Scaling Integrated, Community-First Care through the ECC Programme

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Primary Care and ECC – the scale of Ireland's front door to care

Enhanced Community Care
Care closer to home

General Practice & Primary Care → CHNs → Older Persons & Chronic Disease teams → Diagnostics & Virtual Care → Acute interface

Primary Care provides the local front door. ECC connects that platform to specialist, diagnostic, urgent and virtual care pathways.

c.29m
GP consultations
each year across general practice

1.4m
Primary Care therapy patients
expected to receive Primary Care therapy in 2026

1.2m
Out-of-hours calls
supported through GP out-of-hours services

c.1.4k+
GP practices
a national network of local access

400k +
patients see by PHN's
July 2026 year to date

99.3k
Older Persons contacts
13% above target at July 2026

307.8k
Chronic Disease contacts
14% above target at July 2026

690k
CDM Reviews in General Practice
supporting self-management of chronic conditions

16k
X-rays in Nursing Homes
Supporting appropriate in-reach for Older Persons

2.3m
People with Medical Cards and GP visit cards

188.8k
Community diagnostic scans
supporting diagnosis and treatment closer to home

220k
Women will participate in a Cervical Check Screening

ECC Investment	Local Footprint	Specialist Reach	The Purpose
2.8k WTE	~50k people per CHN	~150k across 3 CHNs per CST	Home first • integrated • Prevention-led

Primary Care and ECC – the scale of Ireland's front door to care

Overview

~6,600 contracted providers

PCRS budget €4.3bn

General Practice

Overview

- c.3,200 GPs across 1,400 practices.
- c. 29m consultations delivered through general practice.
- GP Training Places
- IMG Programme
- Strategic Review of General Practice

Pharmacy

Overview

- Dispensing over 70m GMS items
- Pharmacy Taskforce Review/
- Community Pharmacy Agreement (CPA 25) 1800+ pharmacies.
- Common conditions service – first phase eight common conditions.

Dental

Overview

- National Oral Health Action Plan
- School Dental Programme - 181 HSE dental clinics
- Dental Treatment Services Scheme (DTSS) c.850 dentists & 1 million treatments

Opthalmic/Eye Care

Overview

- c. 446 optometrists with HSE agreements
- 300k+ people treated
- Integrated Eye Care Teams provide assessment, prioritisation, diagnosis and pre-/post-operative care closer to home.

Contracted services are a key enabler of accessible, community-based care, delivering significant capacity across Primary Care.

Why improving access requires a different model of care

From mobilisation to system impact

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1. DEMAND IS GROWING

Ireland's population is ageing rapidly.

65+ population share



Although people aged 80 and over represented just 3.5% of the population, they accounted for **27% of acute hospital bed days in 2024**, highlighting the disproportionate effect of population ageing on hospital demand

2. INCREASING COMPLEXITY OF NEED

- People living longer with complex health needs.
- 50% of adults >65 report living with some level of disability,
- 20% reporting a disability affecting them significantly in day-to-day life.

- 36.6% of CDM patients have 2+ chronic conditions
- 12% have 3+ chronic conditions
- 7.2k new patients with >10 medications consulted with CSTs year-to-date in 2026

Growing Frailty, polypharmacy and chronic disease diagnoses are increasing the need for coordinated care across settings.

3. ECC RESPONSE

A different model of care delivered closer to home.

- Community Health Care Networks & Community Specialist Teams providing integrated frailty and chronic disease care
- Prevention, earlier intervention and proactive management through multidisciplinary community pathways

Supporting more people to access specialist care closer to home

4. ECC's EVIDENCE OF SYSTEM IMPACT

-9.72%

Reduction in discharges for Chronic Disease per 100k 2019 - 2025

VS

+6.4%

Increase in Discharges per 100k 2019 – 2025 – all medical

Change, 2019–2025

Integrated care is no longer an aspiration; it is the way we must work

This represents a significant opportunity to improve access, strengthen integrated community-based care and support a more sustainable health system.

