Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report on the results of the public consultation on the health technology assessment of providing a telephone service for acute, non-urgent medical care needs in the pre-hospital setting

08 July 2025

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children's social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children's social services.

  Health technology assessment — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.

Visit www.hiqa.ie for more information.

Table of contents

1 Introduction

A health technology assessment (HTA) is intended to support evidence-based decision-making in regard to the optimum use of resources in healthcare services. Measured investment and disinvestment decisions are essential to ensure that overall population health gain is maximised, particularly given finite healthcare budgets and increasing demands for services provided.

The aim of this HTA was to assess the requirements for the provision of a national alternative telephone pathway (distinct from the existing 112/999 emergency service) for acute, non-urgent care needs in the pre-hospital setting in Ireland. This assessment provides advice to inform decision-making by the Minister for Health and the Health Service Executive (HSE).

The draft HTA report was published for public consultation in May 2025.[(1)] This Statement of Outcomes report summarises the feedback received during the public consultation period and outlines HIQA's responses to the issues raised, including any changes that were made to the report as a result.

2 Methods

The aim of the public consultation was to seek feedback to identify any issues with the draft HTA report, to consider that feedback and to amend the report, as necessary.

2.1 The consultation process

The draft HTA was published on the HIQA website on 7 May 2025 and was available for public consultation until 18 June 2025. The consultation webpage contained a link to the draft report, a link to the online survey (using the Qualtrics platform) for online submission of feedback, and a consultation feedback form that could be downloaded. To ensure wide accessibility, feedback could be submitted via an online survey, email, or by post.

A press release was issued to a wide range of media outlets at the beginning of the consultation period, and notifications of the public consultation were posted via social media sites (X, Facebook, Instagram and LinkedIn). To maximise awareness, social media notifications were posted on the day of publication, halfway through the consultation period, and towards the end. The findings of the draft HTA were publicised in the media. E-mail requests for feedback were sent to a targeted list of 27 stakeholder organisations with relevant expertise and those who are likely to be affected by the proposed introduction of an alternative telephone pathway.

2.2 Feedback form

The template for submission comprised a general request for feedback to enable respondents to flexibly provide their submission for any aspects of the report. A copy of the submission template is provided in Appendix A.

2.3 Synthesis

Each submission was recorded (excluding personal information), read in its entirety and, where appropriate, broken down into individual components. In cases where a question was skipped by the respondent, it was assumed that there were no issues of concern specific to that question. The submissions were stratified according to whether they were from members of the general public or stakeholder organisations. Feedback considered broad in nature was described narratively. General feedback is presented in Table 1. Feedback relating to specific content in the draft report is presented in tabular format alongside responses to the feedback (Table 2). Feedback submitted by organisations and institutions is outlined in Table 3. Where amendments were made to the report based on feedback, this is highlighted in the HIQA response.

3 Results

Overall, 83 submissions were received during the public consultation period. Incomplete responses with no feedback have been excluded from the summary below. Submissions were received via the online survey and by email. A total of 21 submissions containing feedback were received, 17 from individual members of the general public, and four that were submitted on behalf of stakeholder organisations or institutions.

3.1 Summary of general feedback

In the section of the questionnaire for general feedback, many respondents expressed an opinion on the proposed alternative telephone pathway. Some respondents expressed support for the introduction of such a service, with several highlighting the current gaps in accessing non-urgent care and the potential benefits of a dedicated non-emergency line. Others raised concerns about the cost of the proposed alternative telephone pathway, suggesting that resources might be better allocated to strengthening existing healthcare services, see Table 1.

Table 1 Summary of general feedback

Number	Comment*
1	"I am a retired Fire Officer, I spent my last years in ERCC of Dublin Fire Brigade, this is something that is badly needed. With my experience, I have found the current system been overused or abused. The amount of calls that where queued due to the inability of the organisations, both ourselves and NAS to filter calls. My experience would cause me to consider the timeline involved. The system works in other countries, will we be lagging further behind? Hopefully all the stakeholders will be involved and get on board."
2	"It's an obvious gap to have an acute non urgent phone line. It should be implemented immediately."
3	"Another phone number won't work in Ireland as there is no tool allowing NAS staff to refuse the deployment of the ambulance. On top of that, NAS operational staff can't discharge patient on scene. Those are more urgent problems than an additional phone number."
4	"It is a good idea to have a less urgent emergency number for cases where it may not be a life threatening emergency but there are no other options available."
5	"Having being a healthcare professional in a busy ED and experienced pre hospital incidents including answering Community First Responder calls, I see a real need for an alternative to using the frontline emergency services and emergency departments as an access point for all healthcare needs. I believe the system in place in the UK (NHS 111) is working well and obviously huge public awareness and education on how to use the system will be required."
6	"I agree an alternative telephone number should be provided."
7	"I am a nurse by profession this is a great idea to start a new line. To my understanding people are used to 112/999 for emergencies. If something like this is started then we should be able to give enough time for people to understand the use of the line correctly. Ultimately work should be done at the grass root level before spending such huge amount of money."
8	"I think that the amount of staff proposed in the alternative pathway is quite large and there is a huge amount of money proposed to be spent over 5 years in both the high-demand and the low-demand scenarios. The existing services in the country are already stretched thin. I think this money would be better spent on improving the existing services available to the public and to make them more accessible, including injury units, emergency departments, the national poison centre and out of hours GPs."
9	"As a person with hearing impairment I think the proposed alternative route rather than telephone assessment is essential and hope this is provided."

*Responses have been slightly amended to ensure anonymity and to correct for minor grammatical errors and or typos.

3.2 Comments on overall readability

All but one person either skipped the question on overall clarity of the report, reported no feedback, or noted no issues.

3.3 Specific comments/queries on report content

The feedback received on the report content and the response to this feedback is outlined in Table 2.

Table 2 Comments received on report content and responses

Number	Comment*	Response
1	"The draft still seems to be very vague in terms of reach/use and cost. There is a lack of information regarding potential use and huge variation in the potential range of costs."	The alternative telephone pathway is designed for use by the general population in Ireland who have acute, non-urgent medical care needs. The aim of the service is to guide callers to the right level of care at the right time, improving access to appropriate healthcare while supporting more efficient use of the wider health system. As noted in the international scoping review (Chapter 3), there was conflicting evidence on the impact of alternative telephone pathways on primary care, ambulance services and ED utilisation. However, the international evidence does suggest that these pathways can, and do, positively assist callers to access timely assistance and appropriate care. The countries differed in terms of the existing healthcare system in which the alternative telephone pathway was implemented as well as the maturity of the alternative pathway service. Moreover, there were differences in the level of analysis conducted on the alternative pathway. Due to the mixed experience internationally of implementing similar telephone services, it is challenging to predict the likely impact of introducing such a service Ireland. Regarding use, projected demand is estimated between 270,000 and 960,000 calls annually. This broad range reflects the inherent uncertainty in estimating demand for this service, particularly given that it may generate substantial previously unmet or supplier-induced demand. These projections are informed by national utilisation data. The budget impact analysis outlines a five-year cost range for implementing an alternative telephone service on a 24/7 basis staffed by non-clinical call handlers of €81.7 million to €254.2 million, with an estimated cost per call of €48 to €55, depending on call volumes. Detailed scenario analyses were provided to account for different operational models and levels of demand.

