fear of Falling.

SERVICE-USER QUOTES

"Only for you, I would definitely have ended up back in hospital"

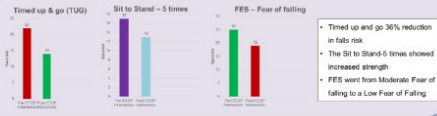
"We'll miss go when you're finished"

"We felt really supported, it's an amazing service"

"I don't know what I would have done without you"

OUTCOMES

- This service-user made significant functional gains. This resulted in a reduction in carer burden
- Pre-ICTOP input, service-user had 3 hospital admissions in the preceding 7 months. 12 months post-input he has had no hospital admissions or ED presentations.
- Clinical Frailty Scale (CFS) scoring improved from a 6 (Moderately Frail) to a 5 (Mildly Frail)
- The following results demonstrates improvements in overall function, mobility, strength and fear of falling.



- Timed up and go 36% reduction in falls risk
- The Sit to Stand 5 times showed increased strength
- FES user from Moderate Fear of falling to a Low Fear of Falling

CONCLUSION

The measurable outcomes and the service user's own words demonstrates first hand his perspective on how ICTOP's input supported him and his family. Provision of a holistic and integrated service within the patient's own home enabled him and his family to improve his health and his wellbeing where he most wanted to be "at home".

Reference: HSE(2023) Enhanced Community Care Available at: <http://www.hse.ie/eng/health/23171/2023>



Development of hybrid model of care for ICTOP service users in Sligo region. Maria Armstrong, Senior C&ST Physiotherapist

Introduction

The National Clinical Programme for Older Persons aims to promote high quality holistic care, with a shared ethos of Steintecare and Community First Approach, by offering a hybrid model of domiciliary or clinic based appointments based on patient needs. By offering a hybrid model that places patients at the centre of care, we aim to provide a one stop shop for our older patients, while reducing travel costs and reducing Emergency Department attendances.

Methodology

Data was collected from October 2024 to March 2025 from 20 patients on:
1) Referral demographic trends
2) (a) Service-user outcomes

(b) Travel and cost savings (c) Admission Avoidance



(a) Service-user outcomes



b) Travel and cost savings

20 service users = 336km in travel per clinician was saved.
Using travel rates of .51cents that represents a financial saving in travel costs of **€273.36** per clinician over 6 months.
Average clinic visit requiring 3 clinicians per patient this resulted in a overall saving of **€820**.

c) Admission Avoidance

A 3 month retrospective analysis was carried out.
85% of cases post clinic intervention, no Emergency Department attendances or Acute admissions occurred.





Comprehensive Geriatric Assessment (CGA):

Activity and Impact

CGA Activity

ICPOP Nursing Home Activity

<u>Year</u>	<u>Total CGAs</u>	<u>Main referral reasons</u>
2024	149	62% post-ED/SUH attendance with fall in function; 20% NHSS Fair Deal support; 18% cognitive decline, BPSD or ongoing delirium follow-up
2025	163	50% post-ED/SUH attendance with fall in function; 22% NHSS Fair Deal support; 28% cognitive decline, BPSD or follow-up needs
2026	108	43% post-ED/SUH attendance with fall in function; 31% NHSS Fair Deal support; 13% post-discharge follow-up; 13% medication refusal, cognitive decline, BPSD, swallowing or social-work issues



Key NH Outcomes following ED presentation

- Medication review, identification of fall-risk-increasing drugs, deprescribing and bone-protection review.
- Identification and management of previously undiagnosed orthostatic hypotension.
- Early recognition of cognitive impairment and its implications for care needs.
- Referral to Occupational Therapy, Physiotherapy, Speech and Language Therapy, Social Work and Dietetics.
- Management of BPSD, including liaison with the POA team and antipsychotic medication review.
- Identification of advanced frailty and referral to Specialist Palliative Care.
- Geriatrician support for staff caring for older people with ongoing delirium.
- ED and Geriatrician CME Meetings with Primary Care Colleagues

The Good - Attend Anywhere


LEADING OUT ON VIRTUAL CARE IN THE COMMUNITY FOR INTEGRATED CARE OF THE OLDER PERSONS SLIGO LEITRIM SOUTH DONEGAL & WEST CAVAN ICPOP

Irene McPartlin, Clinical Nurse Specialist Sligo South Donegal Leitrim West Cavan Integrated Care of the Older Persons ICPOP, Maggie Moran, Therapy Assistant Sligo South Donegal Leitrim West Cavan Integrated Care of the Older Persons ICPOP, Edel Brennan, Clinical Coordinator for Falls and Bone Health Sligo Leitrim Donegal

BACKGROUND

Establish a virtual domiciliary service using Attend Anywhere, delivered by a Clinical Nurse Specialist and a Therapy Assistant from the Sligo South Donegal Leitrim and West Cavan, Integrated Care Team for Older Persons, to improve access for patients in rural areas, enable older persons to remain in the comfort of their own homes, enhance care delivery within the home setting, support timely clinical reviews, and improve service capacity and efficiency.

OBJECTIVE

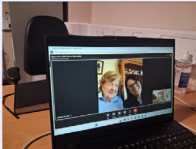
To develop virtual services to support the current focus for Sligo ICPOP which includes ED/general admission avoidance. The catchment area includes remote rural locations which require significant travel from ICPOP multidisciplinary team

METHODOLOGY

Telehealth enables the CNS to dial in virtually to patient domiciliary visits, facilitated by the Therapy Assistant using Attend Anywhere. The Therapy Assistant carries a tablet, enabling CNS access from the outreach clinic to review patients during scheduled or crisis care visits while the TA delivers home-based programmes and records vital signs.

