NCP Respiratory

NATIONAL CLINICAL PROGRAMME RESPIRATORY

Guidance on the Operationalisation of Integrated Respiratory Physiotherapy Posts.

September 2025

Introduction

The Enhanced Community Care programme was established to improve quality of care and facilitate access to specialist care for patients with COPD and Asthma. A substantial number of Integrated Respiratory Physiotherapists are now in position in Specialist Ambulatory Care Hubs around Ireland to provide specialist respiratory input to these patients.

The lived experience of these Physiotherapists has identified differences in the operationalisation of the integrated care components i.e. 80:20, 50:50 of the roles across the Specialist Ambulatory Care Hubs and hospital nationally. This guidance is to inform key stakeholders with examples of good practice in the implementation of Integrated Care Respiratory Physiotherapists posts and to continue embedding new ways of working. The included examples may not be a viable option in every service. It is recommended that work plans should be individualised based on local COPD and Asthma service and population needs, local policies, training and pathway.

This guidance will assist Physiotherapists, Physiotherapy Managers, Respiratory Consultant Clinical Leads and Operational Leads in mapping the workflow and patient caseload of the Physiotherapists while fulfilling the integrated care component of the roles across both Specialist Ambulatory Care Hubs and acute settings. It will also maintain fidelity to the National Framework for the Prevention and Management of Chronic Disease in Ireland (2020-2025) as well as the "End to End Model of Care for COPD" and "End to End Model of Care for Adult Asthma".

Examples of good practice 80:20 Senior Physiotherapist

The following are **examples only**. Work plans should be individualised based on local COPD and Asthma service and population needs, local policies, training and pathways.

Respiratory (COPD and Asthma) Senior Physio 80:20	
80% CD-CST Community based	• Physiotherapy-Led clinics including breathlessness clinics, exercise prescription and home exercise programmes, airway clearance techniques, ambulatory oxygen assessment and/or LTOT assessment for stable patient, cough management, action planning, bone health, smoking cessation advice, lifestyle advice. • MDT clinics with the Consultant. • Review of GP referrals of COPD and Asthma patients to other community respiratory team members where appropriate. • Facilitation of alternative virtual/telehealth pathway with approved HSE virtual platform for patients that may not require face-to-face assessment. • Integrate with cardiology, diabetes and ICPOP teams where appropriate. • Engagement with COPD Outreach team, e.g. Joint 6 week review clinics or extended reviews beyond 2/52. • Link with Acute Respiratory Physiotherapists where appropriate to review if any patients are being seen in respective services to avoid duplication and follow the patient journey. • GP engagement. • Referral to COPD Support Ireland exercise and education support groups. • Referral to Asthma Society of Ireland Asthma adviceline. • Data entry and management. • PPPG review and development. • Audit, research and training. • Provision of patient / staff education. • Support student placements in integrated care. **Supporting the hub Pulmonary rehabilitation team if service need is indicated*
20% Hospital based	• If a patient known to the physiotherapist is attending the acute services, follow and support the patient journey in the episode of care, and provide appropriate follow-up care. This may entail Physiotherapy inpatient review +/- Consultant wards rounds. • Assist in streamlining patient transitions between hospital and community services. • Assist acute physiotherapy team with complex ward-based respiratory care for COPD and asthma. • Physiotherapy led clinics, for example: Post Exacerbation Clinics: in conjunction with IC Consultant, to address a critical service gap. Support early intervention, patient education, and self-management support to improved disease control, reduce long-term complications and assist hospital avoidance. • Weekly OPD Clinic and MDT meeting, in conjunction with the IC Consultant/Hospital Consultant. • Oxygen assessment and review – follow up ABG point of care testing if required. • Facilitation of alternative virtual/telehealth pathway with approved HSE virtual platform for patients that may not require face-to-face assessment. •Attend COPD Outreach MDT. • Data entry and management. • PPPG review and development. • Audit, research and training. • Provision of patient / staff education.