Number	Comment*	Response
2	"I feel the role of paramedics is understated. They should not be required to transport patients to hospital for low acuity conditions."	While we appreciate the concern raised regarding the transport of patients with low-acuity conditions to hospitals, we would note that the operational protocols and clinical decision-making frameworks within the National Ambulance Service (NAS) are outside the scope of this particular health technology assessment (HTA). This HTA focused specifically on the safety, clinical effectiveness, efficiency and budget impact of introducing an alternative telephone pathway for acute, non-urgent medical care needs in the pre-hospital setting.
3	"Section 4.8 states that those who currently attend their GP or primary care nurse will continue to do so after the introduction of an alternative telephone pathway. I do not believe that this statement takes account of the likely behaviour of many healthcare service users in the context of current difficulties many people face in getting access to a face-to-face GP consultation. As accessing GP care becomes more difficult due to a GP shortage and geographical disparity in GP availability; more and more people may become reliant on the proposed alternative telephone pathway giving rise to demand that is significantly higher than what is predicted by the draft report. Assuming that the alternative telephone pathway will guide a service user to contact a GP where appropriate, what will the likely outcome be in the case that a service user expresses difficulty with GP access - this demand is likely to be referred back to already overwhelmed ED services."	The report acknowledges that demand for the proposed alternative telephone pathway will comprise two groups: those switching from existing services and those with previously unmet healthcare needs. The latter group may currently face barriers such as cost, travel distance, or lack of appointment availability. As outlined in Section 4.8, it is estimated that between 150,000 and 300,000 annual calls could come from these individuals with unmet needs, and this is factored into the demand projections. The report also recognises that actual service uptake could exceed these estimates, particularly as service awareness improves over time. We agree that the pathway will not address the needs of individuals who are assessed as requiring GP care but do not have access to such services, except in cases where the call handler may direct the caller to an out-of-hours GP service. However, this does not resolve the broader barriers such as cost or travel distance. As noted in Section 7.2: "Estimates from the international literature of the proportion of callers to alternative telephone pathway services advised to visit their GP varies, ranging from 9% to 69%. However, it may not be possible for those who are not registered with a GP to comply with this advice, likely leading to frustration for both the call operator and caller. In some instances, callers may be able to access primary care through out-of-hours services

Number	Comment*	Response
		without being registered with a GP; however, this is likely to incur a cost and travel burden. The aim of the alternative telephone pathway is to ensure that people enter the health system at the most appropriate point for their healthcare needs. This is contingent on sufficient capacity at the most appropriate point in the system. If an alternative telephone pathway were to be established, consideration would need to be given to what advice should be given to those who are not registered with a GP, when the clinical decision support system (CDSS) suggests that a visit to the GP would be the most appropriate course of action. This would require collaboration with other sectors of the health service." As noted in Section 7.2.2: "… some services including primary care and EDs are currently operating at capacity, with demand often exceeding capacity (Chapter 2). As the international evidence shows that an alternative telephone pathway would refer people to GP services, if there is no capacity in that setting, then the telephone pathway would be unable to fulfil its purpose, and frustration with the health service would likely grow." As noted in Section 4.3, demand for GP services in Ireland is steadily rising. "A report by the ICGP in 2022 on the Workforce and Workload Crisis in General Practice in Ireland stated that the number of GPs is insufficient to meet the needs of an expanding and ageing population with complex care requirements. A 2017 report by the ESRI projected that demand for GP visits would increase by up to 27% from 2015 to 2030. Similarly, a 2018 healthcare capacity review by the Department of Health estimated that the primary care GP workforce needed to increase by 39% by 2031 to meet rising demand and requirements relating to reform of health services.
4	"Section 4.5.2 refers to a "hear and treat" function within the NAS NEOC managing 25,372 calls in an 11 month period. The "hear and treat" function operated by the NAS has several	Text was amended in Section 2.2.4 to reflect the Hear and Treat service is not a 24-hour service.

Number	Comment*	Response
	factors that limit its function: most prominent of which are that it is not a 24 hour service, and that it only receives calls that are initially categorised as low-acuity by the AMPDS system in use by NAS as a call categorisation tool. If "hear and treat" clinical staff also screened calls that were initially over triaged as medium or high acuity this would result in a far greater amount of calls deemed suitable for the "hear and treat" function. Assuming this was the case, combined with 24 hour operation; the number of calls being processed by the "hear and treat" function would be significantly higher. The above must be considered in the context of predicting numbers of calls made to the proposed alternative telephone pathway."	As noted in Section 4.5.2, data from NAS Hear and Treat service were included in the HTA and contributed to the overall demand estimates presented in Section 4.8. These figures were used to provide insight into the existing volume of low-acuity cases managed without ambulance dispatch, and to support modelling of potential call volumes to the proposed alternative telephone pathway. We acknowledge your point that broader triage criteria, such as the inclusion of calls initially categorised as medium or high acuity that may be suitable for telephone management, could result in higher volumes being eligible for a Hear and Treat-style response. However, the internal triage processes and scope of practice within NAS are beyond the scope of this HTA. The figures used in our modelling were developed in consultation with NAS and reflect the current operational parameters of their Hear and Treat service. We have acknowledged in the report that close collaboration and alignment with existing services, including NAS, would be essential in the design and implementation of the proposed alternative telephone pathway.
5	"Section 2.2.4 at page 40 refers to the "See and treat" initiative developed by the NAS. This section should clarify that this initiative, in operation within a limited geographic footprint nationally and is not available 24/7."	Text added in section 2.2.4: "See and Treat initiatives are only available in some locations and do not operate a 24/7 service."
6	"There is no mention in the draft report of the impact, relevance or utilisation of emergency department outreach programmes such as EDITH operated by St. Vincent's University Hospital. This programme is a frailty response / ED avoidance service which is currently accessible to Nursing homes and GPs as an alternative to emergency department attendance. How might this concept integrate with the alternative telephone pathway?"	Text has been added to section 5.2.1 of the report to acknowledge the existence and function of EDITH "EDITH (Emergency Department in the Home) is operated by St. Vincent's University Hospital (SVUH), Dublin. EDITH is a frailty response service providing emergency medical and occupational therapy input to adults aged 65 and over in the SVUH catchment area seven days a week (8am to 6pm) who have been referred to the service by GP, Emergency Services or nursing home. EDITH was established to provide a