Key Stages of the Falls Prevention Project

Results
Virtual Clinic Outcomes
29 patients assessed virtually across: Sligo | South Donegal | Leitrim | West Cavan



CONCLUSION

Attend Anywhere enables older people with complex medical histories to receive appropriate care at home. It highlights key opportunities to expand virtual care within Integrated Care Team for Older Persons, including nursing home support and crisis care with community partners, improving integrated and coordinated care delivery across service

Key Benefits of Telehealth

- Saves clinical time
- Reduced travel for patients and staff
- Faster access to specialist care
- Improved clinician safety
- Strengthened clinical governance
- Hospital avoidance



Integrated Healthcare: Empowering People through Transforming Care

Not so Good - Remote Monitoring

RIGHT IDEA, WRONG FIT
 Lessons from a Virtual Frailty Monitoring Pilot in the Community
 Ciara Moran, Dr John Butler
 Advanced Nurse Practitioner, Frailty ICPOP, Sligo Leitrim and West Cavan South Donegal, Consultant Geriatrician Sligo University Hospital
 Irish Geriatrics Society Annual & Scientific Meeting 2026

THE PILOT IN ONE LINE
 18 patients identified → 0 active platform users
 No clinical-effectiveness outcomes could be measured; the key finding was one of feasibility and implementation

BACKGROUND	METHODS	RESULTS
Remote monitoring is increasingly promoted to support ageing populations, reduce hospital use and enable care closer to home. Within frailty pathways, digital platforms may support symptom tracking, vital sign monitoring and earlier recognition of deterioration. However, evidence for technology-enabled virtual needs to treat older adults remains less established than for clinician-led hospital or home models.	• Success evaluation of an initial remote-monitoring pilot from March 2025. • Community-dwelling and nursing-home patients with frailty were considered. • Digital platform intended for vital signs, symptom tracking and record keeping. • Evaluation focused on patient identification, platform utilisation and implementation outcomes.	18 suitable patients identified 0 actively engaged Therefore, admission avoidance, early intervention and other clinical outcomes could not be meaningfully assessed during the evaluation period.

WHY DID A PLAUSIBLE DIGITAL INTERVENTION FAIL BEFORE EFFECTIVENESS COULD BE TESTED?
 Implementation review identified barriers at patient, technology and system levels.

PATIENT	TECHNOLOGY / MODEL	SYSTEM / WORKFLOW
• Limited digital literacy • High prevalence of cognitive impairment • Functional limitations affecting independent use • Frailty created barriers, changing support needs	• Platform demands exceeded capability for many patients • Vital signs / symptom capture did not reflect the full complexity of frailty • Limited flexibility for dynamic, multidimensional care • Technology was not a substitute for clinical assessment	• Community and acute workflows were difficult to integrate • Clinicians preferred telephone or face-to-face contact for many patients • New monitoring processes created additional work • The model did not align easily with existing care pathways

KEY INTERPRETATION
 The problem was not simply "patient engagement".
 The selected remote-monitoring model was a poor fit for the cognitive, functional and clinical realities of this frailty cohort.
 Zero uptake is therefore an implementation finding: feasibility should be established before clinical effectiveness is expected.

HOW THIS ALIGNED WITH THE EVALUATION:

- Evidence for hospital or home or older people is stronger than the evidence base for virtual visits.
- Clinical virtual visits appear to require in-person selection, multidisciplinary working, communication and care co-ordination.
- Remote qualification evidence requires the uptake of remote monitoring to study pathway and questions is suitability for many patients.
- Digital inclusion and/or non-digital readiness needs separate considerations in older populations.

IMPLICATIONS FOR PRACTICE:

TECHNOLOGY-FIRST ✗

PERSON-CENTRED HYBRID MODEL ✓

- Direct clinician contact when needed
- Selective remote monitoring, not universal monitoring
- Care-supported technology where appropriate
- Integrated hospital or home / acute-community pathways

CONCLUSION
 Remote monitoring should support a frailty pathway - not define it.
 Future models should begin with patient capability, clinical need and workflow, then select technology that fits.

TAKE-HOME MESSAGE
 Design the care model first.
 Choose the technology second.



Integrated Care Future Development: Opportunities and Challenges 2026-2028



- ICPOP Case-mix evolution
- CGA/InterRai to meet Health and wider Social care needs.
- Two Tier approach....follow the evidence base.
- Admission Avoidance and the Pyramid of Need. Community Paramedics
- Using Technology to enhance service.
- Virtual Care vs Virtual Ward vs Hospital @ Home
- What do we do differently.... or not at all?
- Audit, QIP, EBM and Research



Happy Team Happy Outcomes





The Chronic Disease Management Programme in General Practice: Impacts of a Scaled up National Programme

Dr Orlaith O'Reilly

Chronic Disease Management Programme in General Practice



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Imeacht Gaolmhar | Associated Event



