



National Disability Services Needs Analysis (2026)

Commissioned by:

The Health Service Executive

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A scenic view of a rural landscape featuring rolling green hills, scattered trees, and several houses. In the middle ground, a herd of cows is grazing in a field. The foreground shows a dirt path or field. A large, semi-transparent green shape covers the bottom left corner, containing the text '00 Executive Summary'.

00 Executive Summary

Executive Summary



"Disability is part of the human condition – almost everyone will be temporarily or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulties in functioning."

World Health Organisation, World Report on Disability

In Spring 2026, the Health Service Executive (HSE) commissioned a national needs analysis of disability services in Ireland. The purpose of the analysis was to provide an important first step towards developing an evidence-informed understanding of current and future requirements across the disability services system, including demand, capacity, workforce, service pathways and regional variation. The analysis was intended to inform future planning, policy development and investment decisions as services continue to evolve towards more person-centred, community-based and sustainable models of support.

National policy articulates an ambition to support disabled people to live lives of their own choosing, with services designed to promote independence, participation and inclusion. The Action Plan for Disability Services 2024–2026 reiterates this objective through its commitment to progressing person-centred approaches that are responsive to individual needs and preferences. Against this backdrop, the analysis considers the extent to which current arrangements are supporting the delivery of these policy objectives and identifies areas where variation, constraints or implementation challenges may be influencing service delivery and outcomes.

Table 0.1: System at a glance

Theme	
Population context	Census 2022 recorded 1,109,557 people (22% of the population) reporting a long-lasting condition, including 407,342 people (8%) reporting that their daily activities were largely limited.
Specialist services	A total of 101,373 people are recorded as registered for, or in receipt of, HSE-funded disability services for 2025, based on the National Ability Supports System (NASS). 86,871 of these access specialist supports. A total of 38,288 adults are recorded as accessing HSE-funded disability services.
Residential	Residential service capacity comprises approximately 8,469 places, excluding premises with shared respite/residential beds. This compares with identified demand of approximately 12,757 places, encompassing current service users (NASS), active applications (DSMAT), and future identified need (NASS), and indicates a difference of approximately 4,288 places (33%) between current capacity and identified demand.* This reflects an estimate of currently identified need and should be considered alongside ongoing work to update future capacity requirements associated with demographic growth and changing patterns of need.
Respite	A total of 10,457 people were identified as requiring respite supports. Of this cohort, approximately 23.5% represents identified unmet demand.
Children (CDNT)	Nearly 45,000 children are accessing Children's Disability Network Team (CDNT) services. As of May 2026, 7,234 children were awaiting service, while the gap between funded and filled WTE reduced from 29% to 18% between October 2023 and October 2025.
Assessment of Need	The average duration of Assessment of Need (AoN) processes was 24.93 months in Q2 2025. On 31 March 2026, the number of outstanding assessments exceeded 22,000, including 21,782 overdue assessments.
Workforce	Disability services employed 23,078 whole-time equivalent (WTE) staff across the HSE and Section 38 providers as of May 2026. Section 39 providers are estimated to employ a further 27,000 staff. Disability services also experience the highest levels of staff turnover (HSE and Section 38 staff) across HSE-funded care sectors.

*Sources explained in more detail later in report.

Executive Summary (cont.)

What the evidence tells us

Literature review: The review confirms a system in transition towards a rights-based, person-centred model, anchored in Ireland's 2018 ratification of the UNCRPD and the National Human Rights Strategy for Disabled People 2025–2030. It also shows that data and information infrastructure remains uneven and fragmented, demographic change is a structural driver of rising demand, and workforce recruitment and retention continue to limit the ability to turn funding into delivered services.

Data review: Drawing on national, administrative and service-level data sources, including NASS, DSMAT, live CDNT data, Assessment of Need reporting and workforce datasets, the evidence indicates that demand is increasing in both scale and complexity, while service capacity is expanding at a slower rate. Identified demand for residential services (12,757 people) exceeds current capacity (approximately 8,469 places). Occupational therapy and physiotherapy demonstrate some of the highest levels of additional identified demand relative to current service provision. A diagnosis of autism is indicated for a child in almost half of completed Assessment of Need reports, while the number of children in residential services has increased in recent years.



Fig 0.1: Executive Summary Key Metrics

Stakeholder and lived experience engagement: Engagement activities reached over 100 stakeholders and people with lived experience through three distinct methods. Individual interviews were conducted with 27 HSE staff, with a further two participants providing written submissions in lieu of interview. Interviews were also conducted with individuals from four voluntary organisations and three family members. Separate focus groups were held with nine additional family members. A total of 89 survey responses were received across family representatives, service users and voluntary sector providers.

Engagement findings were synthesised into 14 themes across six overarching categories. Across these themes, stakeholders described a system operating under sustained demand pressure, characterised by increasing complexity of need, workforce constraints, limitations in data availability and integration, and challenges in aligning service capacity with demand. Family members frequently described playing a central role in coordinating supports and navigating multiple service pathways, including, in some cases, supplementing publicly funded provision through privately funded supports. These perspectives were broadly consistent with the patterns identified through quantitative analysis and the literature review, providing a complementary source of evidence in understanding current system performance and service delivery.

Evaluation findings: Drawing together the quantitative analysis, literature review, stakeholder engagement and lived experience evidence, the needs analysis identified ten evaluation findings that were consistently reflected across multiple evidence sources. Collectively, these findings describe a system that has demonstrated measurable progress in a number of areas, including the implementation of CDNTs and increased AON activity, while continuing to operate in a context of sustained demand and capacity pressures. Across the findings, several recurring themes emerge. These include increasing demand and complexity of need, workforce constraints affecting service capacity, limitations in data availability and integration, challenges in planning and aligning resources to future demand, complexity in service pathways, variation in access across regions, and the need to align funding and capital planning with the pace and nature of service development. Together, these themes provide a framework for understanding current system performance and the factors influencing the delivery of disability services.



01

Introduction

Introduction

Overview

Ireland's disability services operate within a complex and evolving system, shaped by demographic change, policy reform and rising levels of demand. Disability is a common and lifelong dimension of the population rather than a fixed or marginal characteristic. As the World Health Organisation observes, *"disability is part of the human condition"*, and most people will experience some form of impairment during their lives.

In 2026, the HSE commissioned a National Disability Services Needs Analysis to develop a comprehensive, evidence-informed understanding of current and emerging requirements across disability services in Ireland. The analysis considers need across the full continuum of provision, including assessment pathways, therapeutic supports, day services, respite, residential care and community-based supports, spanning both children's and adult services.

The purpose of the analysis is to inform future planning, policy development and investment decisions, and to support the ongoing transformation of disability services towards more person-centred, equitable and sustainable models of care. The analysis takes a whole-system view, recognising that need is not defined by service volumes alone. It also concerns how effectively services enable participation, autonomy and quality of life, in keeping with the rights-based objectives now embedded in national policy.

This perspective is also consistent with a human security approach, which recognises that sustainable access to essential supports and the protection of rights are fundamental to health, wellbeing and quality of life. As recognised by the United Nations in General Assembly 66/290, human security is concerned with identifying and addressing widespread and cross-cutting challenges to people's survival, livelihood and dignity through people-centred, comprehensive and prevention-oriented responses. In the context of disability services, this reinforces the importance of ensuring that no one is left behind, recognising local circumstances and needs, strengthening resilience, and addressing emerging risks through prevention, early intervention, coordinated planning and timely access to supports.

Context and Rationale

Ireland's disability services are operating under sustained pressure. A combination of demographic, structural and workforce factors is driving increasing demand and greater complexity of need across the system.

Demographic change is a significant factor influencing future demand for disability services. Central Statistics Office projections indicate that the number of people aged 65 years and over will exceed one million by 2030. While some disabilities are present from birth, the majority are acquired across the life course, with Census 2022 indicating that 70% of people aged 20–64 years with a disability acquired their disability after the age of 16. Population growth, increasing longevity among people with disabilities, and rising levels of identified developmental need among children are expected to contribute to increased demand across disability services over the coming decade. Census 2022 is used within this analysis to provide demographic and population context and is not treated as a direct measure of service demand.

The policy and legislative environment has also changed significantly. Ireland's ratification of the UNCRPD in 2018 marked a decisive shift from a needs-based model of service provision to a rights-based framework that positions disabled people as rights-holders. That shift is now carried forward by the National Human Rights Strategy for Disabled People 2025–2030, described by Government as *"the primary whole-of-Government vehicle"* for advancing these rights, alongside the Action Plan for Disability Services 2024–2026. These frameworks set clear expectations around person-centred supports, independent living and equitable access.

The system also continues to face structural challenges. These include capacity constraints in assessment and service provision, fragmented processes and variability in access across regions, workforce shortages, and limitations in data and information systems. Together they contribute to a gap between identified need and the availability of timely, appropriate supports.

Purpose and scope

This needs analysis sets out to build a comprehensive understanding of current and emerging need. Specifically, it assesses demand, capacity and workforce; identifies policy and operational delivery, examines regional variation and system-level pressures, and provides integrated evidence to inform future planning and service development.

The scope of the analysis is intentionally broad, reflecting the interconnected nature of disability need across services, sectors and life stages. Individuals may access a range of supports over the course of their lives, including children's and adult disability services, specialist and mainstream provision, and

Introduction

services delivered across health, education, housing and social care systems. As a result, understanding current and future need requires consideration not only of individual services, but also of how different parts of the system interact, align and contribute to service delivery and outcomes.

Approach to the analysis

To deliver a robust and objective assessment, a phased, mixed-method approach was applied, integrating multiple sources of evidence:

- a **literature and policy review** sets out the strategic and legislative context and summarises published evidence regarding demand, assessment, service models and workforce;
- a **data review** examined national, administrative and service-level datasets, including Census 2022, NASS, DSMAT, live CDNT data, Assessment of Need reporting and workforce data, to establish the measurable scale of demand, capacity and unmet need;
- a **stakeholder and lived experience engagement** captured how services are experienced in practice by staff, providers and families; and an
- **evaluation stage** brought these data collections together, evidence from multiple sources was triangulated, with findings cross-checked across datasets, literature and stakeholder engagements to support a robust and evidence-informed assessment.

The results are expressed through 10 key evaluation findings, each supported across all three evidence strands.

Structure of the report

The report is structured to move from context, through evidence, to conclusions.

Methodology sets out the phased approach in full, including how documents, data and stakeholders were selected, and the limitations that apply to the findings.

Literature Review describes disability in Ireland today, the rights-based policy and legislative framework, assessment pathways, the mixed economy of HSE, Section 38, Section 39 and private provision, and the workforce that underpins it.

Data Review presents the quantitative data across population and service users, residential services, respite, day services, daily living supports, Children's Disability Network Teams and Assessment of Need, and the workforce, including regional variation and multi-year trends.

Stakeholder and Lived Experience Insights sets out the 14 themes identified through engagement, including the lived experience of families navigating the system.

Evaluation Findings brings the evidence together into 10 findings.

Conclusions draws out the overarching messages and considerations to support future planning, policy and investment in disability services in Ireland.

In summary, the analysis describes a disability services system that has demonstrated progress across several areas while continuing to operate under sustained demand and capacity pressures. Demand and complexity of need continue to increase, and variation in access and service experience remains evident across parts of the system. Establishing a clear and evidence-informed understanding of the current position provides an important foundation for future planning, investment and service development, and for monitoring progress over time.