Number	Comment*	Response
		patient-centred approach to ED care, with the aim also of reducing unnecessary ED attendances." With regard to integration, as noted in the report, successful implementation of the proposed telephone pathway would depend on effective integration with existing services, such as those ED outreach programmes.
7	"Specifics such as what is the expected outcome and how do you think it is going to benefit the public should have been addressed."	The HTA report addresses both the expected outcomes of the proposed alternative telephone pathway and the anticipated benefits for the public. The alternative telephone pathway is designed for use by the general population in Ireland who have acute, non-urgent medical care needs. The aim of the service is to guide callers to the right level of care, at the right time, improving access to appropriate healthcare while supporting more efficient use of the wider health system. As noted in the international scoping review (Chapter 3), there was conflicting evidence on the impact of alternative telephone pathways on primary care, ambulance services and ED utilisation. However, the international evidence does suggest that these pathways can, and do, positively assist callers to access timely assistance and appropriate care. As outlined in Chapter 7, the service could particularly benefit those who face barriers to accessing healthcare. Key benefits include: supporting individuals to manage their care safely at home or access the most suitable service; enhancing efficiency across the health system by guiding patients to the right care, at the right time; promoting equity by reaching people who might otherwise delay or forgo care.
8	"It is extremely positive to see the role of the pharmacist and pharmacy recognised throughout the document. The role of the pharmacist and community pharmacy, in particular, to reduce pressure on other healthcare options is vital but often	Thank you for the feedback. No change to the report required.

Number	Comment*	Response
	not appreciated as the impact has not been measured in a meaningful way."	
9	"The development of a shared care record is vital to underpin this service as this will ensure that the information relating to an individual's medical/social history and prescribed/dispensed medicines will be available. It would also ensure that a record of the interaction with the alternative telephone pathway is visible to all relevant healthcare providers."	As noted in Section 7.2: "…the ability to provide a personalised approach can be facilitated if the operator has access to the patient's electronic medical records. The National Shared Care Record, expected to begin rollout at the end of 2025, could enable more tailored care if effectively integrated with the alternative telephone pathway."
10	"Table 6.1 - I believe that a pharmacist at a senior grade or above would be required as the pharmacist would need at least 3 years experience to undertake the role(s) required. Therefore, the starting point for the cost of a pharmacist would rise to €73,313 (October 2024 payscales)."	In this assessment, salary estimates were based on the midpoint of the relevant HSE payscales, which for pharmacists was €61,178. This approach was taken to reflect an average cost across a potential mix of junior and senior staff. Given the uncertainties surrounding actual service utilisation patterns, workforce needs, and optimal staff configuration, the report recommends that ongoing monitoring and evaluation would be essential should the service be implemented. This would allow for the adjustment of staffing models and associated cost assumptions over time, ensuring the service remains responsive, efficient, and aligned with the needs of both callers and the wider healthcare system. As noted in Section 6.4: "The inclusion of basic-grade dentists and pharmacists in the budget impact model reflects a pragmatic approach to estimating staffing costs. However, the demand for a new service of this nature is inherently unpredictable, making it challenging to determine the optimal staff grades needed to effectively address caller queries. If senior-grade pharmacists and dentists were required, this would lead to a modest increase in costs, with a 1.3% and 1.4% rise in the five-year total budget for a low-demand and high-demand service, respectively. These potential cost

Number	Comment*	Response
		variations highlight the uncertainty surrounding service requirements and the need for flexibility in workforce planning as demand patterns emerge."
11	"Who is the call taker are they educated to advice patients and direct them to appropriate service? Will they have appointment slots for example in local MAU's to advise patient's to go there?"	As outlined in the Organisational chapter, section 5.2.4, the service is envisioned to be staffed by non-clinical call handlers supported by clinical staff (such as nurses, doctors, pharmacists, and dentists) who would provide clinical advice when needed. Call handlers would use a clinical decision support software (CDSS) system to guide structured triage and help identify the most appropriate care pathway for each caller. Where cases are complex or outside the scope of non-clinical staff, the call would be escalated to a clinical advisor. Services in England, Italy, Scotland, and Wales employ non-clinical, trained call operators to answer and triage calls. In all four of these countries, the operator can transfer calls to a clinically-trained adviser for further triage and assessment. Regarding the potential for call handlers or clinical advisors to book appointments directly into services such as local Medical Assessment Units (MAUs), the report notes that integration with wider health services would be important to maximise efficiency. However, the current absence of universal electronic health records (EHR) or patient identifiers in Ireland, limits the ability to support this kind of direct integration. As a result, if the service were implemented in the current system context, it is unlikely that appointment booking into MAUs or similar services could occur at scale. The report highlights in that absence of electronic health records is a risk in Section 7.2.1. In Section 5.2.2 it is noted that "The lack of EHR in Ireland could limit the overall benefits of an alternative telephone pathway service if it was introduced in Ireland."
12	"While, in principle, the idea of introducing an alternative pathway to ease pressure on the existing healthcare system is a positive development, I could not determine from the	The HTA recognises that the proposed alternative telephone pathway must be designed to complement, rather than duplicate, existing services. As discussed in the Organisational chapter, the service would require integration

Number	Comment*	Response
	Health Technology Assessment (HTA) how the proposed pathway, in its current form, would effectively achieve this objective. My primary concern is the lack of clarity regarding how this new service will differ from the already established Out-of-Hours GPs service." "Currently, Out-of-Hours GP services already play a critical role in triaging patients and signposting them to the appropriate services—whether that be emergency departments, on-call GPs or nurses, the National Poisons Information Centre (who have not been included in this HTA), Injury Units, or the National Ambulance Service. Without a clear explanation of how the proposed pathway would operate differently or more effectively, it is difficult to assess its added value. The HTA notes that similar services in other countries have led to a reduction in emergency department referrals. However, it is unclear whether those countries had equivalent Out-of-Hours GP services in place prior to implementing their alternative pathways, and whether such factors were accounted for in the HTA's analysis. This is important context when attempting to draw comparisons or predict potential outcomes."	with the existing health system, including GP out-of-hours cooperatives, to be effective. While there are some overlapping functions, such as providing triage and directing people to appropriate care, the proposed telephone pathway would differ in a number of ways: ▪ It would operate as a single, nationally available point of access, rather than a collection of regionally organised GP out-of-hours cooperatives with separate phone numbers and models of operation. ▪ It would use standardised clinical decision support software (CDSS) to triage calls consistently across the country. ▪ It could offer wider hours of operation and potentially include additional functionality (such as advice for mental health, pharmacy, or dental concerns), subject to final design. The intention of the proposed telephone pathway is not to replicate GP out-of-hours services, but to create a coherent and accessible national triage system that supports timely care and alleviates inappropriate pressure on emergency and primary care services. The International Scoping review (Chapter 3), showed studies from five countries reported the impact on ED attendances. Two countries reported a positive effect (avoidance of unnecessary resource use, decreased demand), while three countries reported either no effect or conflicting findings. As such, the international evidence did not clearly demonstrate whether an alternative telephone pathway reduced ED presentations. Moreover, there was conflicting evidence of the impact of an alternative pathway on ambulance and primary care utilisation.
13	"A significant concern is the risk of increased waiting times, particularly for patients who may incorrectly assume their	Chapter 3 of the report, which presents international evidence from countries that have implemented telephone pathways, notes that delays in answering