CDM Programme

3 Sub-Programmes

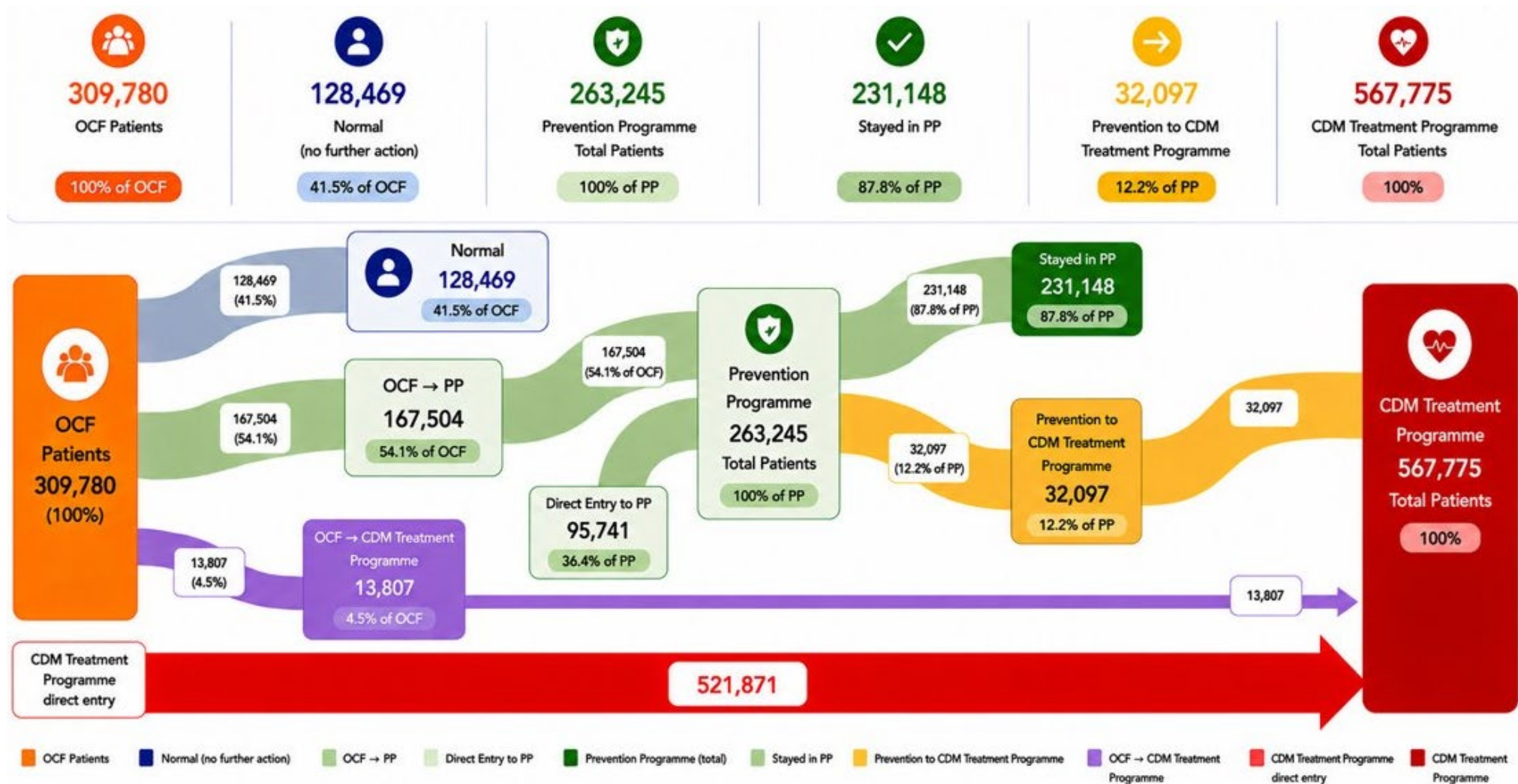


- Treatment Programme from 2020, current conditions;
IHD, Heart-Failure, TIA, CVA, Diabetes T2, A.Fib, COPD, Asthma.
- Prevention Programme from 2022, current conditions;
 - Hypertension
 - Pre-diabetes
 - GDM
 - Pre-eclampsia
 - Q-Risk $\geq 20\%$
 - Elevated BNP.
- Opportunistic Case Finding Programme from 2022.