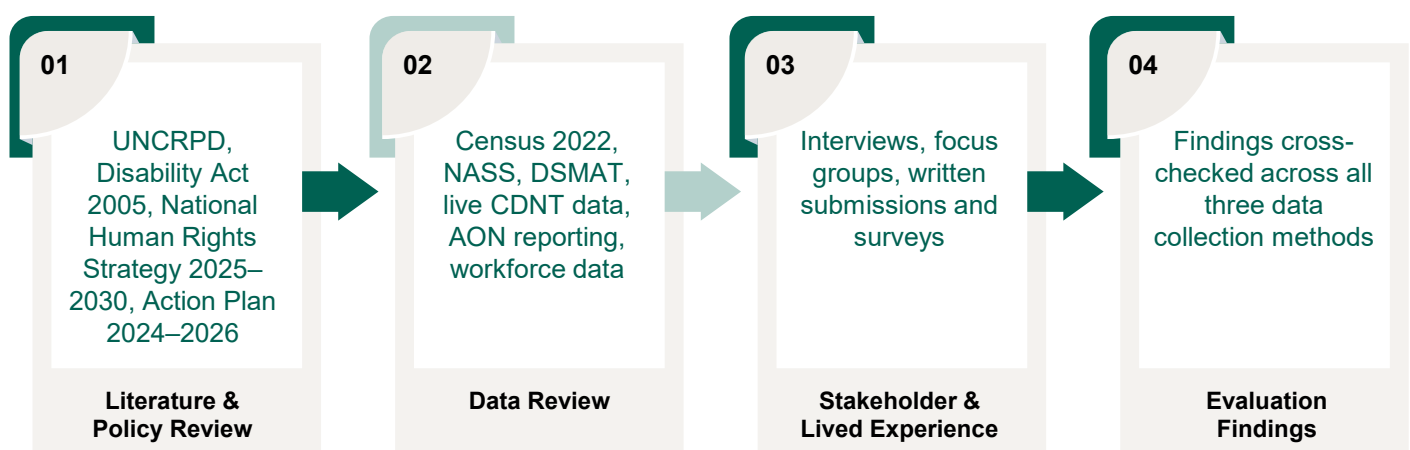


Fig 1.1: Implementation Approach



02

Methodology Overview

Overview of Methodology

Overview of the Review Methodologies

The Health Service Executive commissioned a national needs analysis of disability services to develop an evidence-informed understanding of current and emerging need across the disability services system. The analysis examined demand, capacity, workforce, service pathways and regional variation, with the objective of informing future planning, policy development and investment decisions.

A structured mixed-methods approach was adopted to ensure that findings were grounded in multiple sources of evidence rather than any single dataset or perspective. The methodology combined quantitative analysis, literature review and stakeholder engagement to provide complementary insights into current system performance, future service requirements and the factors influencing service delivery and outcomes.

The analysis was undertaken in four stages. First, a targeted review of national and international literature and policy documentation established the evidence base relating to disability need, service planning and models of care. Second, national, administrative and service-level datasets were analysed to examine patterns of need, service utilisation, workforce capacity and service provision. Third, stakeholder and lived experience engagement was undertaken through interviews, focus groups, surveys and written submissions to capture operational, provider, family and service-user perspectives. Finally, findings from each evidence stream were systematically triangulated and synthesised. This triangulation process enabled observations from one source to be tested and validated against the others, ensuring that conclusions reflected consistent patterns across quantitative, qualitative and documentary evidence.

EVIDENCE REVIEW

Literature Review | Identifying relevant literature via a targeted search strategy and documentation provided by the Health Service Executive and Voluntary Organisations in Disability Services. Once identified, completing a desk-based review of documents to provide a structured overview of how disability need is understood, assessed and responded to in Ireland, with the aim to inform understanding of current and emerging requirements in the service.

Data Review | Gathering and reviewing national data on disability services in Ireland, with a core focus on specialist disability services. Key steps included defining data inclusion and exclusion criteria, assessing data limitations, and extracting and presenting relevant descriptive data. It draws on multiple sources, including national datasets, administrative systems, and service-level data to provide a moment-in-time directional overview of patterns in population characteristics, service use, demand, and capacity.

Stakeholder Consultations | Identifying relevant stakeholders in consultation with the HSE and conducting consultations via interviews, focus groups and written submissions. Completing post-consultation analysis to identify themes and sub-themes and gain understanding of key gaps, needs and opportunities in Disability Services from the perspective and experience of individuals who work in, interact with, or avail of Disability Services in Ireland.

EVALUATION FINDINGS

Data integration | Synthesising quantitative and qualitative data to identify patterns, confirm validity of stakeholder observations and confirm accuracy of evaluation findings.

Findings | Qualifying 10 key findings supported by all three data strands.

REPORT GENERATION

Conclusion Development | Developing a set of overarching findings and considerations, with indicative implementation timelines and dependencies, to support future planning and policy development within disability services in Ireland.

Fig 2.1: Methodology Approach

Limitations to the Analysis

Literature Review Limitations

Availability and Currency of Evidence

The literature review drew on available national and international policy documents, published research, government reports and sectoral evidence. While every effort was made to identify the most relevant and current evidence, the review was limited by the availability, quality and recency of published material. Certain service areas, cohorts and emerging models of support were found to have a more limited evidence base than others.

Transferability of Findings

International research and examples of good practice were considered where relevant; however, differences in policy, funding arrangements, legislative frameworks, service delivery models, populations and context-specific need, may limit the direct applicability of international findings to the Irish disability services context.

Data Review Limitations

Reliance on Multiple Data Sources

This analysis draws on a range of national and local datasets, including NASS, DSMAT, Health Information and Quality Authority (HIQA), HSE operational data, AON reports, CDNT datasets, workforce reports and stakeholder engagement findings. These datasets were developed for different purposes, are collected at different points in time and use different methodologies, definitions and reporting boundaries. As a result, direct comparisons between datasets should be interpreted with caution.

Geographic Granularity and Data Availability

While the analysis incorporates county-level data where available, not all datasets were available at this level of granularity. In several instances, regional (RHA) data was used where county-level or local-level information was unavailable. Consequently, some findings may not fully reflect local variation in population demand, capacity or service access.

Service Demand Estimates May Not Capture All Unmet Need

Many measures of future demand are derived from NASS and DSMAT datasets, which largely reflect individuals known to disability services.

Consequently, the analysis may not fully capture:

- individuals not recorded in national systems;
- hidden or unmet demand;
- future demand associated with demographic change;
- people currently supported solely through family or community networks;

- individuals who do not meet access criteria for particular services.

Stakeholder engagement and provider survey findings suggest unmet demand may extend beyond that captured in administrative datasets.

Residential Capacity Analysis

Residential service use, identified future need, DSMAT applications and HIQA-registered capacity are derived from different datasets and should not be interpreted as a direct measure of occupancy or vacancy.

HIQA capacity reflects registered beds, while NASS and DSMAT measure service users and demand. As a result, comparisons between demand and capacity are intended to provide an indication of potential planning pressures rather than a definitive assessment of capacity shortfalls.

Respite Capacity Analysis

Unlike residential services, respite beds can support multiple individuals over the course of a year. Consequently, respite capacity cannot be directly compared with annual respite service user numbers. Capacity data has therefore been presented as an indicator of infrastructure availability rather than service throughput.

CDNT Data Represents an Operational Snapshot

CDNT datasets provide point-in-time operational information and are subject to ongoing change. Waiting lists, caseloads, referral volumes and service activity can fluctuate over time and therefore represent a snapshot of service demand and service activity rather than a measure of long-term trends or organisational performance. In addition, variation in local recording practices and implementation of national information systems may influence reported figures.

AON Data Reflects Statutory Assessment Activity Rather Than Service Demand

AON datasets provide information on applications, assessment activity, timeliness and identified support needs arising from the statutory Assessment of Need process. While AON data provides valuable insight into assessment demand and identified needs, it should not be interpreted as a direct measure of demand for disability services, as applications may be influenced by a range of clinical, educational and system factors. In addition, AON activity represents a statutory process rather than a service and should be considered separately from measures of service utilisation, capacity or intervention demand.

Limitations to the Analysis

Limited Information on Complexity and Outcomes

Most national datasets provide information on service activity, service utilisation and demand volumes. However, relatively limited information is available on:

- complexity of need;
- level of need and intensity of support required;
- individual outcomes;
- quality-of-life impacts;
- effectiveness of interventions.

As a result, the analysis is primarily focused on service access, capacity and demand, rather than service outcomes.

Workforce Data Limitations

Detailed workforce data was available primarily for HSE and Section 38 services. While Section 39 organisations constitute a significant proportion of the disability services workforce, detailed workforce composition, vacancy, turnover and discipline-specific data were not consistently available for these providers.

Accordingly, workforce findings should be interpreted as representing the available HSE and Section 38 workforce data rather than the entirety of the disability services workforce.

Future Demand Does Not Equal Future Capacity Requirement

Measures such as:

- current service users;
- identified future need;
- DSMAT waiting lists/applications;

represent different aspects of demand and may include overlapping populations. These figures should therefore not be interpreted as cumulative capacity requirements. Instead, they provide complementary perspectives on current utilisation, identified need and active demand for services.

Stakeholder Engagement Limitations

Representativeness of Stakeholder Perspectives

The stakeholder engagement process sought to include a broad range of perspectives from HSE services, service providers, family representatives and service users, advocacy organisations and other key stakeholders. However, the findings reflect the views and experiences of those who participated and may not fully represent the perspectives of all individuals, services or organisations within the disability sector.

Self-Reported Perspectives

Stakeholder findings are based on participant experiences, perceptions and opinions. While these perspectives provide valuable insight into how services operate in practice, they do not necessarily represent objective measures of service performance, service quality or unmet need. Findings have therefore been triangulated with quantitative data where possible.

Participation Bias

As with all voluntary engagement processes, there is a possibility that stakeholders with stronger views, higher levels of engagement or greater familiarity with the service system were more likely to participate. This may result in some issues being more prominently represented than others.

Provider and Family Survey Coverage

Participation in surveys was voluntary, and limited responses were received from the Provider survey. Consequently, findings should be interpreted as indicative of experiences rather than statistically representative of the entire provider and family representative landscapes.

Direct Participation of People with Disabilities

While the study incorporated perspectives from Disabled Persons Organisations, advocacy groups, family representatives and service providers, direct participation by individuals with disabilities was limited in some components of the engagement process. The perspectives presented therefore reflect a combination of lived experience input and representative stakeholder feedback rather than a comprehensive account of all lived experiences.



Interpretation: Findings should be read as a triangulated, evidence-informed assessment rather than a precise measurement of total unmet need.

Fig 2.2: Data Limitations

A photograph of a forest landscape. In the foreground, a dirt path leads into the woods, bordered by several large, moss-covered logs. Tall, slender trees with green foliage line the path, and sunlight filters through the canopy. A large, dark teal diagonal shape covers the bottom-left portion of the image, serving as a background for the title text.