Number	Comment*	Response
	condition is non-urgent. It is critical that any such service be sufficiently staffed to ensure timely access to care. For example, the NHS 111 service in the UK has been widely reported to experience delays, with media coverage highlighting long wait times (https://news.sky.com/story/cant-get-through-to-nhs-111-youre-not-the-only-one-12854861) and anecdotally I have heard reports suggesting delays of over an hour."	calls and long wait times have has an impact on caller's satisfaction. To mitigate these risks, the report recommends that any implementation of an alternative telephone pathway in Ireland should be accompanied by ongoing service monitoring and evaluation, which includes regular review of demand levels, staffing capacity, and performance indicators such as call answer times. The report also acknowledges that recruitment and retention challenges may affect the ability to maintain appropriate staff levels which has direct consequences for timely call handling. A key decision would be whether to staff clinically or non-clinically personnel which has implications for workforce availability.
14	"It does not appear that the proposed telephone line would genuinely create a new care pathway. With the closure of many Emergency Departments across the country over the years, including recently. The ED at St. Michael's Hospital in Dublin also strangely only operates from 08:00 to 20:00 daily. Therefore, there are already fewer options available for referral than there would have been previously. Similarly, most Injury Units appear to close by 20:00. In cases presenting outside these hours, the alternative pathway would still need to refer patients to already burdened emergency services. Overall, I am not convinced that the proposed telephone pathway in its current format actually creates a new path, in fact it may delay patients from accessing the correct pathways and it risks duplicating functions already carried out by Out-of-Hours GP services."	Thank you for this comment, we have updated the text to refer to the proposed telephone line as a service rather than a pathway. The risk of duplication of existing services is highlighted in the executive summary "Adding another layer to the health system may compound issues of inefficiency, duplication, and unnecessary use of resources." The risk is also identified in Section 5.2.1. "A comprehensive understanding of the existing care pathways and the interactions among these health services and the alternative telephone pathway is needed, as some reorganisation within these existing services may be required in order to minimise duplication of assessment and to improve system efficiency and patient experience."
15	"Table 6.1 – Staff Cost Inputs The projected staffing levels in Table 6.1 appear excessive, even in the low-volume scenario. Given the current shortage	We acknowledge that recruitment and retention of healthcare professionals in Ireland is a well-recognised and ongoing challenge, and this issue is reflected in the justice and equity considerations discussed in Section 7.3.3 of the

Number	Comment*	Response
	of healthcare professionals in Ireland, recruiting the number of staff outlined will be a significant challenge. This raises concerns that inexperienced staff may be recruited, or worse, that experienced professionals may be drawn away from already stretched services such as emergency departments, Injury Units, or GP out-of-hours services—as noted in Section 7.3.3 on justice and equity. There also appears to be a high number of clerical and managerial staff proposed, which may not be necessary for the efficient operation of a telephone-based triage service."	report. The potential risk of drawing staff away from existing services such as EDs, Injury Units, and GP out-of-hours care would be an important consideration if the proposed telephone pathway were to be implemented. The staffing levels presented in Table 6.1 were developed using a "bottom-up" approach to reflect the projected call volumes under both low- and high-demand scenarios. This approach incorporated international benchmarks, average call handling times, and assumptions about shift patterns and required clinical support. Notably, the resulting estimates closely align with staffing levels observed in a comparable service in Scotland. These figures are intended to provide an evidence-informed estimate of the resource implications of implementing the proposed alternative telephone service, rather than a definitive staffing plan. The estimates for non-clinical staff, including administrative and managerial roles, were developed based on informed assumptions about the operational requirements of a national telephone service. These roles are intended to support essential functions such as quality assurance, human resources, training, data management, performance monitoring, IT coordination, finance, and general office management. Additionally, as noted in Section 6.4, if the proposed service were to be hosted with an existing organisation, it may be possible to share administrative, managerial and support functions therefore reducing the need for new hires.
16	"Resource Allocation & Implementation Considerations Section 7 of the HTA (Patient, social, ethical and legal considerations) rightly highlights that without the provision of additional resources, the proposed service could inadvertently increase pressure on existing services. This risk is very real. It is vital that any influx of patients to existing providers—such as the NPIC, Out-of-Hours GPs, emergency departments, or	We agree that a robust implementation plan would be required in advance of service roll-out, including stakeholder engagement, workforce planning, capacity assessments and monitoring mechanisms.

Number	Comment*	Response
	the NAS—is anticipated and that these services are resourced accordingly in advance of the pathway's implementation. This includes recruitment, onboarding, and training to ensure readiness from day one."	
17	"Irish Language Legislation A small note that I did not note a reference to the Irish Language Act. As this is relatively recent legislation, many services may not yet have fully adapted to its requirements. Consideration should be given to whether dedicated funding will be needed to ensure compliance with this Act, particularly if the provision of Irish-language services is needed on any new telephone line. This may then impact Out-of-Hours GP services and other services."	Text has been added to section 5.4 of the report to acknowledge the Irish language legislation "Under the Official Languages (Amendment) Act 2021, public services are required to provide services in Irish to the public, where appropriate. Consideration needs to be given to this as it may have implications for staff recruitment, interpreter support, call-handling protocols and the provision of information materials in Irish. Dedicated funding and planning may be required to ensure compliance, and this could also impact downstream services, if Irish-language service delivery is expected across multiple points of contact."
18	"Cost Concerns Finally, the five-year projected cost—under both high- and low-volume scenarios (€81.7 million to €254.2 million)—is a huge amount of expenditure. Given the lack of a clearly defined difference between this new service and existing GP triage services, it is difficult to justify this. In my view, this level of funding would be better invested in strengthening and expanding current services that are already under strain, including the National Poisons Information Centre, Out-of-Hours GPs, Emergency Departments, and related support systems. In conclusion, after my review of the HTA, I feel that the proposed pathway does not demonstrate any meaningful difference to the service carried out by the Out-of-Hours GPs,	The five-year budget impact (€81.7 million to €254.2 million) of implementing an alternative telephone service on a 24/7 basis staffed by non-clinical call handlers represents a significant investment. They are not fixed budgets, but rather estimates of implementing an alternative telephone pathway. While there are some overlapping functions, such as providing triage and directing people to appropriate care, the proposed telephone pathway would differ in a number of ways to GP out-of-hours services. See response to comment 12.