HSE Chronic Disease Management Programme

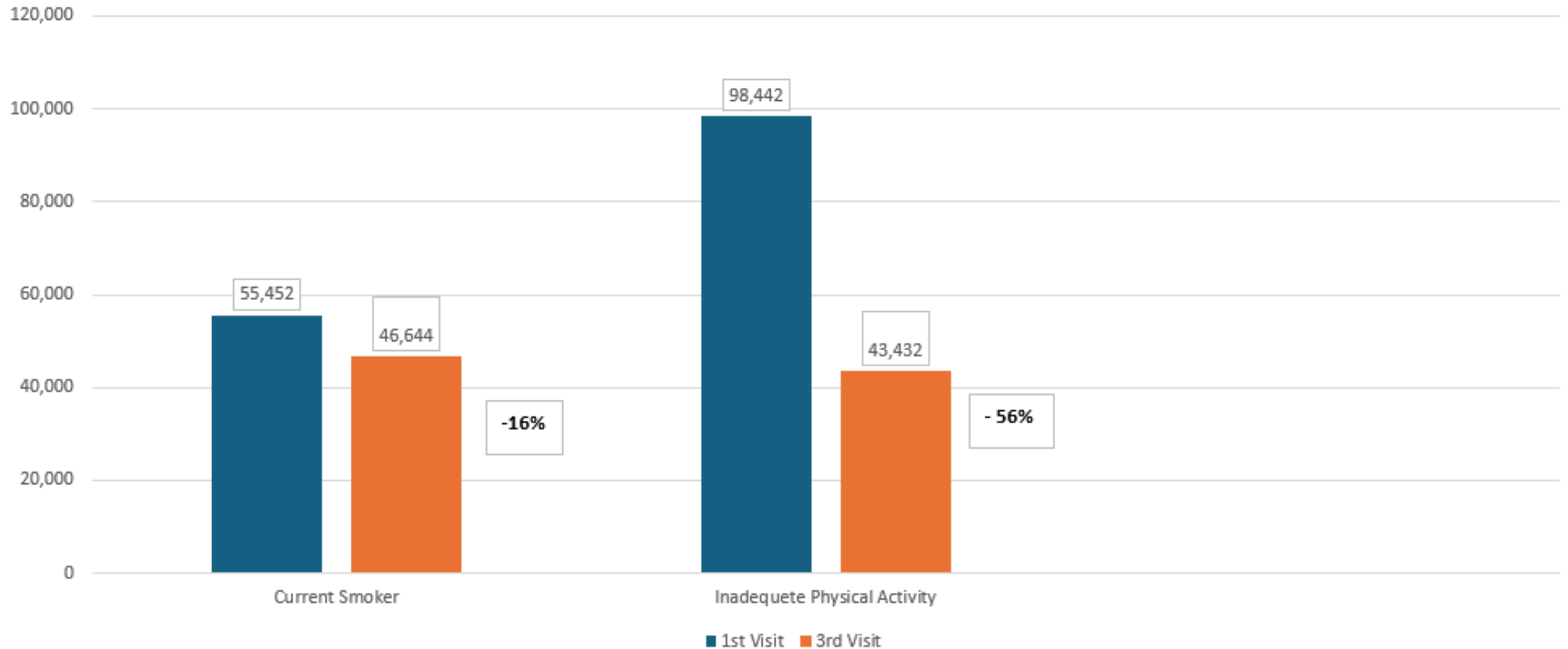
From inception to 31st March 2026





Chronic Disease Management Programme

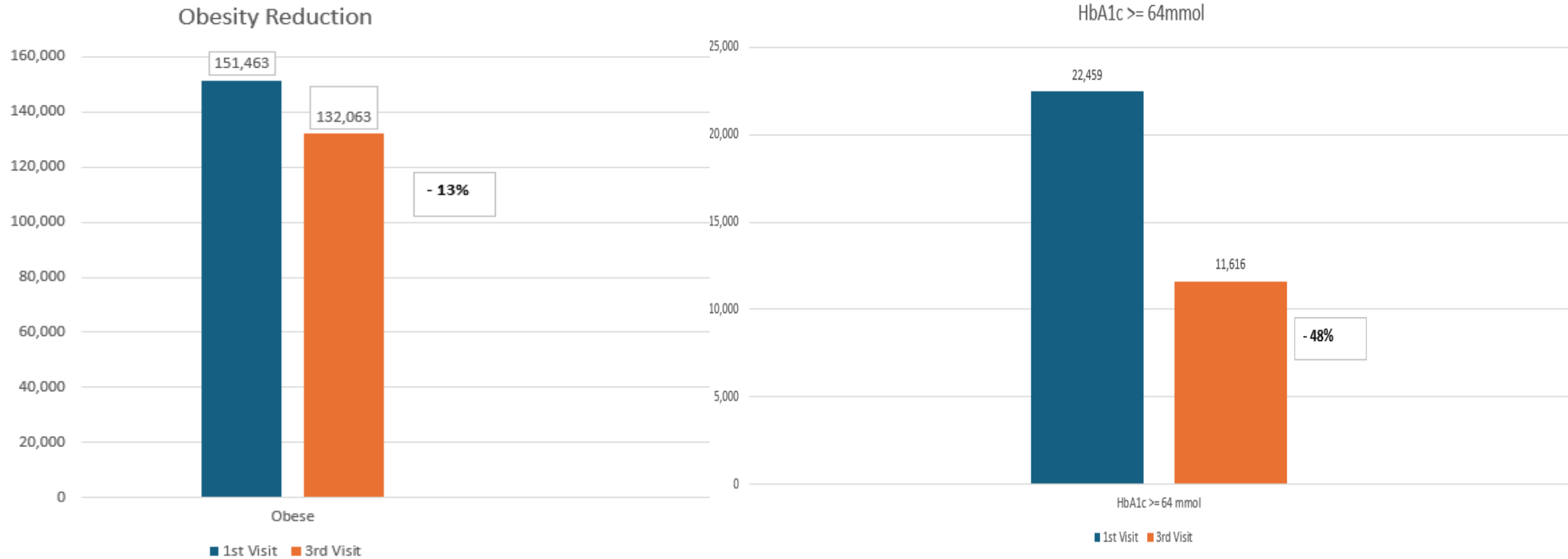
Life Style Outcomes





Chronic Disease Management

Obesity Reduction & HbA1c ≥ 64 mmol

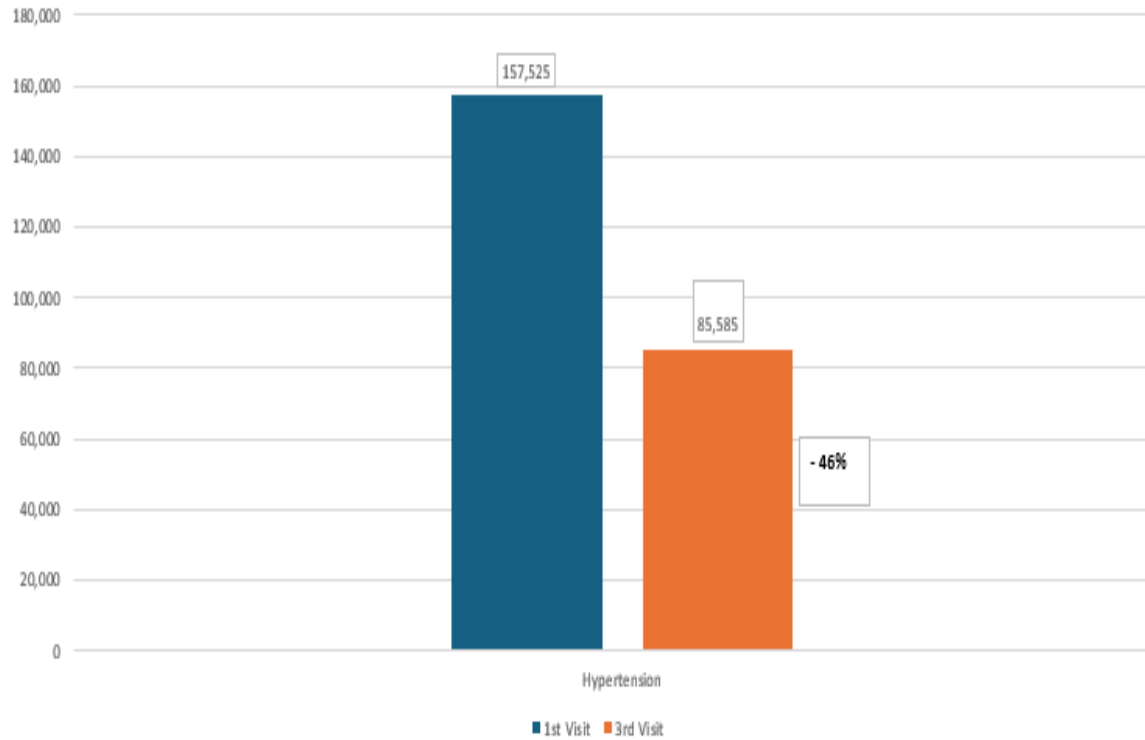




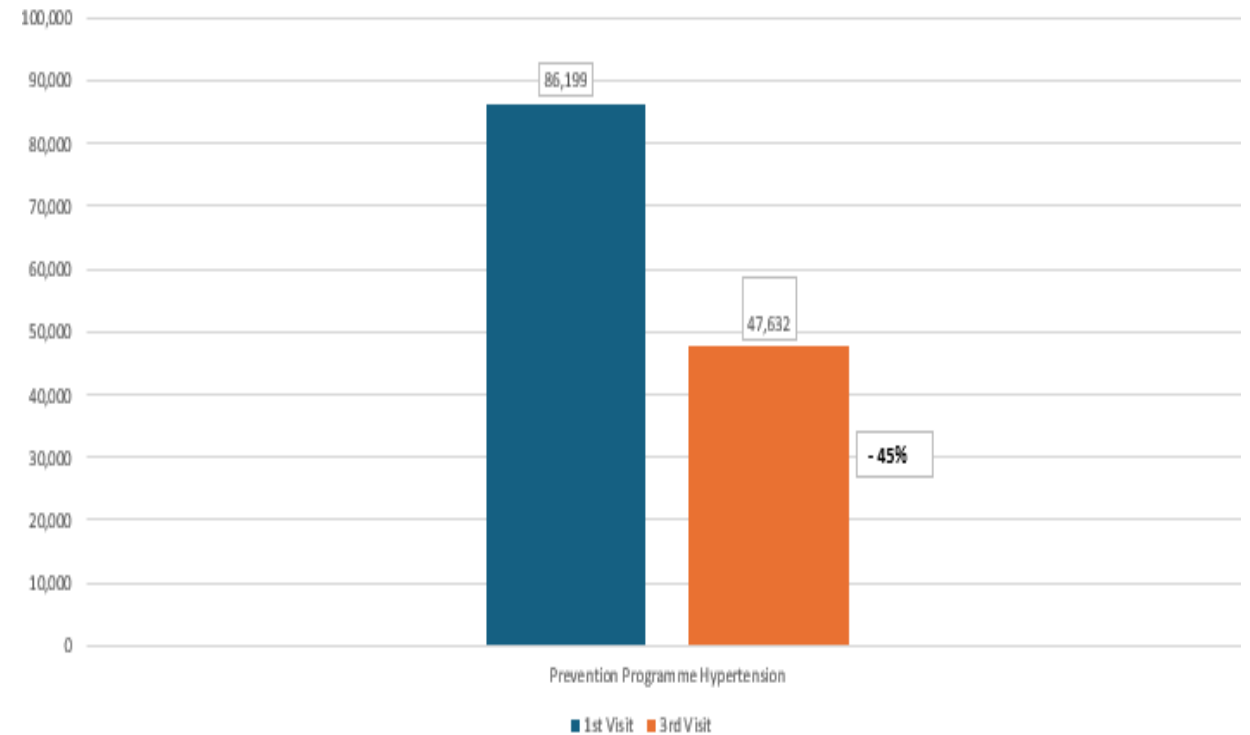