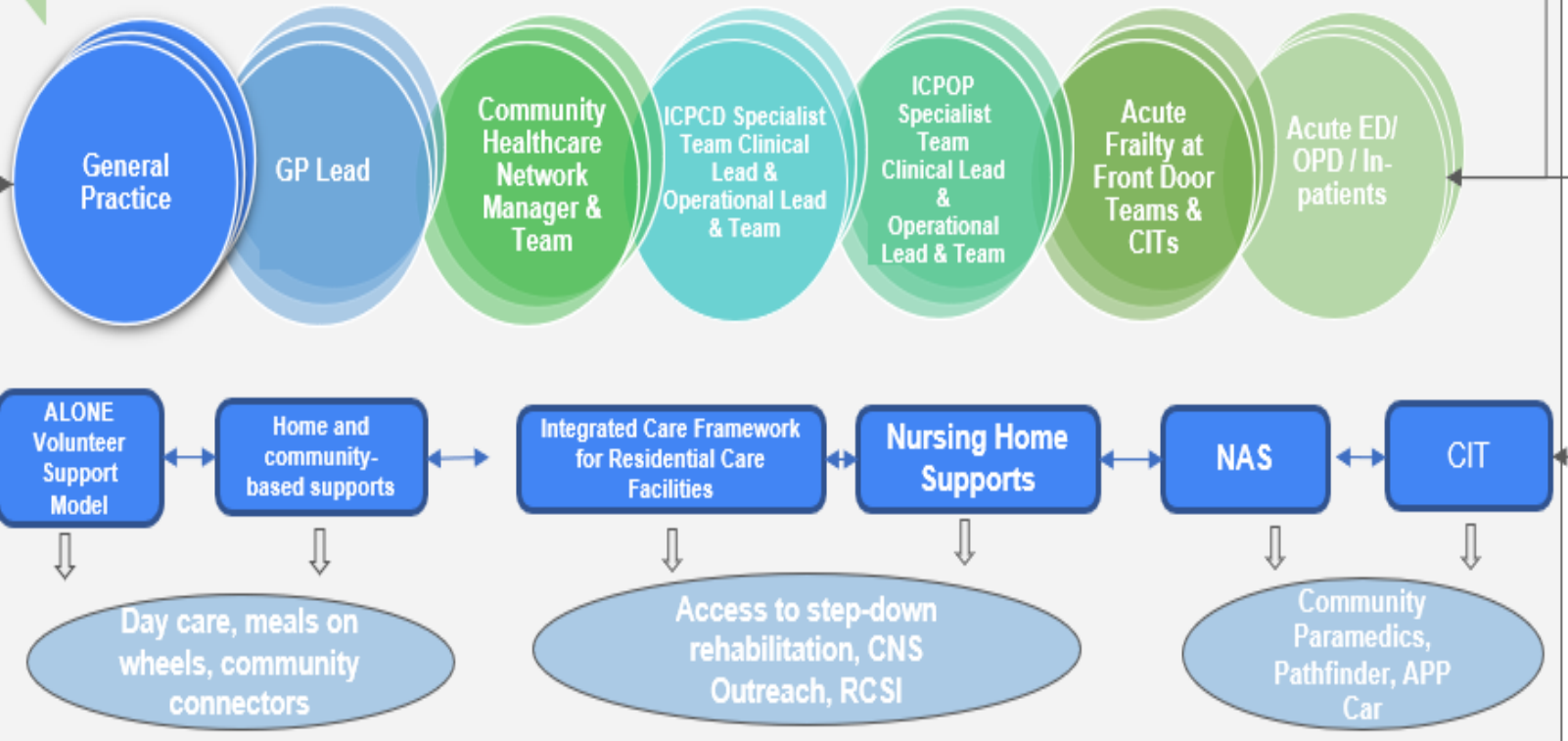
ECC
Delivering local population based integrated care

Population management and care pathway management

- Population health profiling
- End-to-end pathways of care
- Managing populations of ~50k through Community Healthcare Networks
- Managing at risk populations of ~150k through ICPCD and ICPOP specialist teams
- Care closer to home as possible
- OPD / Inpatient Impact

Shifting care to the community & integrating services

Integrated Multidisciplinary Team/s and Way of Working – Right Service, Right Place, Right Time, Right Team



Underpinned and enabled by robust and effective Clinical Governance, Feedback loops to encourage learning and continuous improvement, and tracking of Performance Metrics and Activity Outcomes to demonstrate value. Virtual care models support improved patient access and service experience.