Number	Comment*	Response
	and the cost and staffing requirements of the pathway in its current format may not provide an overall benefit to the healthcare system or to the public. The budget outlined may be better spent at improving access to existing services which are already strained. If a telephone pathway were to proceed, it is critically important that any other services are provided with increased funding and staff to allow them to cope with any increased demand."	
19	"As stated it's important there is a system to link the telephone service to in person service that person may be advise to follow up with, perhaps in the form of a referral or report being sent on to demonstrate the person tried to avoid, for example an emergency department, and help them with gaining the further care which may be required. Maybe an automatic note should go to GP to note the interaction and advice given. Use of video calls would enhance the contact. It should be staffed by suitably qualified persons not just "first aiders". Service users should be made aware of qualifications of persons providing the care and what can be expected of the service."	The aim of this HTA is not to design the service, but rather to identify key considerations that should inform the design and implementation of a proposed alternative telephone pathway. As noted in Section 2.3: "The ability of call operators to direct callers to the most appropriate healthcare service to meet their described needs could streamline the experience of people with acute non-urgent healthcare who are uncertain as to who to contact in order to access appropriate care. At a minimum level, the call operator will be able to triage the caller and determine the appropriate healthcare service to refer the caller to, including seamless transfer of the call to the 112/999 emergency pathway, where clinically indicated. Under an assumption of greater integration of the pathway with wider healthcare services, call operators could also provide clinical advice and schedule appointments with primary care providers and EDs. However, it is noted that due to an absence of centralised services or integration between services, currently this scheduling of appointments would be difficult in Ireland."
20	"It is great to see reference on page 29 of the report to the importance of making any new service accessible to everyone. It is also good that it is noted that the development of any new service needs to contribute to improving our health service not creating more avenues for	Thank you for the feedback. No change to the report required.

Number	Comment*	Response
	delay and must be joined up with other Health services to be effective.”	

*Responses have been slightly amended to ensure anonymity and to correct for minor grammatical errors and or typos.

3.4 Feedback submitted by organisations and institutions

We received feedback from four organisations or institutions as part of this public consultation. Feedback was received from Chime, the National Poisons Information Centre, the Irish Deaf Society and PSI the Pharmacy Regulator.

The full responses to the feedback are provided in this document. Feedback pertinent to this HTA is outlined in Table 3.

Table 3 Feedback submitted by organisations and institutions

Number	Feedback*	Response
	Chime	
1	Chime agreed with the text in the report highlighting the importance of ensuring accessibility for Deaf and hard of hearing people and those with speech or language barriers, highlighting that failure to do so may exacerbate existing health disparities. Chime stressed that human rights legislation and the Irish Sign Language Act 2017 requires all public services to be accessible for ISL users. The Deaf and hard of hearing community often struggle to access health services due to the absence of appropriate assistive technology and ISL interpretation. Any new services must ensure that appropriate, quality accessibility is provided. Chime agreed with the statement in the report that clear public communication would be essential to ensure that people understand when and how to use the service appropriately. They stress that public communication on how to use the service must also be accessible to Deaf and hard of hearing people, including ISL videos, and audio videos with captions.	Thank you for your feedback. Text added to section 5.2.6: "The public information campaign on how to use the service must also be accessible to those who are deaf and hard of hearing, and should include Irish Sign Language (ISL) videos as well as audio-visual materials with captions."

Number	Feedback*	Response
2	Chime agreed with the statement that telephone services are typically not as accessible to those facing language barriers, those who are deaf or hard of hearing, or those with speech impediments. Chime is concerned that another public service would exclude access from Deaf and hard of hearing people. The only other routes that is accessible to Deaf and hard of hearing people is the 112 number, so most will end up going to emergency departments. Chime noted that GP out-of-hours (OOH) are inaccessible to those who are Deaf and hard of hearing, as they can only be contacted by telephone. Chime staff would find it very difficult to support someone with this as it is triaged service and the caller has to wait for a return call to discuss symptoms so it limits accessibility, therefore they would still need to access the emergency route as their primary option. Chime would advocate for the alternative telephone pathway to have access to text/email option or video-calling and access to an ISL interpreter as would be appropriate for ISL users seeking to contact the service. There is a chronic shortage of ISL interpreters at present so this could present a challenge to recruitment and also it would require adequate funding to facilitate this access. Providing a text messaging service alternatively may be useful for some, but not all as literacy can be a challenge for some people in the Deaf community whose first language is ISL. ISL interpreter provision in health services is a significant challenge and Chime has observed that ISL interpreters are not provided to Deaf and hard of hearing people presenting recently to A&E in Beaumont, Tallaght and the Mater. There is a lack of clarity about at what stage an ISL interpreter is sought. Chime stress the need for inclusive service design to avoid exacerbating inequities.	Text added to section 5.2.3.: "Existing telephone-only services, such as GP out-of-hours, are currently inaccessible to many in the Deaf and hard of hearing community. To avoid reinforcing this barrier, the alternative telephone pathway should provide accessible communication options from the outset, including real-time text messaging, email, and video-calling with access to Irish Sign Language (ISL) interpretation. While the availability of ISL interpreters is currently limited, planning and funding must anticipate these needs to meet legal and equity obligations under the Irish Sign Language Act 2017." Text added to section 7.3.3: "Existing telephone-only services such as GP out-of-hours are currently inaccessible to many in the Deaf community. To ensure the service does not create or exacerbate inequities, it should be designed to be inclusive and accessible for the entire population. This would include accessible communication options from the outset, such as text-based, email, or video-calling platforms with access to Irish Sign Language (ISL) interpretation." With regard to the question of when an ISL interpreter would be engaged during a call, it is important to note the aim of this HTA is not to design the service, but rather to identify key considerations that should inform the design and implementation of a proposed alternative telephone pathway. These implementation-level details should be addressed during the service planning and design phase if a decision is taken to implement an alternative ambulance pathway.
	National Poisons Information Centre (NPIC)	
1	The NPIC welcomed the opportunity to contribute to the consultation and noted the comprehensive nature of the HTA. However, they expressed	Thank you for your feedback.

Number	Feedback*	Response
	concern that the NPIC was not included among the "Healthcare options currently available in Ireland," and that the potential impact of the proposed service on their operations was not considered. The Public Poisons Line (Tel: 01 809 2166) enables members of the public to speak with trained specialists in poisons information, and access timely, appropriate medical advice directly if poisoning/suspected poisoning occurred. They highlighted that the new telephone pathway may receive calls related to poisoning, suspected poisoning, or therapeutic errors, areas currently within NPIC's remit, and emphasised the need to avoid duplication of services.	Text has been added to Section 5.2.2: "In addition to these services, integration with existing national helplines and specialist advisory services should also be considered. One such service is the Public Poisons Information Line, provided by the National Poisons Information Centre (NPIC). This phone line enables members of the public to speak with trained specialists in poisons information and access timely, appropriate medical advice in cases of poisoning or suspected poisoning. Integrating the alternative telephone pathway with services like the NPIC could support more streamlined triage, avoid duplication, and ensure callers are directed to the most appropriate clinical expertise when required."
2	Organisational considerations Technology section 5.2.3 A tailored Clinical Decision Support System (CDSS) will be required to support assessment and management of calls as outlined in section 5 (pg 13, pg142). If a poisoning enquiry is received by the alternative pathway, the NPIC has an important clinical role to play but this will depend on the staffing model chosen for the proposed telephone triage service.	Text added to Section 5.2.3 "In addition to identifying emergency calls, the CDSS should be designed to facilitate seamless redirection of calls to other national helplines and specialist advisory services where appropriate. For example, a call relating to a suspected poisoning could be directly transferred to the National Poisons Information Centre (NPIC) for specialist input."
3	Staffing The staffing options outlined in the HTA include an option (described as option 3; pg 135) of non-clinical call handlers with clinical support whereby calls would initially be answered by non-clinical staff trained to use clinical decision support software (CDSS). More complex or higher-risk cases would be escalated to clinical supervisors (e.g. nurses or paramedics). The report expresses a preference for this model as a cost-effective compromise, particularly for triaging lower-risk queries, with escalation routes available for	In regards to recognising the NPIC and other helplines and advisory services into the CDSS pathway, please see response to comment 2 above.