Chronic Disease Management

Hypertension

Hypertension Treatment Programme



Prevention Programme Hypertension Reduction

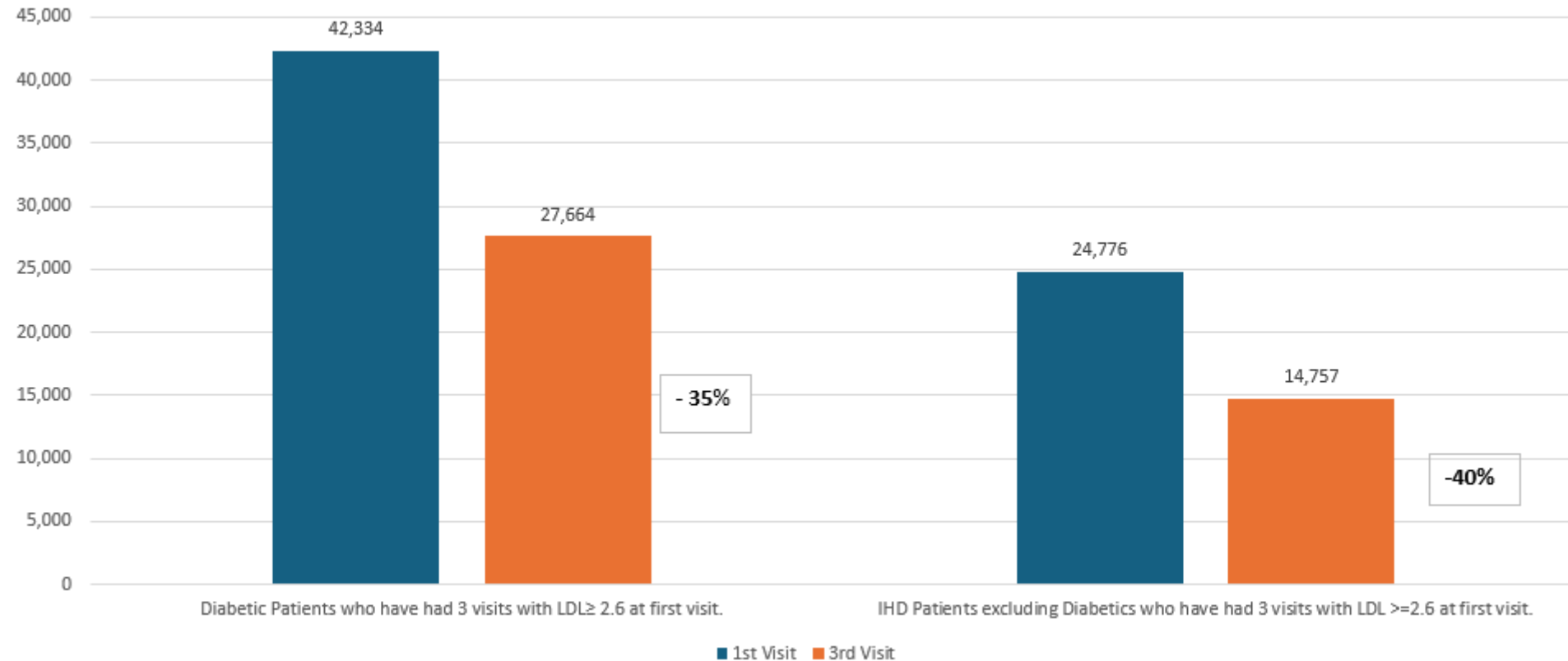


31% had reduced BP by ≥ 10 mmHg after 3 visits



Chronic Disease Management

Changes in LDL Cholesterol





Chronic Disease Management

LDL-C falls progressively with longer programme exposure