Performance metrics and activity tracked across pathways

- **CHN / CHA**
  - Therapies
  - Nursing
  - Integrating Care
  - Community Intervention Teams
- **ICPOP**
  - Referral Activity
  - Specialist Pathways Activity
  - Referral Source Case mix
- **ICPCD**
  - Cardiology
  - Diabetes
  - Respiratory

The ECC Programme and the end-to-end pathway

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The ECC Programme is enabling increasing numbers of people to be **assessed, treated and supported safely outside acute hospitals**. The structures that support population-based, community healthcare delivery are based on the Community Healthcare Networks (CHNs) and Community Healthcare Areas (CHAs), and form the basis for a sustainably funded model of integrated, community-based care in Ireland.

One Population-based, End-to-End Pathway

People step up or step down according to need,
with support maintained across the full journey

1. **Stay Well & Identify Need Early**
   Prevention • self-management • population profiling • GP and CHN-led proactive care
2. **Access, Triage & Coordinate**
   Direct referral • clinical queries • diagnostics • virtual and urgent routes
3. **Deliver Specialist Care Closer to Home**
   ICPOP • ICPCD • CIT • therapies rehabilitation • multidisciplinary care
4. **Escalate Only Where Clinically Required**
   NAS pathways • front-door frailty • ED, OPD and inpatient care when needed
5. **Support Return Home & Ongoing Care**
   Early discharge • Home Support • reablement • GP and CHN follow-up

Right care • Right time • Right place • Right team

Traditional delivery
- Reactive
- Hospital-centred
- Episodic care

ECC delivery
- Proactive
- Community-centred
- Continuous

Home First

Community First

Virtual First

What access looks like across the patient pathway

One pathway, with hospital care used where clinically required, rather than as the default

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CHNs provide the local, population-based infrastructure that connects General Practice, Primary Care, specialist community teams, urgent response and acute services around patient need. The end-to-end pathway must start outside the acute setting: community-first, with engagement with acute teams only when clinically required.

1 Identify & Stay Well

- Population profiling
- Prevention & early identification

Enabled by

- GP • CHN • Primary Care

2 Access & Triage

- Direct GP query / referral
- Early clinical triage
- Community-based MDT meeting – triage patient for suitable treatment

Enabled by

- Standard • Urgent • Virtual routes

3 Community Intervention

- CHN nursing & therapies
- ICPOP • ICPCD • CIT
- Community-based MDT meeting – support planned intervention

Enabled by

- Diagnostics • Rehab • Self-management

4 Urgent Community Response

- NAS pathways
- Pathfinder • Community Paramedics

Enabled by

- Rapid advice & admission avoidance

5 Acute Interface (*if required*)

- Frailty at the Front Door
- ED • AMAU/CDU • OPD / inpatient
- COPD Outreach Teams

Enabled by

- Plan discharge from admission

6 Return & Follow-Up

- Supported discharge & rehab and home support
- GP + CHN coordinated follow-up
- COPD Outreach Teams – Coordinated follow-up
- Community-based MDT Meeting to ensure supportive follow-up

Enabled by

- Virtual review • Step-up / Step-down • Home support

Enablers across the pathway

Joint Leadership	Integrated Governance	Protected Capacity	Digitally-enabled system	Access to Diagnostics	Mature Pathways	Measure & Improve
Clinical + Operational	Acute + Community + GP	MDT Workforce + Pathway time	Records + Virtual Care	Community Access	Needs-led, patient-centred pathways	Population based planning based on clear data and outcomes

Right Care, Right Place, Right Time, Right Team

When CHNs, General Practice, specialist community teams, NAS and acute services operate as one pathway, more people can receive the right care in the community, with hospital care used only when clinically required.

“Mrs. O’Neill” - the patient at the heart of the end-to-end pathway

Community care supports the patient to stay well, manage changing needs and remain safely at home

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MRS. O’NEILL *

78 years old | Widowed | Lives at home

What matters to her

“I want to stay independent, know who to call, and avoid hospital when it is safe to do so.”