Number	Feedback*	Response
	higher-risk situations. This staffing option will rely on a CDSS to guide triage and referral decisions. We would suggest that the NPIC is integrated into the CDSS pathway as a designated referral point for all poisoning-related enquiries to ensure they are managed optimally; (section 5.2.2 Integration and collaboration with existing health services pg 140). When a member of the public phones the national triage line, the non-clinical call handler answers and if the CDSS script identifies poisoning queries and medication errors then the call should be transferred directly to the NPIC between 8am and 10pm every day. Overnight (from 10pm to 8am the following day), the CDSS script should direct the enquiry to the clinically trained personnel during the hours on duty at the alternative phone pathway. Clinical staff should take a clinical history similar to the Out-of-hours GP Co-Ops and contact the NPIS via the NPIC Healthcare professional line.	
4	The importance of integrating with existing health services cannot be underestimated. For example, NHS 111 in the UK doesn't have a mechanism to inform the emergency department why they are sending a patient in, and it would sometimes be useful to send a notification that "all this patient needs is an ECG and they can be discharged" or "this patient has taken a very serious overdose; please call the poison centre as soon as they present". A unique patient identifier across the system that could be accessed by health care services could potentially overcome this problem. Will the alternative telephone pathway support the integration of other health services such as the NPIC, through an electronic health record or unique patient identifier?	We agree with the importance of integrating the alternative telephone pathway with existing services. The report notes that integration with wider health services would be important to maximise efficiency. However, the current absence of electronic health records (EHR) or patient identifiers in Ireland, limits the ability to support this kind of direct integration. As noted in Section 7.2 "…the ability to provide a personalised approach can be facilitated if the operator has access to the patient's electronic medical records. The National Shared Care Record, expected to begin rollout at the end of 2025, could enable more tailored care if effectively integrated with the alternative telephone pathway." The report highlights that absence of electronic health records is a risk in Section 7.2.1. And in Section 5.2.2 it is noted that "The lack of EHR

Number	Feedback*	Response
		in Ireland could limit the overall benefits of an alternative telephone pathway service if it was introduced in Ireland."
5	International telephone pathways and the role of the Poisons Information Centre (Section 3: Governance Structure pg 68) The HTA document includes a review of international practice (section 3) in relation to an alternative non-urgent acute care telephone service and a full review was undertaken for Denmark, Sweden, England, Scotland and Australia. Denmark, Sweden, and Australia have implemented an alternative telephone pathway while maintaining and supporting their poison information centres, all of which continue to take member of the public calls. England and Scotland's Poison Information Centres only take calls from healthcare professionals but also receive queries from NHS 111 regarding poisonings. The experience of the National Poisons Information Service in the UK NHS patient advice services are the heaviest users of the UK National Poisons Information Service (NPIS) national helpline number, accounting for 43.0% of all enquiries received (National Poisons Information Service Report 2023 to 2024 https://www.npis.org/Download/NPIS%20Report%202023-24.pdf Accessed 28/05/25). 99.5% of enquiries to the NPIS where no or only minor symptoms were reported originated from NHS patient advice services and only 28.9% of these were referred to emergency departments. This is not appear to be included in the report on the NHS governance structure.	In section 3.4 of the HTA, the aim was to provide a high-level overview of international alternative telephone pathways for pre-hospital healthcare. This included outlining the broader context in which these services operate, along with a summary of their service models and governance structures. As such, while the model and governance of NHS 111 in England were discussed, we did not include detailed operational data such as the volume or nature of calls routed from NHS 111 to other telephone services operating in the UK, including the UK National Poisons Information Service (NPIS). Text has been added to Section 3.2.5: "We acknowledge that each country included in this international review may operate multiple helplines and advisory services that provide telephone-based health information. However, it was beyond the scope of this review to identify or assess how such services are integrated with, or operate alongside, the national acute, non-urgent telephone services. As such, our analysis focused primarily on the main national service in each jurisdiction, rather than the broader ecosystem of health-related helplines."
6	Value for Money	As noted in section 3.5.2 the international evidence showed there was conflicting evidence on the alternative telephone pathways impact on

Number	Feedback*	Response
	Table 3.3 (page 88) looked at the impact on other services (Primary care, ED and ambulance), in England and Scotland and the impact was inconclusive for ED's and ambulances. Australia was the only country that reported a positive impact for both ED's and ambulances. Given the projected cost of the project and the uncertainty about positive impact, is this good value for money? Will the alternative telephone service increase demand for GP services or negatively impact it as it did in Sweden and has the impact of this being considered or discussed with out of hour GP practices? If the money was redirected to the current triage services including out of hour GP practices, pharmacies, injury units etc would it have more of a positive impact on reducing ambulance use, and Emergency Department attendances.	primary care, ambulance services and EDs. However, assessing whether the proposed service represents good value for money or whether funding might yield greater benefits if redirected to existing services (such as GP out-of-hours, pharmacies, or injury units) was beyond the scope of this HTA. To do such an analysis would require data on longer-term patient outcomes and service utilisation, neither of which are reported in sufficient detail in the international literature. The objective of this assessment was to evaluate the organisational, clinical, and implementation considerations of establishing an alternative telephone pathway, rather than to conduct a full economic evaluation or determine resource allocation decisions.
7	The NPIC provided feedback highlighting a number of important operation and implementation-related questions. These included queries regarding clinical governance structures, training curriculums for clinical staff, call-back protocols, service-level agreements with third-party providers, clinical audit processes, complaint management procedures, and the resourcing of the service during peak demand periods.	The aim of this HTA was to assess the main requirements for the provision of a national alternative telephone pathway for acute, non-urgent care needs in the pre-hospital setting in Ireland. The focus of the HTA was specifically on examining the efficiency, safety, clinical effectiveness, and budget impact of introducing an alternative telephone pathway. As such, the HTA is intended to inform policy-makers and service planners by identifying key considerations that should guide the design and implementation of any future service. It was not within the scope of this assessment to design the service model itself, nor to address implementation-specific issues such as clinical governance structures, training curriculum, call-back protocols, service-level agreements with third-party providers, or the operational policies for complaints management and data capture.
	Irish Deaf Society	