Patients with Diabetes and no prior CVD

2.48 → 2.02

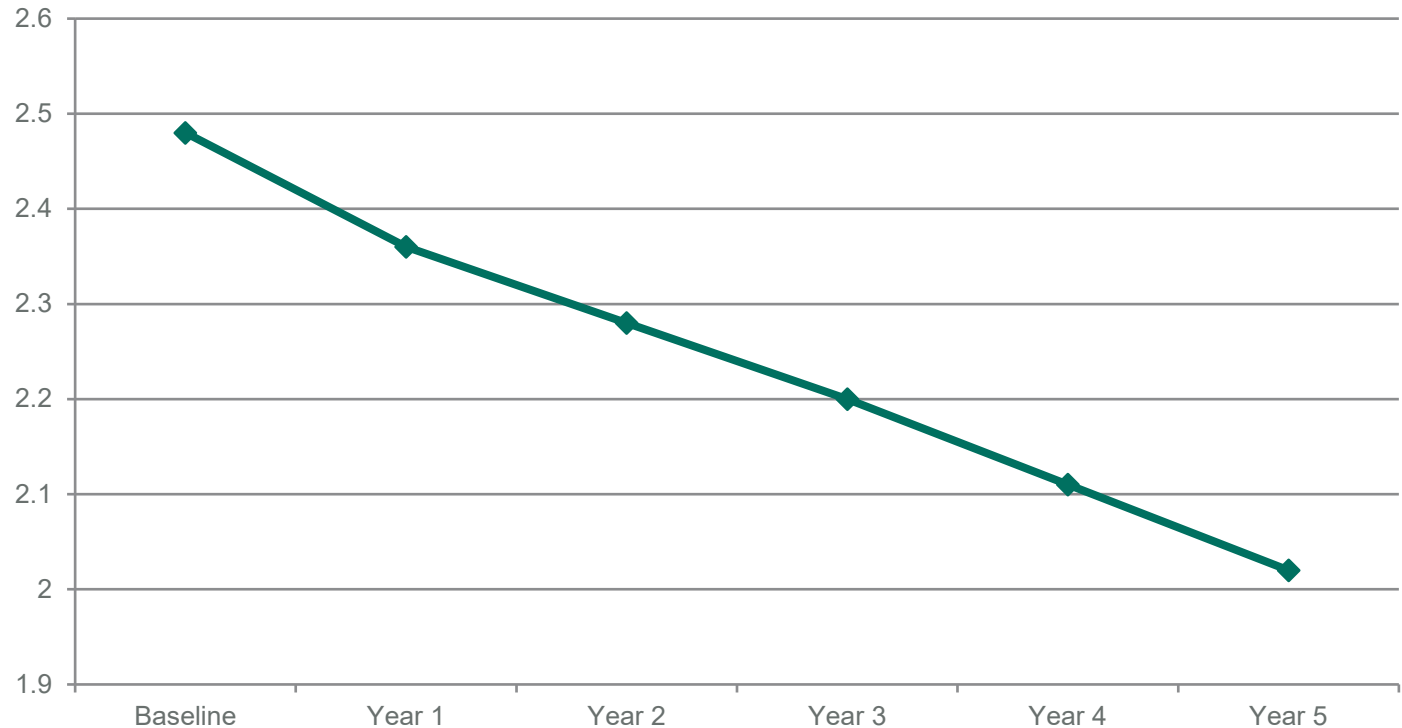
mmol/L mean LDL-C

-0.46 mmol/L | -18.6% over 5 years

Baseline: 147,830 patients

Year 5: 19,622 patients

Impact = 86 fewer MI/CVA events per year – (approx. 1200 BDU).



Consistent direction

Every additional year shows a lower mean LDL-C.



COPD is a leading cause of morbidity and mortality

Unscheduled Care 2019 Vs 2023 ICGP Audit

- ED attendance 30% reduction.
- Admission 26% reduction.
- GP OOH 33% reduction.

GMS Vs Non-GMS 2019 Vs 2024 Audit

• BP Monitoring	99%	79%
BMI Monitoring	98%	58%
Diabetic Foot Exam	90%	21%
• BP Reduction	3.5 mmHg	0.9 mmHg
% achieving LDL Target	86%	74%
• GP Unscheduled Care	↓ 18%	↑ 44%