03

Current Service Landscape Review



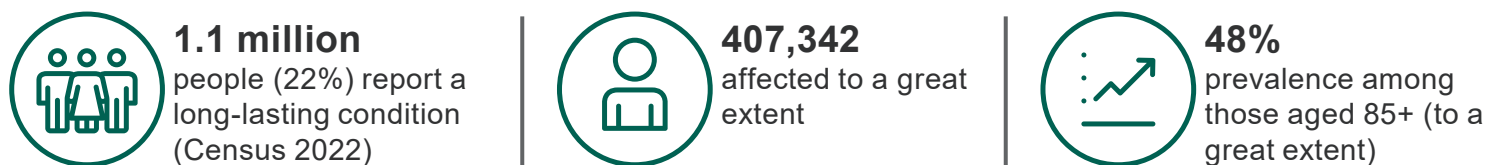
Literature Review



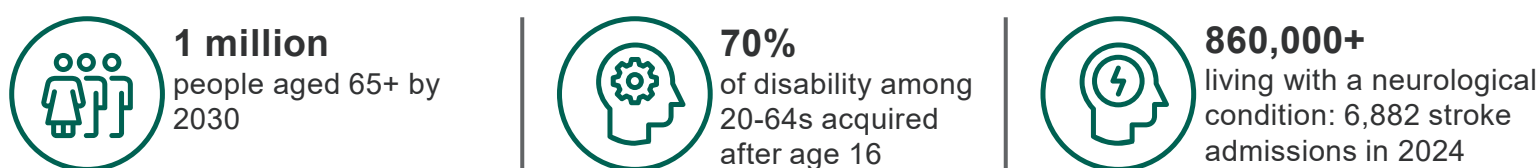
National Disability Services Needs Analysis 2026 – Literature Review at a Glance

Evidence base for Ireland's specialist disability services

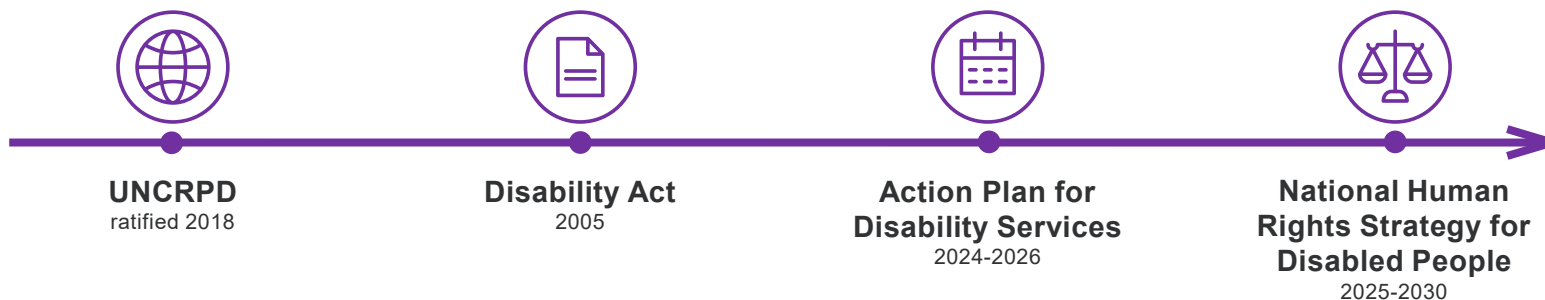
DISABILITY IN IRELAND



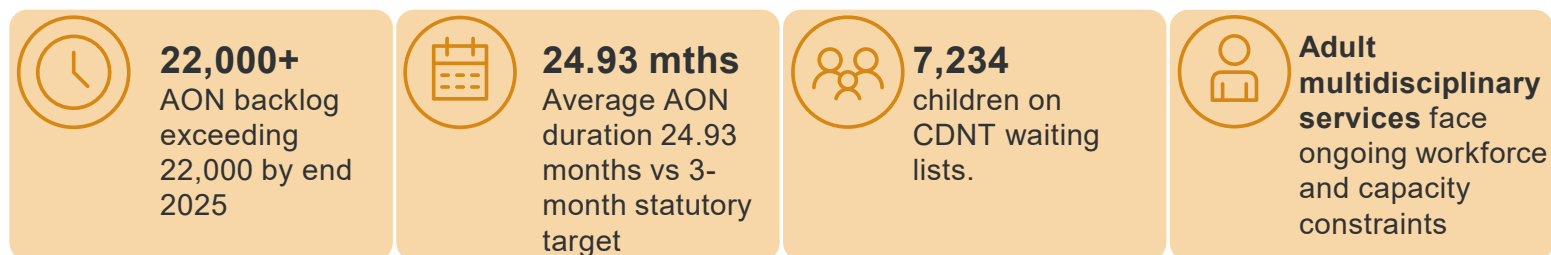
KEY DRIVERS OF DEMAND



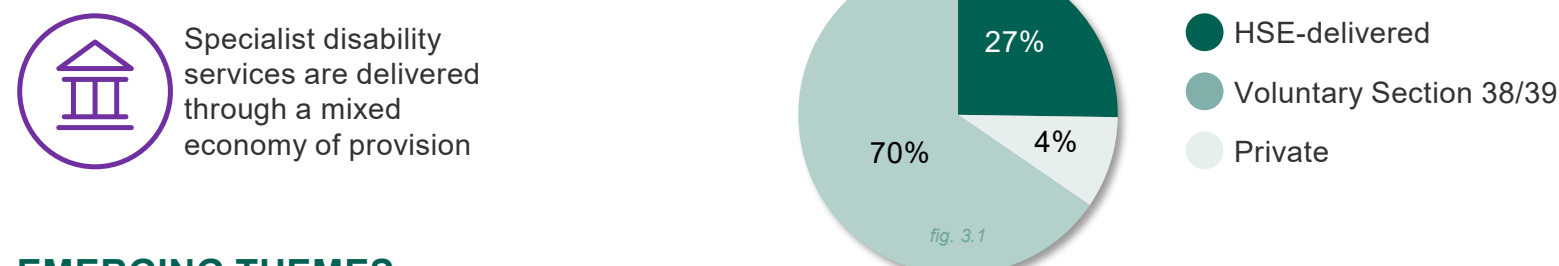
POLICY & LEGISLATIVE CONTEXT



SYSTEM PRESSURES



GOVERNANCE & DELIVERY



EMERGING THEMES



Fig 4.1: Literature Review Infographic

Literature Review Roadmap

How the evidence base is structured – National Disability Services Needs Analysis 2026

1



Disability in Ireland

- Pre-natal & Early Life Disability
- Childhood Disability
- Adult Acquired Disability
- Social Inclusion & Marginalised Groups
- Policy & Legislative Context
- Rights Based Legislative Framework
- Strategic Direction: Person-Centred Support
- Governance & Governmental Co-Ordination

2



Demographic Growth

3



Data Information Systems & Evidence Infrastructure

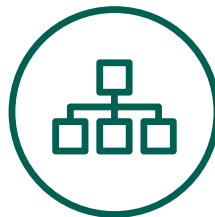
4



Disability Assessment Pathways & Access

- Models of Need
- Assessment and Eligibility Determination
- Timeliness and Consistency of Assessment Pathways
- Barriers to Access
- Equity of Access to Individuals with Complex or High Level Needs

5



Service Provision Models & Care Pathways

- Overview of Service Provision Across the Continuum
- Early Intervention and Children's Disabilities Services
- Therapeutic and Multi-Disciplinary Supports Across The Life Course
- Day Services and Meaningful Activities Supports
- Respite Services
- Residential & Community Living Supports
- Transitions Across The Life Course
- Effectiveness of Integrated & Community-Based Models

6



Workforce Capacity & Sustainability

- Workforce Supply, Demand and Skill-Mix in Disability Services
- Retention Challenges Across Disciplines
- Regional Workforce Variation
- Workforce Planning Models Aligned with Projected Demand



EVIDENCE SYNTHESIS → 10 EVALUATION FINDINGS

Triangulated across literature, data and stakeholder engagement

Literature Review Findings

Introduction

Disability is a significant and enduring concern for health and social care systems, with implications for individuals, families, services, and public policy. Understanding disability need involves more than identifying impairment or service use. It encompasses how people experience restrictions in daily life and the extent to which available supports enable participation, autonomy, and inclusion. For policymakers and planners, robust evidence on disability prevalence, patterns of need, and service responses is essential to inform decisions about resource allocation, service design, and long-term system sustainability.

In Ireland, disability services operate within a complex and evolving policy and service environment. Over recent decades, national legislation and policy have increasingly framed disability within a rights-based and person-centred perspective, emphasising equality, independence, and participation in community life. At the same time, disability supports are provided through a mixed system of mainstream and specialist services, delivered across multiple settings and stages of the life course. In this analysis, disability need is considered across the policy and legislative context, demographic and social change, data and evidence, access and assessment pathways, service provision, and the capacity of the workforce to deliver supports.

This literature review situates disability need and disability services within the contemporary Irish context. It draws together evidence from peer-reviewed academic literature alongside grey literature sources, including government policy documents, statutory reports, national datasets and publications from relevant agencies and organisations, to provide a structured overview of how disability need is understood, assessed, and responded to in Ireland. The purpose of the review is to inform understanding of current and emerging disability service requirements, with particular relevance to planning and service development.

Disability in Ireland

Understanding the scale and profile of disability and long-term health conditions within the population provides important context for assessing current and future service needs. The most recent national data comes from Census 2022, in which over 1.1 million people in Ireland reported at least one long-lasting condition or difficulty to any extent, representing 22% of the population. Of these, 407,342 people reported experiencing such a condition or difficulty to a great extent, while 702,215 reported experiencing one to some extent.¹

The proportion of the population reporting a long-lasting condition or difficulty in Census 2022 exceeds the World Health Organisation's global estimate of disability prevalence of 16%.² This difference may be partially attributable to changes in the Census methodology, including revised questions designed to capture a broader range of functional difficulties, including those with less severe impacts.¹ Consequently, the findings reflect a wider spectrum of disability and long-term health conditions than may have been identified through previous approaches to measurement.^{1,2} As Census 2022 is based on measures of functional limitation rather than medical diagnosis, it is used in this report as an indicator of disability prevalence. For the purposes of this analysis, the Census measure is considered broadly synonymous with disability, while recognising that it encompasses a wide range of long-lasting conditions and varying levels of functional impact.

Disability prevalence demonstrates a pronounced age-related pattern, increasing steadily across the life course. Prevalence is 4% among children aged 0–4 years, 17% among 15–19-year-olds and 16–19% across the 20–49 age band. It then rises to 22% at ages 50–54 and 38% at ages 70–74, reaching 76% among those aged 85 and over of whom almost half (48%) experience a condition to a 'great extent' as categorised in the Census.^{1,3} These patterns support the application of a life-course perspective in understanding disability prevalence and support needs consistent with the social and human-rights models articulated by the UNCRPD.⁴

The World Health Organisation's Framework to Implement a Life Course Approach in Practice (2025) provides the most recent international framework for applying a life-course perspective. The framework conceptualises health and well-being as the product of interacting genetic, biological, psychosocial and environmental factors that accumulate across sensitive and critical periods and are transmitted intergenerationally, strengthening equity by recognising how transitions and cumulative exposures shape health trajectories.⁵

From this perspective, disability experience is not a fixed individual attribute but is shaped over time by cumulative exposures across the life course, from early life and childhood development through adulthood and into healthy ageing.⁵

Literature Review Findings

This reflects how health, social conditions, and service access interact from early life onwards, with early intervention and equitable access to care playing a key role in influencing long-term outcomes.