Her health and daily life

- Type 2 diabetic with moderate COPD
- Takes several medications each day
- Slower walking and reduced strength, with a moderate frailty score
- Needs help with some everyday tasks

Support around her

- ✓ Home Support Service
- ✓ ALONE check-ins
- ✓ Local GP and practice nurse

IDENTIFY & STAY WELL

“Regular reviews and a care plan help me manage at home.”

- GP-led CDM identifies risk early.
- Local CHN teams review her COPD and Type-2 diabetes in tandem.
- Inhaler use, blood-glucose management, nutrition, mobility, home safety and support needs are managed.

RAPID ACCESS

“I am more breathless than usual, everyday tasks are harder, and I feel less steady on my feet.”

- Reduced function and increased falls risk are early warning signs.
- Her action plan triggers rapid advice, triage, guiding access to appropriate CHN therapies, ICPCD and / or ICPOP pathway.

INTEGRATED ASSESSMENT

“I am assessed at home, virtually or in a local clinic.”

- ICPOP and ICPCD work together through MDT assessment and frailty review.
- Frailty makes travel difficult, so care closer to home is prioritised.
- OT assesses daily function, falls risk and home environment, while specialist respiratory and diabetes input shapes one coordinated response.

COMMUNITY INTERVENTION

“My treatment and daily routines are adjusted to help me manage at home.”

- ICPCD and PC therapies deliver pulmonary rehab closer to home.
- Respiratory and diabetes care are adjusted together.
- OT works with the patient on pacing, equipment, adaptations and safer daily routines, with needs flagged to Home Support.

URGENT COMMUNITY RESPONSE

“If I become very unwell, I get urgent advice and assessment.”

- Rapid advice and agreed escalation routes connect her with the Clinical Hub, NAS or Community Paramedic See & Treat to provide alternatives to ED.
- Frailty at the Front Door links in if hospital is needed.

SUPPORTED DISCHARGE

“If admitted to hospital, planning for my return home starts early.”

- ICPOP and ICPCD connect acute and community teams for supported discharge.
- Rehab, coordinated follow-up and virtual care are linked back to CHN and GP
- An updated action plan gives her confidence to recover safely and reduce the risk of readmission.

COORDINATED FOLLOW-UP

“My goals and ability to manage at home are reviewed.”

- One integrated care plan links GP, CHN, ICPOP, ICPCD, Primary Care Therapies, Home Support and ALONE.
- Regular follow-up reviews her condition, with support stepping up or down as needs change.

**Please note that Mrs. O’Neill is a composite patient, used for illustrative purposes only **

Integrated Care Programme for Chronic Disease

CDM supports older people to stay well and manage chronic conditions at home

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Structured, proactive care in general practice is supporting an older, increasingly complex population with increasingly complex needs to stay well at home

OLDER PEOPLE – A CORE CDM COHORT

71% of CDM Treatment Programme participants are aged 65+

44% of patients enrolled are aged 75+

40% of adults aged 65+ enrolled live with multimorbidity (2+ chronic conditions)

91% **of the 65+ treatment cohort is managed exclusively in general practice**

WHAT STRUCTURED PRIMARY CARE PROVIDES

Routine evidence-based care

1. **Medication optimisation is embedded**
   100% received a medication review in the previous six months,.

2. **Care planning supports self-management**
   76% had a co-developed care plan with their GP, helping patients to manage their condition(s) at home & to support earlier intervention

3. **Preventive care is a core component of the Programme**
   The CDM Programme provides structured opportunities for vaccination with 79% having flu vaccine up to date.

Significantly, the populations under discussion for engagement through the CDM Programme continue to be those with complex CD needs and multimorbidities

ACUTE CARE UTILISATION | 2025

Supporting older people to stay well at home

88.5% **had no ED attendance in 2025**

88.4% **had no hospital admission in 2025**

The CDM Programme represents a consistent cycle of review, prevention and shared care planning for chronic conditions that enables prevention, early intervention & proactive management to improve patient outcomes and reduce pressure acute hospitals.

ECC Programme – Chronic Disease

Urgent community care can turn early warning into avoided heart failure admissions

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Completing the end-to-end chronic disease pathway by intervening before deterioration becomes an emergency is critical for the prevention, diagnosis and long-term management in the community of heart failure.