The GP and the Patient at the heart of CDM

Dr Suzanne Kelly
GP, Ballincollig

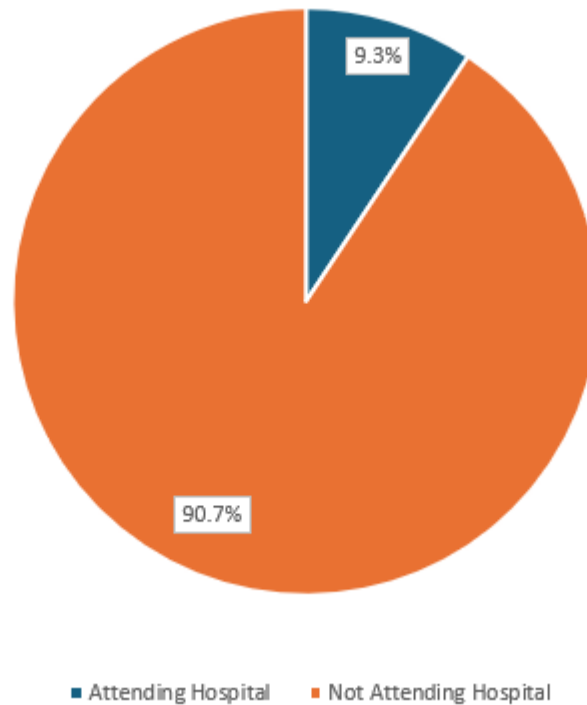


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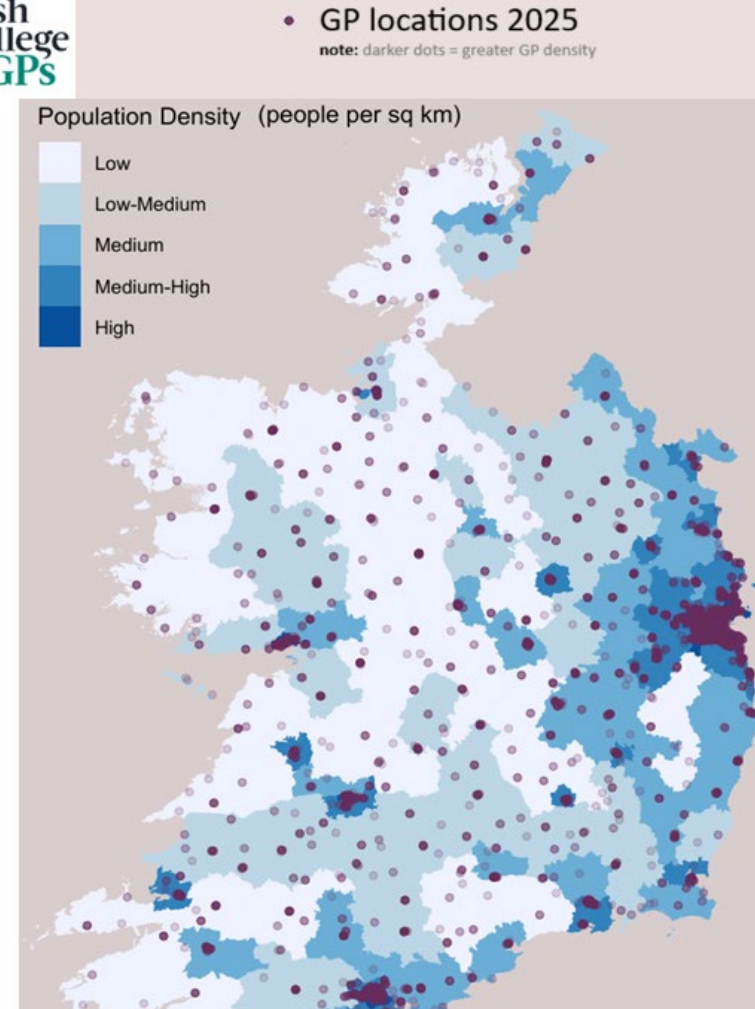
HSE The programme is scaled

- 4900 GPs
- 97% signed up to provide

91% of chronic disease care provided exclusively in General Practice



Irish College of GPs





CDM implemented at lightning speed



CDM reimbursement claims from PCRS Open Data 2026

	2023	2024	2025
CDM reviews	561,402	648,855	655,741
preventative program	71,801	161,445	189,971
opportunistic case finding	126,132	73,593	52,050
total	759,335	883,893	897,762
cost to HSE	€78m	€92m	€94m

- Since its launch in 2020, CDM has been enthusiastically adopted by GP teams
- Approx 900k comprehensive reviews are now being completed by GP teams nationally each year via the CDM programme.
- Each review involves a patient (+/- their carers), phlebotomy, results management, recall, review, clinical measurement, coding, monitoring and data submission.
- Based on recent PCRS open data, CDM/Prevention/Opportunistic Case Finding payments were approximately €78m in 2023, €92m in 2024 and €94m in 2025. This is less than 0.4% of a health budget of €25b+
- As a proportion of overall HSE funding going to general practice, CDM comprises <10% of our overall funding... This additional resourcing (for additional work) should not be conflated with general investment in practice viability or infrastructure.
- Table above shows that rate of increase in new CDM reviews is slowing down, preventative program reviews are continuing to grow as patients develop chronic disease, while GP teams are running out of patients to complete OCFs on (unsurprising as this element of CDM is allowed once every five years).



Successful so far

First study of its kind

CDM Patient and Provider views study published in BMC Family practice

- <https://link.springer.com/article/10.1186/s12875-026-03497-x>

Results

- In total, 110 patient and 217 provider responses were analysed. Overall, 97% of patients reported a positive impression, with benefits in self-management and understanding of their condition. Among providers, 93% of GPs and 81% of nurses reported a positive impression, with particular improved quality in type 2 diabetes management. Key barriers included staffing shortages, workload pressures, and IT challenges.

Conclusions

- Among respondents, the CDM programme was highly valued and perceived to improve chronic disease care and patient self-management. Addressing capacity and system constraints will be important for long-term sustainability.



Patient care journey: hospital outpatients vs. GP-led CDM reviews

Same three conditions - diabetes, COPD and atrial fibrillation - managed closer to home

BEFORE - Hospital outpatients

- 5 outpatient visits a year (2 COPD, 2 diabetes, 1 AF)
- 2 hours travelling + 3 hours in clinic per visit
- About 25 hours a year spent on appointments
- Parking at €3/hour - €45 a year
- Daughter drove to all 5 visits, taking 5 days off work
- Vaccines arranged separately

NOW - GP practice under CDM

- 2 GP visits a year covering all three conditions
- Minutes from home - no long journey
- About 2 hours a year spent on appointments
- Parking at the practice is free - €0
- Daughter attends 2 visits, taking 2 days off work
- Flu and pneumococcal vaccines given at the practice



3 fewer
trips to hospital

~23 hours
given back each year

€45
saved on parking

3 days
of leave saved for his daughter



The relationship is the intervention

- Patients know their GP and practice team
- We know our patients
- Trust develops over time
- Care is personalised because it is based on context, not just a diagnosis



- As of early 2026, over **1.1 million individuals** living with chronic disease had enrolled in the CDM programme
 - **Better clinical outcomes:** GMS patients are achieving outcomes comparable to—or in some areas better than—private patients
 - **Care closer to home:** reductions in acute hospital & OOH use
 - **Better patient experience** – trust & care continuity
- **Extend to full population**





Panel Discussion

- **Emily Smyth** (Patient Representative)
- **Martina Queally**
- **Prof. Sinead Walsh**
- **Prof. Breda Cushen**
- **Prof. Ken McDonald**
- **Dr John Butler**
- **Dr Suzanne Kelly**
- **Dr Orlaith O'Reilly**



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Closing Remarks

Dr Sarah O' Brien
NCAGL for Chronic Disease



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