The World Health Organisation (WHO) framework therefore prioritises equity-orientated, multisectoral action, early intervention and the reorientation of primary health care to interrupt cumulative disadvantage, aligning closely with the social and human-rights models advanced under the UNCRPD.^{4,5} These findings highlight the importance of adopting a life-course approach to disability planning, recognising that support needs emerge and evolve over time and that effective intervention at key transition points can influence long-term outcomes and service demand. This approach is also consistent with the principles of Universal Health Coverage, which emphasise equitable access to necessary services without financial hardship and increasingly recognise disability inclusion as a core component of health equity.⁵

Prenatal and Early-Life Disability

Prenatal and early-life disability is associated with a range of health conditions and developmental risks, with outcomes influenced by maternal and child health, socioeconomic circumstances, and access to health services and early interventions, including maternal and child healthcare.⁶ High-quality prenatal and antenatal care supports improve maternal and infant outcomes through early identification and management of potential issues, alongside preventive interventions that help reduce the likelihood of adverse pregnancy and early-life outcomes.⁷

In life-course terms, prenatal risks illustrate how early-life health outcomes are shaped by interacting biological, psychosocial and environmental factors, including socioeconomic conditions, health literacy, service access and wider social norms influencing alcohol use in pregnancy.^{5,7,8}

Childhood Disability

Census 2022 indicates that intellectual disability is reported more frequently among younger age cohorts, while difficulties relating to learning, memory and concentration affect a notable proportion of the population.¹ Among those reporting such difficulties to a great extent, approximately one-third are aged under 20 years. Males are disproportionately represented within this population group.⁹

Longitudinal evidence from the Growing Up in Ireland study indicates that identified disability is more prevalent among children from lone-parent households, families in lower socio-economic groups, and those living in rented accommodation. These findings suggest an association between socio-economic circumstances and patterns of disability identification,

highlighting the influence of broader social determinants on child health and development outcomes.¹⁰ Households that include a person with a disability often face higher living costs alongside lower household incomes, increasing the risk of material deprivation and financial hardship and reducing their capacity to absorb additional expenses.¹¹ These challenges may be compounded by factors such as lower levels of health literacy, communication barriers, and limited access to clear and accessible information. Reliance on family members or carers to navigate services can further affect awareness of available supports and influence engagement with screening, assessment, and service-access pathways.¹²

These inequalities may be further exacerbated by delays within the public AON process. Families with greater financial resources may be able to access private assessments and therapeutic supports, whereas lower-income households are more likely to depend on publicly funded services, potentially resulting in differences in the timeliness of assessment and access to intervention.¹⁰

Adult Acquired Disability

The Healthy Ireland Survey 2025 indicates that a substantial proportion of the population experiences a long-lasting condition or difficulty, with 36% reporting such a condition.¹³ The prevalence of long-lasting conditions increases progressively with age, reflecting the cumulative impact of health-related challenges across the life course and highlighting the growing demand for health and social care supports among older population groups.¹³

Socioeconomic conditions compound adult-acquired disability across the life course. Irish Human Rights and Equality Commission (IHREC)/Economic and Social Research Institute (ESRI) analysis estimates the additional cost of disability at approximately 52–59% of disposable income on average, rising to around 83–93% for households with severe limitations depending on the method used.¹⁴

When these additional costs are accounted for, the at-risk-of-poverty rate for disabled adults increases from approximately 24% to between 65% and 76%.¹⁴ State-commissioned evidence similarly identifies a sustained "spectrum" of unmet costs across care, transport, equipment and energy.¹⁴ These pressures constrain disabled adults' capacity to meet out-of-pocket charges for therapy, assistive technology, accessible transport and home adaptations.

Literature Review Findings

Social inclusion and marginalised groups

Applying a social inclusion perspective highlights the potential for compounded disadvantage where disability intersects with other axes of exclusion.

Irish Travellers experience life expectancy approximately 15 years lower for men and 11.5 years lower for women than the general population, infant mortality 3.6 times higher and male suicide rates seven times the national average.¹⁵ Experiences of discrimination and broader structural and engagement-related factors may also influence how individuals access and interact with health services.^{15,16}

Within LGBTQI+ communities, the national Being LGBTQI+ in Ireland study documents significant rises since 2016 in severe symptoms of depression (+17%), anxiety (+30%) and stress (+33%), with younger and transgender respondents particularly affected.¹⁷ The National LGBTQI+ Inclusion Strategy II 2024-2028 acknowledges persistent gaps in inclusive healthcare for LGBTQI+ people, including those who are disabled.¹⁸

Among people experiencing homelessness in Dublin, physical and cognitive rehabilitation needs were identified in over half of inclusion-health cases, yet none of those with identified needs had access to rehabilitation services.¹⁹ In response to these challenges, the HSE published its first National Strategic Plan to Improve the Health of People Experiencing Homelessness 2024–2027, establishing a framework to address health inequalities and improve access to integrated and person-centred services.²⁰

Migrants and international protection applicants with disabilities are recognised as a particularly vulnerable group; while Ireland has introduced a vulnerability assessment programme since late 2024, its application remains uneven, with some applicants still subject to a more limited triage approach.²¹ Taken together, these findings suggest that the exclusion experienced by many people with disabilities is not merely the result of individual circumstances but reflects broader structural and systemic inequalities. Addressing these challenges, and fulfilling Ireland's obligations under the UNCRPD, will require a coordinated, cross-sectoral response spanning health, education, housing, social protection, and other public services.⁴

Policy and Legislative Context for Disability Services

This section outlines the national policy and legislative frameworks shaping disability service planning in Ireland, providing critical context for understanding current service expectations, constraints, and future demand.

Rights Based Legislative Framework

The contemporary policy landscape for disability services in Ireland is fundamentally structured around Ireland's ratification of the UNCRPD in March 2018.⁴ This ratification marked a paradigm shift from a needs-based service provision model to a rights-based framework positioning disabled people as rights-holders entitled to human rights on an equal basis with others.⁴ The National Human Rights Strategy for Disabled People 2025-2030, published in September 2025, represents the first overarching disability strategy developed since ratification and establishes the primary whole-of-government vehicle intended to advance human rights for disabled people, providing a progressive realisation of UNCRPD obligations over a five year timeframe.²² This rights-based framework is legally underpinned by a set of complementary statutes that collectively define the structure of disability services in Ireland. The Disability Act 2005 establishes statutory obligations in relation to public service accessibility, employment quotas, and sectoral planning mechanisms.²³ This is further strengthened by the Assisted Decision-Making (Capacity) Act 2015, which introduces supported decision-making and sets out a replacement for the wardship system,²⁴ directly implementing UNCRPD Article 12 on legal capacity.³

In parallel, the Health Act 2007 provides the regulatory infrastructure for independent oversight of service quality and safety by the HIQA.²⁵ Together, these instruments form a coherent legislative architecture to support both rights protection and the regulation of service delivery.

The UNCRPD framework emphasises that persons with disabilities are rights holders and that supports should enable autonomy, choice, and full participation, shifting the focus of “need” beyond purely service provision or functional limitations.²⁶ Within this framework, fulfilment can be understood as the extent to which individuals are enabled to exercise independence, choice, community participation, and equal citizenship.^{4,26} This is consistent with the United Nations approach that States should take steps, using the maximum of available resources, towards the progressive realisation of economic, social and cultural rights where immediate full provision is not feasible.²⁷ The legislative architecture therefore establishes an enabling framework for rights protection, while also highlighting the practical interaction between rights commitments and resource allocation that influences implementation.

Literature Review Findings

Strategic Direction: Person-Centred Support

Policy frameworks are increasingly aligned around a transformative vision for disability services, characterised by a shift away from provider-led, group-based models towards individualised, person-centred supports that promote autonomy, independence, and community inclusion. The Action Plan for Disability Services 2024-2026 articulates the vision "to transform traditional services to a person-centred model which supports individuals to live lives of their choosing, as independently as possible, through supports that are tailored to their needs".²⁸ This philosophy is reflected in New Directions policy for day services and the "Time to Move on from Congregated Settings" strategy for residential care. These position individual choice, autonomy, and community integration as core policy goals, directly aligned with UNCRPD Article 19 for independent living.^{4,28,29}

The National Human Rights Strategy 2025–2030 supports this transformation through specific actions. These include developing a National Policy on Personal Assistance, trialling personalised budgets so disabled people can purchase tailored supports and gradually aligning community-based residential services with independent living principles.²² Independent living is not classified as living without support, but having "choice and control over your life".²² Realising this approach has implications for how supports are organised, including the commissioning, funding, and delivery of services in line with independent living principles.²²

The transformation agenda places increased emphasis on a person-centred understanding of need, moving beyond a sole focus on service provision towards supports that promote choice, autonomy and independence.^{22,28} An aspirational future-state model would see flexible, individualised funding mechanisms rather than block-grant service packages, requiring different planning, commissioning, and oversight infrastructures. The persistence of congregated settings, despite policy commitments to deinstitutionalisation since 2011,²⁸ may indicate ongoing challenges in achieving full system transformation.

These challenges are often associated with factors such as capital investment requirements, workforce capacity, and governance arrangements needed to support person-centred service delivery. From a needs analysis perspective, this involves considering not only the availability of service capacity (number of places), but also the requirements associated with planning and implementing deinstitutionalisation, including the development of community-based and inclusive support services.³⁰

Governance and Governmental Coordination

The National Human Rights Strategy for Disabled People 2025 - 2030 establishes whole-of-government delivery structures to enable coordinated implementation and strengthen oversight. Responsibility for delivering the commitments under each of the Strategy's five Pillars rests with the relevant Government Departments and State Agencies, organised into five pillar groupings. Oversight is provided by the Cabinet Committee on Disability, supported by the Senior Officials Group and the Disability Unit in the Department of the Taoiseach, while a Delivery and Monitoring Committee, chaired by the Taoiseach and including Disabled Persons' Organisations, directs implementation, supported by a Data and Evidence Working Group led by the National Disability Authority.²²

The governance landscape is characterised by structural complexity shaped by the transfer of specialist disability services from the Department of Health (DOH) to the Department of Children, Disability and Equality (DCDE) on 1 March 2023.³¹ This saw DCDE assume responsibility for a disability health budget of €2.3 billion p.a and for future investment in specialist disability services. This aimed to transform service delivery by investing in community-based supports and improving integration between services, while aligning disability policy with DCDE, the department responsible for equality and UNCRPD coordination.³¹

As highlighted by the Disability Federation of Ireland, this approach is dependent in particular on the effective and coordinated integration of services.³¹ They note that, at the time of publication of the Disability Capacity Review to 2032 (2021), approximately 90% of disabled people were not availing of specialist services, but instead were relying on general community health and social services which remain under DOH remit.³¹ This division may give rise to challenges in ensuring continuity of care within a complex healthcare system, particularly for individuals who acquire a disability, experience changing needs or require shifting mixes of specialist and mainstream supports.³¹ The Disability Capacity Review to 2032 identified approximately 27% of specialist disability services are HSE-delivered, almost 70% delivered by Section 38 or Section 39 voluntary organisations, and 4% by private providers.³² Pay parity issues between Section 39 staff and equivalent HSE/Section 38 staff have led to recruitment and retention difficulties, creating workforce constraints that limit system capacity to convert funding into delivered services.^{32,33} While these workforce issues are explored in more detail later in this review, they form an important aspect of the governance context within which policy commitments are implemented.