THE CARE GAP

PREVENT Prevention › **DIAGNOSE** Early diagnosis › **MANAGE** Self-care & structured review › **INTERVENE** Urgent care for deterioration

Heart failure is well suited to community urgent care

1. **COMMON** — High and growing emergency bed demand
2. **PREDICTABLE** — ~50% have 3-day warning; ~30% have 7-day warning
3. **TREATABLE** — Simple interventions can be delivered outside hospital
4. **INTEGRATED** — Same team can return patients to routine follow-up

PROOF OF CONCEPT

SVUH pilot

Consultant-delivered ambulatory care over 3 years

~550
patients treated

75%
admissions prevented

~4,000
bed days saved

Linked virtual follow-up returns patients to routine community care

NATIONAL OPPORTUNITY

Earlier intervention can release hospital capacity at scale

3-DAY WARNING	7-DAY WARNING
3,750 admissions prevented	2,250 admissions prevented
37,000 bed days	22,000 bed days

Equivalent to ~60–100 “new beds”

IMPACT: A rapid, integrated response protects patients from hospital-related harm while releasing meaningful acute capacity.

Integrated Care for Older Persons

One Integrated Pathway to Support Older People to Live Well at Home

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One Integrated Pathway
bringing together CHNs, GPs, Primary Care, CSTs, Home Support, acute services and community partners around the older person.



1 STAY WELL & CONNECTED AT HOME

- Proactive review through GP, CHNs and PC teams
- Prevention and medication optimisation
- Early identification of frailty, falls risk and functional decline
- Social connection and community participation

2 IDENTIFY & RESPOND EARLY

- Changes in support needs identified early
- **Coordinated local response through CHNs, PC, Home Support and CSTs**
- Rapid advice, triage and specialist input

3 CARE AT HOME WHERE APPROPRIATE

- GP, CHNs, Older Persons' teams, CIT working as one pathway
- Rapid diagnostics and specialist assessment
- Rapid Home Support
- Community rehab
- Virtual and in-person follow-up
- Access to NAS pathways where clinically required

4 PLAN EARLY AND ENABLE A SAFE TRANSITION HOME

- Early discharge planning from admission
- **Acute and community teams work as one pathway**
- Coordinated discharge supported by CSTs where required
- Home Support, rehab and virtual follow-up activated rapidly

5 SUSTAIN INDEPENDENCE

- Home Support and home care
- Care and Repair and home adaptations
- Meals on Wheels and practical supports
- Carer support and respite
- ALONE check-ins and community supports
- Proactive review as needs change

WHAT THIS ENABLES

- **Earlier identification of changing needs**
- **More older people receiving care closer to home**
- **Fewer avoidable ED attendances and hospital admissions**
- **Safer and more timely transitions home**
- **Independence maintained for longer**
- **Long term residential care delayed or avoided where appropriate**

The Next Phase: Consistent Access, Scaled Nationally

Home First, Community First, Virtual First

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The ECC Programme is **moving into mature delivery**, demonstrating that community-based care:

- Improves access
- Enables early intervention
- Reduces acute hospital reliance.

Developing integrated care infrastructure is foundational for wider transformation.

Central to this is an **outward-facing model of specialist care**, with consultant expertise extending beyond the hospital to support GPs and community teams.

The future of our health service is the story of **increasingly embedded integrated care, with local innovations scaled nationally.**

1



Home First, Community First, Virtual First

Shift appropriate activity closer to home through enhanced community, diagnostic and virtual services.

Working in partnership with vol bodies such as COPD, Asthma, Alone, etc.

Care delivered at the lowest safe level of complexity

2



Organise around the person

Plan around population need and the full patient journey, connecting community, primary, acute and specialist care.

One pathway, measured through patient experience

3



Scale what works nationally

Share, standardise and replicate proven integrated care models across Health Regions and services to improve access.

Consistency of access, delivery and outcomes

4



Realise the full value of reform

Use integrated care to translate workforce, digital and service investment into measurable, sustainable benefit.

Data, governance and benefits realisation

Mature, Regionally-delivered ECC Model

System-wide Integration and Reform

Thank You