Number	Feedback*	Response
1	To ensure equitable access to the proposed alternative telephone triage pathway, HIQA should explicitly recommend the integration of accessible communication options for Deaf people. This includes an Irish Sign Language (ISL) video relay service, text-based triage (via SMS or web chat), an accessible digital platform with ISL content and comprehensive Deaf Awareness Training for staff. Irish Sign Language (ISL) is the first and/or preferred language of the Deaf community and it is recognised as a language in its own right by means of the ISL Act 2017. Section 6 of the ISL Act 2017 requires public bodies to provide access to their services in ISL via ISL interpretation. Further, the State has the following obligations under the UNCRPD: ▪ Article 9 (Accessibility) obliges the State to ensure access to services, including ICT and emergency services. ▪ Article 21 (Freedom of Expression and Access to Information) requires the provision of information in accessible formats and technologies. ▪ Article 25 (Health) mandates that people with disabilities must receive the same range, quality and standard of healthcare services as others. Additionally under Section 42 of the Irish Human Rights and Equality Commission Act, public bodies must: ▪ Eliminate discrimination ▪ Promote equality of opportunity ▪ Protect the human rights of service users HIQA and the HSE have a duty to proactively consider the communication requirements of Deaf people and integrate accessible options from the outset, not as reactive add-ons.	Thank you for your feedback. Text has been added to section 5.2.3: "…the alternative telephone pathway should provide accessible communication options from the outset, including real-time text messaging, email, and video-calling with access to Irish Sign Language (ISL) interpretation. While the availability of ISL interpreters is currently limited, planning and funding must anticipate these needs to meet legal and equity obligations under the Irish Sign Language Act 2017."

Number	Feedback*	Response
2	A model operates in the UK called NHS 111 that is also designed to be accessible for Deaf people. It serves as a best practice example and comprises the following: ▪ Text Relay (Relay UK): Deaf users can type their message via the Relay UK app or a textphone and a relay assistant voices it to the NHS 111 call handler and vice versa. See here- https://www.relayuk.bt.com/how-to-use-relay-uk.html ▪ British Sign Language (BSL) Video Relay: Users can access NHS 111 through a BSL interpreter using services like SignVideo. See here- https://signvideo.co.uk/nhs111/ This model ensures that Deaf people can access urgent health advice independently and without needing to rely on hearing family members.	Text has been added to Section 5.2.3: "NHS 111 in England operates a text relay service which allows users to communicate via text using the Relay UK app, where a relay assistant converts the typed message in to spoken communication for the NHS 111 call handler and vice versa. NHS 111 also provides access via British Sign Language (BSL) video relay, enabling those who are deaf to communicate through a BSL interpreter using platforms such as SignVideo."
	PSI - The Pharmacy Regulator	
1	Workforce Planning and the Role of Pharmacists (Section 5: Organisational and System Implications; Section 6: Economic Evaluation) The draft assessment presents a thoughtful analysis of the triage workforce, distinguishing between clinical and non-clinical call handlers. We welcome the recognition of the valuable role that community pharmacists currently play in responding to symptoms and triaging. This acknowledgment reflects the understanding of and respect for pharmacists' expertise and their potential contribution to triage and support clinical decision-making processes within a future telephone triage pathway. We would suggest that further elaboration will be needed on the nature and extent of pharmacists' involvement in any future service, including the impact on existing workforce and associated workforce planning considerations.	Thank you for your feedback. The aim of this HTA was to assess the main requirements for the provision of a national alternative telephone pathway for acute, non-urgent care in the pre-hospital setting in Ireland. The focus was on evaluating the safety, clinical effectiveness, efficiency, and budget impact of such a service to inform decision-makers about key considerations for its potential implementation. As such, this assessment does not propose a definitive service model, nor does it address implementation-specific issues such as detailed workforce planning or the specific role and extent of pharmacist involvement. However, we agree that these will be important issues for policy-makers and service planners to consider in the design and roll-out of any future service. As noted in Section 7.3.3 "Implementation of an

Number	Feedback*	Response
		alternative telephone pathway could lead to workforce expansion, with more staff being employed and additional roles created. The health sector in Ireland is currently experiencing staff shortages, and services face significant resourcing challenges. Introduction of an alternative telephone pathway may worsen existing resource challenges in the health system. It is likely that many of the staff needed for this alternative telephone pathway would move from another section of the health service. Hiring embargoes would also have an impact on recruitment to this pathway."
2	Medication Safety and Integration with Pharmacy Services We suggest the report could consider in more detail how the proposed triage pathway will interact with existing community pharmacy services, and its role in supporting safe and effective use of medicines. We would recommend considering the incorporation of how integration of community pharmacy into the triage process could be best achieved. This could include areas such as protocols for onward referral, access to emergency supplies of medicines, and communication pathways to ensure continuity of care following telephone consultations. Following the implementation of the Common Conditions Service, there will also be the potential for conditions covered by this service to be signposted to as part of the triage pathway, and it may be worth referencing plans to introduce this service later this year.	While a service design or implementation plan is out of scope for this HTA, the assessment acknowledges the need for integration with existing services, as a key consideration for policymakers and service planners. Sections 5.2.1 and 5.2.2 discuss the impact the proposed telephone pathway would have on existing health services and key considerations for integration and collaborating with existing services. The implementation of the Common Conditions Service is referenced in Section 4.3 of the report: "In 2023, the Minister for Health launched an Expert Taskforce to support the expansion of the role of pharmacists. The objectives include expanding the scope of practice pharmacists, reducing the workload for GPs, and improving access for patients."
3	Continuity of Care and Communication with Primary Care Providers The draft HTA proposes the use of the alternative telephone triage service to redirect patients to more appropriate services, including general practice. However, the current lack of a national shared care record in Ireland poses challenges to continuity of care when a patient is advised to attend a GP or	We agree that implementation of the shared care record would be a key enabler to ensure appropriate information is accessible and to reduce duplication. The current absence of electronic health records (EHR) or patient identifiers in Ireland limits the ability to support this kind of direct integration. As noted in Section 7.2: "…the ability to provide a personalised approach can be facilitated if the operator has

Number	Feedback*	Response
	other healthcare professional urgently. Implementation of the shared care record would be a key enabler to ensure appropriate information is accessible and to reduce duplication. We would recommend that any model would also include clear protocols for when it is appropriate to communicate with the patient's GP or primary care team, e.g., when urgent in-person follow-up is advised.	access to the patient's electronic medical records. The National Shared Care Record, expected to begin rollout at the end of 2025, could enable more tailored care if effectively integrated with the alternative telephone pathway." The report highlights that absence of electronic health records is a risk in Section 7.2.1. And in Section 5.2.2 it is noted that "The lack of EHR in Ireland could limit the overall benefits of an alternative telephone pathway service if it was introduced in Ireland." We acknowledge the recommendation for clear protocols on when it is appropriate to communicate with the patient's GP or primary care team. While developing these protocols is outside the scope of this HTA, it is an important consideration for future service planning to ensure continuity of care.
4	The document is highly informative and reflects a significant depth of analysis across multiple domains. However, its overall length and density may present challenges for readers seeking to navigate the report efficiently, particularly those without a technical or clinical background. Figures such as workforce flow diagrams are helpful in illustrating key concepts, but these are often embedded within lengthy narrative sections, which may limit their effectiveness in clearly conveying the intended messages. We would recommend expanding the use of summary boxes, infographics, and visual aids to distil complex organisational and system content into more accessible formats. The inclusion of the brief key-point sections at the start of each major chapter is very helpful. The PSI is supportive of the development of a high-quality, patient-centred telephone triage system. We welcome the comprehensive nature of the draft	We acknowledge the concern regarding the report's length and density, especially for readers without a technical or clinical background. We have included a plain language summary and an executive summary specifically designed to support accessibility for non-technical audiences. These sections aim to distil key information and findings in a more concise and reader-friendly format. It should also be borne in mind that a HTA includes a range of domains to inform decision-making, and that decisions are based on consideration of all of those domains. We always strive to improve the accessibility, and we appreciate your recommendation to expand the use of summary boxes, infographics, and visual aids. We will take this on board as we continue to refine our approach to presenting complex organisational and system-level information in a more user-friendly format.