Literature Review Findings



Disability in Ireland Summary

Ireland's disability service framework is fundamentally structured around the UNCRPD ratified in March 2018, marking a shift from needs-based provision to a rights-based model.⁴ The National Human Rights Strategy for Disabled People 2025–2030 provides the primary whole-of-government vehicle for implementing UNCRPD obligations.²² Key legislation includes the Disability Act 2005 (public service accessibility and sectoral planning), the Assisted Decision-Making (Capacity) Act 2015 (supported decision-making), and the Health Act 2007 (regulatory oversight by HIQA).^{23,24,25}

Strategic policy emphasises transformation from provider-led, group-based models to person-centred, individually tailored supports enabling independent living and community participation. The Action Plan for Disability Services 2024–2026, New Directions, and Time to Move on from Congregated Settings articulate this vision.^{28,29}

Governance structures include the Cabinet Committee on Disability and coordination by DCDE, which assumed responsibility for specialist services from the Department of Health in March 2023.³¹ Service delivery involves mixed economy arrangements: 27% HSE-delivered, 70% voluntary organisations, 4% private providers.³² Workforce constraints and uncertainty regarding multi-annual funding present implementation challenges.^{22,31,32}

Finally, uncertainty regarding multi-annual funding presents challenges for longer-term governance and planning. The Disability Capacity Review to 2032 and advocacy organisations have emphasised the importance of multi-annual funding to support forward planning, workforce planning, and the planned expansion and reform of disability services over the long term..^{22,31,32} The absence of fully established medium-term funding certainty may affect providers' ability to plan services, develop infrastructure, and implement reforms at scale.^{22,31}

Demographic Growth

This section examines demographic trends which are a key determinant of current and future patterns of disability need in Ireland. Two interrelated demographic trends are particularly significant in this context: population ageing and increasing longevity among people with disabilities.

Ireland's population is ageing rapidly. The Central Statistics Office projects that the number of people aged 65 years and over will exceed 1 million by 2030, with significant implications for disability prevalence and support needs.³⁴ Census 2022 data demonstrates a clear age-related gradient in disability, with prevalence rising markedly in older cohorts.³⁴ This demographic shift is associated with increased demand for disability services, reflecting both projected population ageing and higher disability prevalence in older age groups.³⁴

Demographic change is also altering the profile of need among people with disabilities. The literature suggests that the historical development of intellectual disability services in Ireland was predicated by assumptions regarding lower life expectancy among people with intellectual disabilities. Improvements in longevity have since altered the demographic profile of this population, creating new considerations for service planning, particularly in relation to ageing, health needs, and long-term support requirements.³⁵ This has given rise to new and more complex needs, as demographics have become increasingly diverse, with health issues varied and multi-faceted.³⁵ Consequently, the proportion of older people within intellectual disability services is increasing, accompanied by previously under-acknowledged age-related complexity.³⁵



Emerging themes

Governance complexity

Workforce Constraints

Multi-annual Funding Uncertainty

Literature Review Findings

Alongside these trends, changing family structures are also influencing the context in which support needs arise. Increasing longevity has led to a growing cohort of individuals with disabilities living with, or relying on, ageing parents.^{32,35} As parents and primary carers advance in age, this dynamic introduces additional considerations in relation to sustainability of informal care arrangements, forward planning, and the timing and nature of engagement with formal services.

The interaction between population ageing and advances in life expectancy creates compounding pressure on disability services. Changes in the age profile and life expectancy of people with disabilities are reshaping the nature and distribution of support needs.³ This demographic evolution is not a transient phenomenon but a structural shift that will continue to influence the level and profile of support needs over the coming decades. While many individuals who acquire a disability in later life are supported through mainstream health and social care services, including Older Persons' Services, increasing longevity among people already engaged with specialist disability services is also contributing to changing patterns of need.

While congenital and childhood-onset disabilities remain important considerations, evidence from Ireland and internationally indicates that the majority of disabilities are acquired over the course of an individual's lifetime rather than being present from birth.^{36,37} The National Disability Authority's (NDA) 2024 Disability Statistics Factsheet found that the proportion of people with a disability rises with age because most disabilities result from accident or illness during adulthood.^{36,37} Compounding this, the Disability Federation of Ireland notes that 70% of people aged 20-64 with a disability acquired it after the age of 16, highlighting the centrality of adult-onset pathways.^{36,37}

Census 2022 confirms this life-course pattern with reported long lasting conditions rising from 4% of children aged 0-4 to 76% of those aged 85+, with a rise from age 50.¹ Internationally, the World Health Organisation attributes the increase in disability prevalence, now estimated at 1.3 billion people or 16% of the global population, primarily to population ageing and the growing burden of non-communicable diseases.³⁸ Neurological conditions such as stroke, dementia and migraine are now the leading global cause of illness and disability.³⁹

In Ireland, more than 860,000 people live with a neurological condition.⁴⁰ Data published by the National Office of Clinical Audit (NOCA) show that stroke admissions reached 6,882 in 2024, extending the upward trend observed in recent years and underscoring the increasing burden of stroke-related disability and rehabilitation need.⁴¹

The NOCA reported that 73% of stroke patients were admitted to a stroke unit in 2024, representing a modest improvement in access to specialist stroke care, although this remained below the national target of 90%. Early Supported Discharge was provided to approximately 11% of patients, and 5% received psychological assessment.⁴¹

Implications for service planning are substantial. The Health Research Board's (HRB) 2026 NASS publications recorded 38,288 adults engaging with HSE-funded disability services in 2025.⁴² This represents an improvement in the coverage of the dataset, and continued increase in the number of adults in contact with services, particularly day services. Demand remains evident across a range of supports, including residential care, home support, personal assistance and specialist therapies.⁴² This suggests that consideration of disability pathways encompasses not only congenital and childhood-onset disabilities, but also chronic illness, injury, and neurological conditions, together with the rehabilitation, community-based, and longer-term supports that may be required across the life course.

Data, Information Systems, and Evidence Infrastructure

The assessment of disability need in Ireland is informed by a range of data and information sources that vary in scope, coverage, methodology, and level of maturity.

The HRB's National Intellectual Disability Database (NIDD) has historically provided robust data relating to people with intellectual disabilities using or requiring specialist services, while the former National Physical and Sensory Disability Database (NPSDD) experienced incomplete and inconsistent participation, limiting its representativeness.³² These systems were replaced by the introduction of the NASS which provides a more comprehensive, integrated approach to collecting information on people using specialist disability services, including people with physical or sensory disabilities and autism.³² NASS commenced data collection in 2019 and continues to evolve as a national information source. While NASS has expanded over time, the coverage of disability data collection, the dataset continues to evolve in terms of completeness and breadth of participation.³²

CSO Census data provides population-level prevalence and demographic profiles, with Census 2022 offering enhanced detail on disability and functional limitation.¹ However, the disability questions in Census 2022 were substantially revised and thus results are not directly comparable with earlier census waves, reinforcing the need to triangulate Census data with administrative sources.¹

Literature Review Findings

At service level, HSE administrative systems, such as the National Day Service Database, provide detailed information on referrals, support needs and service use.²⁹ However, some aspects of provider reporting are not yet fully standardised.²⁹ Effective needs assessment draws on multiple data sources, is updated as new evidence emerges, and recognises uncertainty in projections.⁴³ Further integration of population, service-use, and workforce datasets will strengthen the evidence base for system-wide analysis of disability need.^{29,31}

Disability Assessment Pathways and Access to Services

This section examines disability assessment pathways and access to services in Ireland, outlining how statutory frameworks and operational practices shape entry to, and navigation of, the disability services system. It provides context on how assessment processes interact with service capacity, timeliness, and equity of access.

Assessment Pathways and Eligibility Determination

The statutory framework for disability needs assessment in Ireland is established under Part 2 of the Disability Act 2005, which provides AON to determine the health or educational services required by a person with a disability.²³ The Act defines disability as a substantial restriction in the capacity to carry on a profession, business or occupation, or to participate in social or cultural life, by reason of an enduring physical, sensory, mental health or intellectual impairment.²³ Eligibility for assessment was initially restricted but was expanded following a High Court ruling in 2009, which opened eligibility to all persons born after 1st June 2002 who are suspected of having a disability.^{23,32,44} Since June 2020, all persons born after 1 June 2002 are eligible for assessment.^{23,32,44}

The assessment process is undertaken or arranged by the HSE and must be carried out in accordance with standards determined by HIQA.²³ Under the Disability Act, the HSE must commence the assessment within three months of application, and complete it without undue delay.²³ The AON aims to identify whether a person has a disability, the nature and extent of that disability, any health and education needs arising from it, and what services are required to meet those needs.²⁸ While an AON is not required to access disability services, it provides a formal statutory assessment of disability-related needs and associated service requirements.

For adults, access to disability services is generally determined through service-specific referral, assessment and eligibility processes rather than through a statutory assessment process equivalent to AON. Depending on the service required, assessments may be undertaken by disability service providers, multidisciplinary teams or healthcare professionals, with access informed by the individual's support needs, eligibility criteria and local service availability.

A significant development in the AON process came from a High Court judgement ruling in March 2022. The ruling found that the Preliminary Team Assessment approach did not fulfil the statutory requirements of the AON under the Disability Act, stating that a diagnosis is required to determine the nature and extent of a person's disability.²⁸ This judgement necessitated significant adjustments to assessment processes and led to a large percentage of AONs needing to be repeated leading to backlogs and necessitating specific funding measures.²⁸

In December 2025, DCDE announced targeted reforms to the AON process.⁴⁵

These introduced assessment officers supported by eleven new teams comprising 44 expert staff (psychologist, speech and language therapist, occupational therapist, and administrator per team).⁴⁵ These reforms aim to focus the AON process on establishing needs rather than producing lengthy diagnostic reports, whilst maintaining statutory timelines and parental rights.⁴⁵

Access to Children's Disability Network Teams

Access to CDNTs is separate from the statutory AON pathway and does not require completion of an AON.⁴⁶ Children access CDNTs through referral, with healthcare professionals assessing whether a CDNT or another service is most appropriate based on the information provided.⁴⁶ CDNTs are composed of multidisciplinary teams including occupational therapists, speech and language therapists, psychologists, physiotherapists, social workers, and clinical nurse specialists, operating under a family centred practice model.⁴⁶ CDNTs support children up to age 18 with complex needs arising from intellectual disability, physical disability, sensory disability, chromosomal disorders, neurological disorders, or neurodevelopmental disability.⁴⁶

Timeliness and Consistency of Assessment Pathways

Data on the timeliness of AON processes indicate delays relative to statutory timelines. In September 2025, the Minister for Children, Disability and Equality reported that the average duration of the assessment

Literature Review Findings

process was 24.93 months for AON reports completed nationally in Q2 2025.⁴⁷

Demand for AONs has increased in recent years. The number of assessment referrals rose from 4,700 in 2020 to 10,000 in 2024,⁴⁸ with evidence suggesting continued growth, including an 8 per cent year-on-year increase reported by the midlands area CDNT over a three-year period.⁴⁸

DCDE estimated that the backlog of AON applications would exceed 22,000 by the end of 2025.⁴⁵ Progress has been observed in efforts to narrow this gap; in the first three quarters of 2025, 4,534 AON assessments were conducted, with an estimated 6,000 assessments to be completed by year end, representing a 44% increase compared to 2024.⁴⁵