**The Senior Physiotherapist may be asked to support and/or provide cover for the pulmonary rehabilitation teams during times of staff shortages etc. These arrangements are dependent on the needs of the local service, and should be made in consultation with clinical, physiotherapy and operations leads at a local level.*

Examples of good practice 50:50 Senior Physiotherapist

Respiratory (COPD and Asthma) Senior Physiotherapist 50:50	
50% CD-CST Community based	• Physiotherapy-Led clinics including breathlessness clinics, exercise prescription and home exercise programmes, airway clearance techniques, ambulatory oxygen assessment, cough management, action planning, bone health, smoking cessation advice, lifestyle advice. • Review of GP referrals of COPD and Asthma patients to other community respiratory team members where appropriate. • Follow up patients seen during their hospitalisation following discharge if needed to complete episode of care. • Facilitation of alternative virtual/telehealth pathway with approved HSE virtual platform for patients that may not require face-to-face assessment. • MDT clinics with the Consultant. • Link with Acute Respiratory Physiotherapists and COPD outreach team where appropriate to review if any patients are been seen in respective services to avoid duplication and follow the patient journey patient. •Integrate with cardiology, diabetes and ICPOP teams where appropriate. • GP engagement. • Referral to COPD Support Ireland exercise and education support groups. • Referral to Asthma Society of Ireland Asthma adviceline. • Data entry and management. • PPPG review and development. • Audit, research and training. • Provision of patient / staff education. • Support student placements in integrated care. *Supporting the hub Pulmonary rehabilitation team if service need is indicated*
50% Hospital Based	• In-reach support to patients admitted with exacerbations of COPD and Asthma. • Assist acute physiotherapy team with complex ward-based respiratory care for COPD and asthma. • If a patient known to the physiotherapist is attending the acute services, follow and support the patient journey in the episode of care, and provide appropriate follow-up care. This may entail Physiotherapy inpatient review +/- Consultant wards rounds. • Assist in streamlining patient transitions between hospital and community services. •Physiotherapy led clinics: • Oxygen assessment and review – follow up point of care testing if required, including overnight oximetry and NIV review • Post Exacerbation Clinics. • Facilitation of alternative virtual/telehealth pathway with approved HSE virtual platform for patients that may not require face-to-face assessment. • Weekly OPD Clinic and MDT meeting, in conjunction with the IC Consultant/Hospital Consultant. • Attend COPD Outreach MDT. • Data entry and management. • PPPG review and development. • Audit, research and training. • Provision of staff and patient education.

Examples of good practice for Pulmonary Rehabilitation

Pulmonary Rehabilitation Clinical Specialist Physiotherapist & Staff Grade Physiotherapist	
100% Community Based	PR Service Co-Ordinator including: • Promotion and education of the service to referrers and potential service users. • Clinical triage and prioritisation of referrals and ensuring urgent/ post exacerbations are offered a program as soon as available. • Overseeing referral management including tracking appropriate and inappropriate referrals. • Overseeing waiting list management including DNAs and long waiters, waiting times • DNA management procedure for the service. • Measuring completion rates for PR including numbers completed, number dropouts. • Onward referrals as appropriate. • Clinical management of those who, on screening, are not suitable for PR, and ensuring they are placed on correct treatment pathway. • Facilitation of alternative virtual/telehealth pathway with approved HSE virtual platform for PR. • Exercise design, delivery, prescription and modification. • Coordinating patient assessments – pre and post assessments. • Ensure inclusion of validated measure of exercise capacity, breathlessness and health status as well as a measure of lower limb strength and disease specific quality of life questionnaires. • Programme implementation. • Coordinate educational component of PR. • Act as expert clinical resource offering supervision education and ongoing support to staff and teams managing PR patients. • Liaise with other members of hub team and COPD Outreach where relevant and attend MDT meetings. • Liaise with members of the acute teams to discuss shared patients. • Referral to COPD Support Ireland Exercise and education support groups on completion of PR. • Complete ECC metrics. • Complete relevant local and clinical metrics for service evaluation. Measuring data against Minimal Clinically Important Differences. Annual audit to ensure quality targets met. • Continued Professional Development. • Research and future planning. • Evaluation and review of the PR service keeping abreast of latest research in PR evidence and inform the future development of the service locally. • Patient satisfaction/experience surveys. • Assist in local SOP/PPPG development.
Staff Grade Physiotherapist 100% Community based- may be a rotational post	• PR Service Planning. • Assist in the organisation and implementation of the PR programme to include triaging referrals, patient assessments and overall day-to-day delivery of PR. • Onward referrals as appropriate. • Exercise design, delivery, prescription and modification. • Develop and deliver educational content of PR. • Deliver care in line with programme Local PPPG guideline. • Record dataset for patients. • Liaise with other members of hub team and COPD Outreach where relevant and attend MDT meetings. • Liaise with members of the acute teams to discuss shared patients. • Provide feedback as required to Respiratory Consultant/GP providing governance in collaboration with Local Governance/Oversight Group. • Audit, research and training.

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- HSE 2019 End to End model of care for COPD