Number	Feedback*	Response
	HTA and appreciate the opportunity to provide input. We look forward to continued engagement in this process and remain available to provide further input or clarification as required.	

*Responses have been slightly amended to ensure anonymity and to correct for minor grammatical errors and or typos.

3.5 Changes to the report from the consultation process

The following changes were made to the draft report in response to comments and feedback received through the consultation process:

- Text throughout the report has been updated to refer to the proposed telephone line as a service rather than a pathway
- Section 2.2 has been updated to reflect Hear and Treat service is not a 24-hour service
- Section 2.2.3 has been updated to acknowledge the existence and function of ED outreach programmes such as EDITH
- Section 2.2.4 has been updated to reflect See and Treat initiatives are only available in some locations and do not operate a 24/7 service
- Section 3.2.5 has been updated to clarify that the international scoping review focused on the main national acute, non-urgent telephone service in each country, and did not access the integration of additional health-related helplines or advisory services
- Section 5.2.2 has been revised to recommend integration with national helplines and advisory services such as the National Poisons Information Centre
- Section 5.2.3 and 7.3.3 have been updated to highlight the importance of accessible communication options for individuals who are deaf and hard of hearing
- Section 5.2.3 has been updated to note that the CDSS should support redirection of relevant calls to national helplines and specialist advisory services
- Section 5.2.3 has been updated to include examples from NHS 111, highlighting accessibility features
- Section 5.2.6 has been revised to include considerations for ensuring the public information campaign is accessible to individuals who are deaf and hard of hearing
- Text has been added to section 5.4 of the report to acknowledge the Irish language legislation

In addition to the changes made above, the Advice to the Minister, an Executive Summary and a plain language summary are presented in the final report. Every attempt has been made in the plain language summary, the Executive Summary and

the Advice to the Minister to further emphasise issues of importance that were highlighted during the consultation process.

References

1. Health Information and Quality Authority. Draft health technology assessment of providing an alternative telephone pathway for acute, non-urgent medical care needs in the pre-hospital setting: Health Infomation and Quality Authority; 2025 [June 2025]. Available from: https://www.hiqa.ie/reports-and-publications/consultation/health-technology-assessment-providing-alternative-telephone.

Appendix A – copy of submission feedback form

Health Technology Assessment of providing an alternative telephone pathway for acute, non-urgent medical care needs in the pre-hospital setting.

Public Consultation feedback form

The Health Information and Quality Authority (HIQA) is holding a six-week public consultation to give people an opportunity to provide feedback on the health technology assessment (HTA) of providing a telephone pathway for acute, non-urgent medical care needs in the pre-hospital setting.

Your views are important to us. HIQA will carefully assess all feedback received and incorporate feedback into the report, where appropriate.

The final HTA and a statement of outcomes report (a summary of the consultation responses) will be published on HIQA's website once the HTA has been completed.

The closing date for the public consultation is 5pm on Wednesday 18 June 2025.

How to provide feedback:

- If you are commenting in a personal capacity, there is no need to provide your name or any other personal information.
- If you are commenting on behalf of an organisation, please combine all feedback from your organisation into one submission form. We will request a name and contact number for a designated representative from your organisation in case we need to clarify your feedback.
- If your feedback contains any commercially sensitive or confidential information, please highlight this at the time of submission, so it can be excluded from the summary of feedback that will be published by HIQA.
- Please spell out any abbreviations that you use.

You can **email** the completed form to consultation@hiqa.ie

OR

Print the consultation feedback form and **post** the completed form to:

Health Information and Quality Authority
Public consultation for Alternative Telephone Pathway
Health Technology Assessment
Dublin Regional Office
George's Court, George's Lane
Smithfield, Dublin 7
D07 E98Y

Data protection and Freedom of Information

HIQA will only collect personal information, such as the names of individuals who provided feedback or any other personal details during this consultation, for the purposes of seeking clarification on your feedback, if necessary. No personal information will be included in the stakeholder consultation document that will be published by HIQA.

Any response you provide will be held securely and anonymised. Information provided in your response, for example, an anecdote or statement about an experience may be included in the statement of outcomes that will be published by HIQA at the end of the HTA process. However, information will be provided in a manner which protects the privacy of respondents. All personal information will be deleted once no longer needed, in line with HIQA's record retention policy.

For further information on how HIQA uses personal information, please see our Privacy Notice available here. If you have any concerns regarding your personal information, please contact HIQA's Data Protection Officer on dpo@hiqa.ie.

Please note that HIQA is subject to the Freedom of Information (FOI) Act and the statutory Code of Practice in relation to FOI. We cannot give you an assurance that confidentiality can be maintained in all circumstances due to the requirements of the FOI Act.

☐ **I agree to take part in the public consultation**

1. About you

1.1 Your name:

1.2 Are you providing feedback as:

☐ an individual

☐ on behalf of an organisation

1.3 If answer is 'on behalf of an organisation', please give the name of the organisation:

If applicable, for clarification purposes, please provide your name, your role in the above organisation and your contact details:

You can request that your organisation's name be kept confidential and excluded from the published summary of responses:

☐ Do not publish organisation name

☐ Publish organisation name

This form contains two questions focused on the draft assessment. These relate to (i) general or specific feedback on the draft assessment, and (ii) the clarity or presentation of the draft report.

These questions are presented on the following two pages.

2. Your feedback on the draft health technology assessment

2.1 Please provide any general or specific feedback you have on the draft assessment. Where applicable, please specify the section of the draft assessment to which you are referring.

2.2 Please outline any issues with the clarity or presentation of the draft assessment. In your response, where applicable, please specify the section to which you are referring.

Thank you for taking the time to give us your views

After the closing date, we will carefully access all feedback and incorporate it into the report, where appropriate. The final report and the Statement of Outcomes (a summary of responses) will be published on www.hiqa.ie

If you have any questions, please contact the evaluation team at consultation@hiqa.ie or by phoning: (021) 240 9300.

Please ensure that you return your form to us either by email or post, to reach us by Wednesday 18 June 2025.

Published by the Health Information and Quality Authority (HIQA).

For further information please contact:

Health Information and Quality Authority

George's Court

George's Lane

Smithfield

Dublin 7

D07 E98Y

+353 (0)1 8147400

info@hiqa.ie

www.hiqa.ie