Capacity constraints are evident in the difference between demand levels and the system's ability to respond. As of March 2025, the HSE's public health service capacity to deliver assessments of need was estimated at approximately 3,600 per year.⁴⁸

To support the reduction of waiting lists, the government procured 2,100 private needs assessments between May and November 2024 at a cost of €6.9 million (average €3,300 per assessment), with a further €10 million allocated for approximately 2,850 private assessments in 2025.⁴⁸ Projections suggested that waiting lists would increase by approximately 3,500 in 2025, despite the measures implemented.⁴⁸

For access to CDNTs, separate waiting time data indicates variability across teams and regions. As of May 2026, 7,234 children were on CDNT waiting lists across 93 CDNTs.⁵⁰ Approximately 64% (4,625) had been waiting over 12 months (13–24 months or over 25 months).⁴⁹ An illustrative example from the Dublin North Inner City CDNT showed 65 children on the waiting list with an average wait of 13 months, though 72% of those waiting had attended or been offered waitlist interventions such as advice clinics or brief episodes of intervention.²⁸ Prior to reconfiguration, the same geographic area had 79 children on waiting lists of up to five years.²⁸

Evidence from a 2025 clinical workforce survey suggests inconsistency in prioritisation and pathway application.⁵⁰ Surveyed speech and language therapists working in CDNTs reported variation in the application of prioritisation criteria, both within and across teams, which was associated with inconsistent access to disability services. The definition of “complex needs”, which forms the basis for CDNT eligibility, was described as insufficiently clear in practice. Therapists reported spending considerable time determining

whether a child's needs met the threshold for CDNT services or whether referral to primary care was more appropriate.⁵⁰

Barriers to Access

A range of structural and systemic factors can influence access to assessment and disability services. The Action Plan identifies workforce capacity, including recruitment and retention challenges and shortages of suitably qualified staff, as a significant factor affecting service access and delivery.²⁸ Between 2019 and 2023, additional posts were allocated to children's specialist disability network teams.²⁸ However, these developments were accompanied by ongoing challenges in recruitment in some areas.²⁸

As of July 2025, there were no fully staffed Children's Disability Network Teams (CDNTs).⁵¹ However, HSE data from April 2025 indicates that the CDNT workforce had grown to 2,009 WTE, representing an increase of 414.5 WTE since October 2023. Over the same period, the vacancy rate fell from 29% to 18%, the lowest level recorded since October 2021.⁵¹

A further barrier relates to the time required to complete Assessments of Need. At the time of the DCDE 2025 reforms, therapists were reported to be spending up to one third of their time producing clinical assessments as part of the AON process, reducing availability for therapeutic intervention.⁴⁵

Geographic variation in service access has been a longstanding characteristic of the Irish disability services system. Historically, service access has been influenced by the nature of disability and geographical location.⁵² The Progressing Disability Services for Children and Young People (PDS) programme, introduced a national model of geographically based interdisciplinary disability teams, which underpin the current CDNT structure. The programme was designed to address these geographic disparities and achieve more equitable access to services for all children with disabilities based on need.⁵² However, Implementation of the PDS programme has progressed at varying rates across different regions, which may be reflected in differences in service delivery.⁵²

The administrative requirements associated with service access may also contribute to delays. Although an AON is not required to access CDNTs or primary care health services, in practice it functions as a key element in accessing services. The cumulative nature of the AON process, whereby applications accumulate as children age, has resulted in older children and school-going children representing an increasing proportion of applications (from 26% in 2011 to 55% throughout 2022).²⁸

Literature Review Findings

Equity of Access for Individuals with Complex or High-Level Needs

The question of equitable access for individuals with complex or high-level support needs intersects with both assessment pathway design and service system capacity.

Data on diagnostic profiles indicate a changing and diverse pattern of needs among children accessing specialist disability services.²⁸ AON data for Q1 2026 (based on 1,528 completed assessment reports) indicates that Autism Spectrum Disorder (ASD) accounted for 47% of recorded disability categories in completed reports.⁵³ The needs of individuals with autism are described as often complex and resource-intensive, particularly where concurrent mental health difficulties or challenging behaviours are present.²⁸

Evidence suggests that children with complex disabilities require longer assessment time due to the necessity of non-standardised assessment methods and coordination across disciplines.⁵⁰ Survey responses from a 2025 academic indicated that from lived experiences of clinical staff, children with multiple communication needs might receive assessment and intervention for some needs (prioritised) whilst other needs remain unaddressed due to capacity constraints and prioritisation decisions.⁵⁰

Workforce shortages in key multidisciplinary roles, particularly occupational therapists and psychologists, are identified by the Action Plan for Disability Services as adding to difficulties in providing support to individuals with complex needs.²⁸ Furthermore, it reports that redeployment of multidisciplinary staff into local CDNTs has reduced availability of these resources to serve adults attending specialist disability services,²⁸ creating possibility for potential inequities across the lifespan.



Disability Assessment Pathways and Access to Services Summary

The AON, established under the Disability Act 2005, is a statutory process for assessing health and educational needs for persons with disabilities.²³ Eligibility was expanded to all children by June 2020.⁴⁴ December 2025 reforms introduced assessment officers and expert teams to refocus AON on needs identification.⁴⁵ AON is a statutory right to a statement of need, but does not in itself provide access to services.

Access to adult disability services is generally based on assessment of need and service-specific eligibility processes. Similarly, access to Children's Disability Network Teams (CDNTs) is separate from the statutory AON pathway and does not require completion of an AON, providing multidisciplinary support to children with complex needs.⁴⁶

Timeliness remains a challenge: average AON duration reached 24.93 months in Q2 2025, with demand rising from 4,700 referrals in 2020 to 10,000 in 2024.^{47,48} System capacity constraints persist despite private procurement, and CDNT waiting lists show regional variability.⁴⁹

Barriers include workforce shortages, recruitment challenges, and geographic variation in implementation of the Progressing Disability Services programme. Defining 'complex needs' eligibility remains inconsistent, affecting equitable access.^{28,50,51,52}



Emerging themes

Eligibility
Ambiguity

AON Delays

Workforce
capacity

Geographic
Variation

Literature Review Findings

Service Provision Models and Care Pathways

This section examines how disability services are planned, delivered and coordinated across Ireland, highlighting supports available across the life course and the pathways through which individuals access and move between services. It also considers how service design, integration, transitions and delivery arrangements influence continuity of care and person-centred support.

Overview of Service Provision Across the Continuum

Disability services in Ireland are delivered through a mixed economy of provision involving the HSE directly, alongside voluntary sector organisations funded under Section 38 or Section 39 of the Health Act 2004 and a cohort of private, for profit providers.

Approximately 80% of specialised disability provision is delivered through non-statutory service providers, while disability home support services are delivered either directly by the HSE or indirectly through a range of voluntary and private service providers.⁵⁴

Approximately 101,000 people receive or are registered for HSE-funded specialist disability services, representing around 9% of all persons recorded with a disability in the 2022 Census, or approximately 25% of those disabled 'to a great extent'.^{3,42} These specialist community-based services complement the mainstream health and social care services provided to people with disabilities alongside the rest of the population. Individuals' needs can change over time, requiring adjustments to the type and level of support provided. This can support continuity of care and help align services with individuals' circumstances and goals.

The service continuum encompasses early intervention and multidisciplinary therapies for children, adult therapy services, day services and supports to engage in community life, personal assistance, home support, respite, and residential care. Provision is structured around the national Transforming Lives reform programme, which was established to implement recommendations of the 2012 Value for Money and Policy Review of Disability Services in Ireland.²⁸ This reform programme seeks to transition services from segregated provision towards community-based, person-centred models of support.²⁸

People with disabilities access both specialist disability services and mainstream services throughout their lives, including primary care, mental health, acute healthcare, education, housing and transport. Outcomes depend on both the availability of specialist supports and effective coordination with mainstream systems.

Early Intervention and Children's Disability Services

As outlined earlier, early intervention and children's disability services are delivered through the 93 geographically based CDNTs. Depending on the nature and complexity of need, supports may also be provided through primary care and mental health services. The CDNT teams operate under a family-centred practice model, working closely with families and creating Individual Family Support Plans (IFSPs) that set out goals for the child.

Implementation of the children's disability network model has faced challenges, including capacity constraints arising from workforce vacancies and the time demands of the Assessment of Need process.^{44,51}

Therapeutic and Multidisciplinary Supports Across the Life Course

Access to therapeutic and multidisciplinary supports differ across the life course. Children predominantly access supports via CDNTs. In contrast, adults typically access services through a range of disability, health and community service providers, with access determined by individual support requirements, service-specific eligibility criteria and availability.

For children, multidisciplinary supports are embedded within the CDNT model and as previously mentioned, include occupational therapy, speech and language therapy, psychology, physiotherapy, social work, and clinical nursing.⁴⁶

Individuals with complex behaviour may require multidisciplinary support through disability services, Disability Regional Enhanced Services and Supports (DRESS) for Complex Behaviour, and, where severe mental health needs are present, Mental Health in Intellectual Disability (MHID) services. More intensive behavioural presentations may require higher levels of support and supervision, which can influence the suitability of particular living environments and support arrangements.^{55,56}

The Action Plan for Disability Services 2024-2026 includes provision for an additional 222 posts in specialist adult therapy services, alongside development of a nationwide network of neuro-rehabilitation services including managed community rehabilitation networks as the community-based specialist tier.²⁸ The National Strategy and Policy for Neuro-Rehabilitation Services and associated implementation framework established the development of Community Neuro-Rehabilitation Teams (CNRTs), envisaged to support earlier rehabilitation of those with neurorehabilitation needs, including individuals with progressive neurological conditions and those following acute neurological events.⁵⁷

Literature Review Findings

Meta-Analysis evidence further underscores the importance of timely neuro-rehabilitation. Early, intensive, and coordinated multidisciplinary rehabilitation following neurological events (e.g., stroke, acquired brain injury) is associated with improved functional recovery, greater independence, and enhanced participation outcomes.⁵⁸ Delays in access can limit recovery potential, while integrated community-based neuro-rehabilitation models support continuity of care and reduce long-term support needs.⁴¹ This reinforces the critical role of early intervention and equitable access to specialist rehabilitation services in shaping long-term disability trajectories.

Day Services and Meaningful Activity Supports

Adult day services represent a significant component of disability service provision in Ireland. Adult day services are HSE-funded programmes providing supports to people aged 18 and over with intellectual disabilities, autism, or complex physical disabilities.²⁹

The services assist individuals to make choices and plans and to be active, independent members of the community. Rehabilitative Training (RT) programmes are training programmes designed to develop life skills, social skills, and basic work skills, typically lasting two to four years.²⁹

Development funding for day service places is available for individuals exiting existing RT programmes and school leavers. Those who defer a place can defer for up to five years. Historically, those outside these groups often relied on vacancies becoming available; however, adults with disabilities may also access services through alternative referral pathways based on assessed need.²⁹

The New Directions policy, published in 2012, governs adult day service provision and represents the HSE's approach to supporting adults with disabilities who use day services.²⁹ New Directions promotes person-centred day services that support individuals to maximise their potential and engage in mainstream activities of their choice in their community.²⁹ The policy shift envisions day service locations acting as 'hubs' from which individuals are supported to access community-based services aligned with their ambitions and goals.²⁹

The Action Plan for Disability Services 2024-2026 commits to providing on average approximately 1,200 additional day service places each year to ensure places for school leavers who require them.²⁸ This goal was exceeded in 2025 with 1,790 places provided and 1,340 of these requiring funding for new places.⁵⁹ Day services are delivered through a combination of Section 38, Section 39, HSE organisations, and private providers, with funding allocated based on assessed support needs through a profiling process.^{28, 29}

Respite Services

Respite services provide short breaks to support families and caregivers of individuals with disabilities, and also offer service users opportunities to socialise and have new experiences away from their usual home setting.

Respite care is delivered in a range of formats, including centre-based overnight provision and alternative models such as home sharing, after-school and weekend supports, and summer schemes.⁶⁰ HSE-funded disability respite services are delivered mainly through Section 38 or Section 39 not-for-profit providers (90%), with approximately 6% delivered by the HSE itself and 4% by for-profit providers.⁶¹

Demand for respite is outpacing the capacity of the system to respond.⁶¹ A DCDE publication from 2024 indicated that a 40% increase in provision would be needed to address known unmet need.⁶¹ Budget 2024 saw a record investment of €15 million assigned to respite provision, which, when all measures are implemented, would have a full year cost of €25 million.⁶¹

DCDE and the HSE are seeking to expand provision not only through traditional overnight respite but also through exploration of alternative forms such as home sharing, after-school clubs, weekend breaks, and tea-time respite.⁶¹ However, challenges to respite provision remain, with ongoing efforts required to ensure sufficient access for children and adults with disabilities to address increased demand, as reflected in continued policy focus on expanding capacity, improving availability, and enhancing the flexibility of services.⁶¹

Residential and Community Living Supports

Residential supports for people with disabilities in Ireland are delivered through a network of designated centres operating within a regulated framework.⁶² Provision includes services delivered directly by the HSE as well as services funded by the HSE and operated by voluntary organisations under Section 38 and Section 39 arrangements.⁶² Residential services are provided for adults and children, reflecting differing care models and support requirements across the life course.^{60, 62} These settings range from dedicated children's residential services to adult-focused provision, and centres providing both adult and children services, and form a core component of the overall continuum of specialist disability supports.^{60, 62}

The Time to Move on from Congregated Settings strategy, launched in 2011, provides the policy framework for transitioning residents from institutional and campus settings to supported community-based housing.⁶³

Literature Review Findings

Congregated settings in this context, are defined as residential settings where ten or more people with disabilities live together or where living arrangements are campus-based.⁶³ At the end of 2024, 208 centres were based in congregated settings, accounting for 12.6% of registered centres and 22.8% of residential places, with a total capacity to support 2,111 persons, a reduction of 145 compared with the end of 2023.⁶⁰ As recorded in DCDE's 2025 Spending Review, as of April 2025, 1,335 persons remained in congregated settings.⁶²

Progress in decongregation has resulted in improved living conditions and quality of life for individuals who have moved from congregated to community settings, though costs have increased due to higher staff-to-resident ratios. Average service delivery costs rising from €139,000 in congregated settings to €223,000 in community housing.⁶²

The Action Plan for Disability Services 2024-2026 commits to 500 new community-based residential care places to replace disability care in large institutional and campus-based settings, with a view to ending that form of provision by 2030.²⁸

The plan also includes approximately 900 additional residential care places to tackle unmet need and ensure supply keeps pace with demographic change, alongside increased support for people with disabilities to access supported independent living.²⁸

The proportion of individuals under the age of 65 living in nursing homes provides an important context for understanding residential care provision.

The Wasted Lives policy agenda aims to reduce and eliminate these placements by strengthening community-based, person-centred supports, reflecting that over 1,300 people under 65 were living in nursing homes at the time of the report (2020),⁶⁴ with numbers still reported at approximately 1,227 in 2025.⁶⁵

Daily Living Supports

Alongside residential and supported living arrangements, Personal Assistance (PA) and Home Support services form a core component of community-based disability support. As among the most widely used supports, they assist individuals with activities of daily living, personal care and community participation, helping people to remain in their own homes and reducing reliance on more intensive service models.

Transitions Across the Life Course

Transition points represent critical junctures in disability service pathways, particularly the transition from child to adult services.

The transition from school to adult services involves a formal referral and profiling process managed by Day Opportunities Teams within each former HSE Community Healthcare Organisation (CHOs), now Regional Health Areas.²⁹

Transition planning requires collaborative profiling and a person-centred approach involving multiple stakeholders. Successful transitions depend on high-quality career guidance and coordination between health and education services to support children and young people with disabilities to reach their full potential.⁶⁶ Evidence suggests that transition from child to adult services can be challenging, with individuals and families experiencing the transition from integrated children's services (delivered through CDNTs) to adult services that may be delivered through multiple providers and separate funding streams.^{66,67}

The HSE's 2023-2026 Roadmap for Service Improvement for Disability Services for Children and Young People details actions to enhance integrated services among various organisations including CDNTs, Primary Care, Child and Adolescent Mental Health Services, Tusla, and the Department of Education.⁶⁸

Actions focus on improving service access and quality including workforce retention and recruitment, communication with children and families, and engagement of staff in disability services with education and support for special schools.⁶⁸

Effectiveness of Integrated and Community-Based Models

The evidence base on integrated and community-based service models in Ireland reflects both regulatory oversight findings and research on implementation. HIQA's 2024 overview report on 10 years of regulating designated centres for people with disabilities (2013-2023) documented that a human rights-based approach to care is being embedded in services, with a changing culture in centres and improvement in the quality of life for residents. Many individuals have moved from large institutional-style residential settings into community-based settings which can better meet their needs.⁶⁹

The 2024 HIQA overview highlights that effective residential service delivery is underpinned by strong governance and management, alongside a person-centred, human rights based approach to care that supports residents' needs, rights and quality of life.⁶⁹ Research examining outcomes of decongregation found that individuals moving from congregated to community settings experienced improved living conditions and quality of life.⁶³

Literature Review Findings



Service Provision Models and Care Pathways Summary

Disability services in Ireland operate through a mixed economy involving the HSE and voluntary sector organisations funded under Section 38 or Section 39 arrangements, serving approximately 101,000 people.⁴² The service continuum spans early intervention, multidisciplinary therapies, day services, personal assistance, respite, and residential care, structured around the Transforming Lives reform programme aimed at transitioning from segregated to community-based, person-centred support models.²⁸

Children's services are delivered through 93 geographically based Children's Disability Network Teams using family-centred practice, though facing capacity constraints.^{45,51} Adult day services assist individuals aged 18 and over to engage as independent community members, governed by the New Directions policy promoting person-centred hubs.²⁹

Respite services provide short breaks in various formats, primarily through voluntary providers, with demand outpacing capacity.⁶³ Residential supports include designated centres operated within a regulated framework, with the Time to Move on from Congregated Settings strategy guiding transition to community housing.⁶³

Transition from child to adult services represents a critical juncture requiring coordination across multiple providers. Evidence indicates improved quality of life through community-based models, though implementation challenges persist.^{29,69}

Supporting health and wellbeing outcomes across the life course, including mental health, healthy ageing, preventative healthcare and access to mainstream health services, is increasingly recognised as a key component of disability service provision.



Emerging themes

Demand vs Capacity

Transition Importance

Workforce capacity

Policy Implementation challenges

For children's disability services, the reconfiguration to CDNTs aimed to provide equitable, child and family-centred services based on need rather than diagnosis.⁴⁴ However, implementation challenges have seemingly affected consistency as previously explored.^{50,51,52}

For adult day services, the New Directions policy shift toward person-centred, community-based supports represents a substantial transformation from traditional building-based models. The development of local Day Opportunities Teams, a National Day Services Database tracking individuals and support needs, and standardised profiling processes for allocating funding based on assessed need have enabled more consistent application of person-centred principles.²⁹ However, the transformation is ongoing, with supports provided to people who commenced pre-2015 not yet fully aligned with New Directions policy.²⁹

Workforce Capacity and Sustainability

This section examines the importance of Workforce capacity and sustainability within the ongoing reconfiguration of disability services towards community-based, person-centred models of care. As outlined earlier in this review, reforms including the move towards community settings, the establishment of Children's Disability Network Teams (CDNTs), and the implementation of New Directions have contributed to increased demands on the existing workforce. This section synthesises evidence on workforce supply and demand, recruitment and retention challenges, regional variations in staffing, and the adequacy of workforce planning mechanisms to sustain service transformation and meet projected need.

Workforce Supply, Demand, and Skill-Mix in Disability Services

Ireland's disability services workforce faces differing levels of supply and demand across a range of professional disciplines. The most recent workforce data indicates that as of May 2026, the disability services sector employed 23,078 WTE nationally (HSE and Section 38), representing growth of 7.2% since December 2024.⁷⁰ However, this expansion has not kept pace with growing service demand. Therapy professionals, comprising speech and language therapists, physiotherapists, occupational therapists and dietitians, numbered 1,079 WTE nationally in May 2026, representing an increase of 14.13% (134 WTE) since December 2024,⁷⁰ yet vacancy rates across CDNTs as of latest available data remain significant. As of 2025, vacancy levels across the 93 established CDNTs stood at 18%, indicating a gap in workforce capacity.⁵¹

Literature Review Findings

While detailed workforce data is available for CDNTs, equivalent information on adult multidisciplinary service capacity is less developed, limiting system-wide assessment of workforce needs across the life course.

The transformation to community-based models necessitates fundamental shifts in workforce competencies and skill-mix beyond simple headcount increases.³² The National Disability Authority's Review of Competency Frameworks for Disability Service Staff emphasises that staff transitioning from institutional to community settings require competencies aligned with the social model of disability, including skills in supporting positive risk-taking, promoting independent living, and delivering person-centred approaches.⁷¹ This entails moving away from workforce configurations that are historically rooted in the medical-model of care delivery.⁷²

Recruitment and Retention Challenges Across Disciplines

Recruitment and retention difficulties represent the most immediate challenge to workforce sustainability across all professional disciplines within disability services. A 2022 survey by the Association of Occupational Therapists of Ireland (AOTI) of over 430 occupational therapists found that two-thirds had experienced burnout in the preceding 12 months, while 55% considered leaving their current job and almost half had considered leaving the profession entirely.⁷³

Evidence indicates that stress, burnout and job satisfaction are factors associated with staff retention across therapeutic professions. A 2025 study found that resource constraints were most strongly associated with burnout, followed by administrative requirements and work-home balance.⁷⁴ Separate evidence from a 2023 publication, found that quality of working life among occupational therapists in Ireland was lower than available benchmark norms, with 41% of respondents reporting overall satisfaction.⁷⁵ Qualitative findings highlight factors such as workload pressures, high caseloads, organisational constraints and elements of clinical governance as influencing professional experience and retention.^{74,77} Beyond workforce retention, burnout and sustained workplace pressures may adversely affect staff wellbeing, engagement and continuity of care.

Structural factors also influence workforce experience and recruitment. As noted earlier in this review, Section 39 staff do not have pay parity with Section 38 and HSE-employed counterparts, resulting in differences in employment conditions across the system that can affect recruitment to key service provider organisations.^{32,33} Furthermore, the global market for healthcare professionals is itself competitive, which is compounded further by shortages of qualified

therapists, nurses, and care staff internationally.⁷⁷

Recruitment challenges are particularly evident in rural areas, where difficulties in attracting and retaining staff have direct impacts on service delivery, including the provision of respite supports for families.⁷⁷ Parliamentary discussion has highlighted a "recruitment crisis" in respite care staffing, underscoring the scale of workforce pressures, though, ongoing efforts are being made to address shortages through workforce planning and recruitment initiatives.⁷⁷

Service users identified staff turnover as a concern. Residents participating in HIQA resident forums reported that frequent staff changes and reliance on agency staff could affect their sense of safety and highlighted the importance of having regular, familiar staff.⁷⁸

Regional Workforce Variation

Workforce capacity varies markedly across Ireland's health regions, with implications for equity of access and service quality. Employment data for May 2026 reveals notable regional variation in staffing growth rates. HSE Dublin & Midlands recorded the strongest growth among the larger regions, with disability services staffing increasing by 11.68% from 5,295 WTE in December 2024 to 5,913 WTE in May 2026.⁷⁰ In contrast, HSE Dublin & North East experienced more modest growth of 1.65%, reaching 4,875 WTE over the same period.⁷⁰

While these figures indicate overall workforce expansion (not including Section 39), growth has not consistently aligned with regional population needs or addressed longstanding gaps in historically underserved areas.⁶⁹

Therapy professional staffing also exhibits regional variation.⁷⁰ Health & Social Care Professional staffing in HSE Dublin & Midlands increased by 9.82% to 1,339 WTE between December 2024 and May 2026, compared with growth of 2.68% to 1,379 WTE in HSE Dublin & North East.⁷⁰ These variations reflect differential recruitment success, regional labour market conditions, and historical service development patterns. Rural areas face disproportionate recruitment challenges, as acknowledged in a recent parliamentary debate concerning HSE South West Disability Services, where staffing shortages are highlighted as particularly detrimental to respite services in Kerry.⁷⁷

Workforce Planning Models Aligned with Projected Demand

Ongoing reforms and anticipated demographic change have implications for strategic workforce planning within disability services.

Literature Review Findings

In response to escalating workforce pressures, in 2025 the government committed to the development of a dedicated Disability Workforce Strategy to address recruitment and retention challenges across specialist disability services.⁷⁷ At the time of writing, the specific parameters, implementation timelines, and resource commitments for this strategy remain undefined.

In 2018, the NDA recommended the development of a national disability competency framework for Ireland.⁷² Such a framework would require extensive stakeholder consultation, validation, and integration into service provider Human Resources policies and professional education curricula. To date, this work has not been undertaken systematically.

The incorporation of evidence-based caseload standards and skill-mix models within workforce planning approaches appears to be at an early stage of development.

As previously mentioned there is variation in the availability and application of policy guidance relating to caseload prioritisation, clinical pathways, caseload size and workforce configuration within CDNTs.⁵²

International best practice recommends setting caseload standards based on comprehensive workload analyses that account for assessment time, direct intervention, care coordination, administrative responsibilities, and professional development.⁵² The availability of caseload standards may support the assessment of staffing requirements, resource planning, and consistency in workforce distribution. Workforce planning tools have also been identified as an area for further research and development.



Workforce Capacity and Sustainability Summary

Despite growth to 23,078 WTE nationally by May 2026, expansion has not matched service demand.⁷⁰ Therapy professionals increased by 14.13% since December 2024, reaching 1,079 WTE nationally,⁷⁰ yet Vacancy Rate across Children's Disability Network Teams remained at 18% as of 2025.^{52,69}

Community-based transformation requires fundamental skill-mix shifts aligned with social models of disability, emphasising person-centred competencies rather than medical-model configurations.³²

Burnout and job dissatisfaction threaten workforce sustainability across disciplines, with resource constraints, administrative burdens, and pay parity gaps (Section 39 versus Section 38 staff) affecting retention.^{32,33,77}

Rural areas face disproportionate recruitment challenges, impacting service delivery.⁷⁷ Regional staffing growth varies considerably, with historical gaps persisting.⁶⁹

Strategic workforce planning remains limited; a Disability Workforce Strategy was committed in 2025, though implementation details remain undefined.⁷⁷ Evidence-based caseload standards and comprehensive workforce planning frameworks are not yet well established.^{52,71}

Literature Review Findings

Conclusion

The ratification of the UNCRPD in March 2018 fundamentally repositioned disability policy from a needs-based service provision model to a rights-based framework positioning disabled people as rights-holders entitled to human rights on an equal basis with others.⁴ The National Human Rights Strategy for Disabled People 2025–2030, published in September 2025, now serves as the primary whole-of-government vehicle for progressive realisation of these obligations.²²

Current policy and literature reveals a system undergoing profound transformation to align with national and international policy commitments on the rights of disabled people and the delivery of person-centred care.^{4,22,28,29,60} This shift from congregated, provider-led models towards person-centred, community-based supports reflected in New Directions and Time to Move on from Congregated Settings is well established in policy intent.^{29,60} However, progress has varied and, in some areas, has been more gradual than initially envisaged.³¹ Implementation of disability service reform takes place within a context shaped by governance arrangements, workforce capacity, capital and infrastructure requirements, and evolving data and planning systems.^{29,31,32,35,51}

Demographic change represents a fundamental structural driver of future demand. Ireland's population is ageing rapidly, with the Central Statistics Office projecting that the number of people aged 65 and over will exceed 1 million by 2030.³⁴ At the same time, improvements in healthcare have been associated with increased longevity for people with intellectual disabilities, with more individuals living into older age and presenting a broader range of health needs.³⁵ The combination of population ageing and longer life expectancy reflects a longer-term demographic shift, which is expected to influence both the level and profile of service demand over time.^{34,35}

Assessment Pathways and Access to Services remains shaped by capacity gaps and procedural inconsistency.^{50,51,52} Under the Disability Act 2005, the HSE must commence statutory AON within three months of application.²³ The average duration of AON processes was 24.93 months for reports completed nationally in Q2 2025.⁵¹ The backlog of AON applications was estimated to exceed 22,000 by the end of 2025.⁴⁵ Although activity has increased, demand continues to exceed current system throughput.^{44,51} Access challenges extend beyond AON processes to other access pathways including for adult multidisciplinary therapies, respite, personal assistance, home support and residential supports.

Service availability, workforce constraints, local capacity and variations in eligibility processes continue to influence the timeliness and consistency of access across the disability services system.

Workforce capacity constraints continue to present an ongoing consideration for service delivery across disability services.^{51,70,71,74} While significant investment has been directed towards expanding CDNTs and broader specialist services, recruitment and retention factors have, at times, influenced the extent to which this investment can be fully realised in practice.^{28,51,69,71,74} Challenges in attracting and retaining suitably skilled staff, particularly across multidisciplinary therapy roles, can affect service throughput and continuity in some areas.^{51,70,71,74} These dynamics are also associated with structural features of the mixed-economy delivery model, including differences in pay arrangements for Section 39 providers, which may have implications for workforce stability and the distribution of available staff.³³ Taken together, these factors suggest that workforce capacity, alongside funding, plays an important role in shaping the system's ability to translate planned service expansion into timely and accessible supports.

Governance arrangements can be understood as a structural feature influencing how disability need is experienced and expressed in Ireland.^{4,22,31,32} The reconfiguration of departmental responsibilities and the use of a mixed economy of provision reflect ongoing efforts to align services with rights-based, person-centred policy frameworks, including the UNCRPD.^{4,22,31} Governance arrangements form part of the context within which disability services are planned and delivered. Where responsibilities, funding streams and delivery arrangements are distributed across multiple organisations, individuals may interact with a range of specialist and mainstream services over time.^{31,32,33} From a needs analysis perspective, consideration may therefore be given to service capacity, coordination arrangements, service interfaces and the way in which services support individuals with changing needs across the life course.

Data and information infrastructure remains uneven.^{42,43} The NASS, which replaced the NIDD and NPSDD, aims to integrate data across intellectual, physical, sensory and neurological disability, and autism.⁴² However, coverage is not yet comprehensive, and diagnostic and service-use data remain incomplete in some areas, constraining analytical potential.^{31,32} Persistent fragmentation across population, service-use, and workforce datasets constrains comprehensive, system wide analysis of inclusive and integrated services to meet the needs of people with a disability.



Data Review

Data Review

Introduction

This section provides a structured analysis of the available data relating to disability services, to support understanding of current and emerging service needs in Ireland, with a focus on specialist disability services. It draws on multiple sources. These include national datasets, administrative systems, and service-level data. The aim is to provide an overview of trends in population characteristics, service use, demand, and capacity across disability services.

Across the system, the availability and coherence of data varies across sources. The data on disability need and service provision is distributed across multiple datasets, leading to fragmented data. Each of these datasets have differing levels of coverage, maturity, and consistency. Some systems, such as the NASS represent an important step towards integrated data. However, gaps in completeness, differences in definitions, and limited linkage between population, service use, and workforce data constrain the ability to generate a fully comprehensive, system-wide view. This leads to the absence of a single, integrated view of service users across datasets. In this context, the data review adopts a pragmatic and triangulated approach through the use of multiple data sources. The best available evidence was used to identify key trends, while acknowledging the limitations and fragmentation in the current data landscape.

Census 2022 data is included to provide population-level context and should not be interpreted as a direct measure of demand for specialist disability services. Its data is used as a contextual baseline as opposed to a direct measure of service need within the disability service system. It should be noted that all data reflects an extract of a point-in-time, which should be considered with assessing trends and system performance.

Sources:

National Ability Supports System (NASS)

The NASS, published by the HRB, is the primary data source used in this analysis. NASS is a national database that records information provided by service providers on individuals who are receiving, or are assessed as requiring (currently or within a five-year horizon), HSE-funded disability services across a range of disability types. Its purpose is to support the planning, development and organisation of disability services by capturing data on current service provision, enhancements required to existing supports, and new services required. It allows for an examination of disability service utilisation, enhancement needs, identified future requirements, and multi-year trends across service categories. However, a number of limitations should be noted:

- While coverage has improved over time, NASS is not fully complete, with some datasets excluding individuals where information is unavailable, unrecorded (due to its self-report nature), or still being incorporated (e.g. during system rollouts for children's and support services data).
- Data gaps and staged system implementation (e.g. CDNTIMS rollout) mean that certain service areas, particularly children's specialist supports, may be only partially captured in a given reporting year.
- Differences in data definitions and collection methodologies can result in variation when compared with other HSE data sources, including potential under-reporting or inconsistencies across datasets.
- Changes to classification approaches, service categories, and data collection processes across reporting periods limit the comparability of multi-year trend analysis.
- Individuals may be omitted from specific data tables where required information is missing, incomplete, or not captured at the relevant level of detail.
- Regional totals presented in NASS outputs may not reconcile with national totals in service provision, enhancement, or future need tables, reflecting factors such as unassigned regions, cross-regional service provision, or services delivered outside the State.

Disability Supports Application Management Tool (DSMAT)

The DSMAT is used within this analysis as the secondary source for service provision and future demand, primarily for current waiting list data, addressing a key gap in the NASS, which does not comprehensively capture live unmet demand instead capturing future identified need for the following 5 years at time of publication. DSMAT provides a structured, national listing of individuals requiring additional funded supports beyond the current service capacity, capturing both residential and non-residential needs across RHAs. It functions as an "indicator of need," reflecting those actively presenting for supports rather than the full population of unmet need. In addition to waiting list data, DSMAT also provides supplementary insight into service activity, including residential placements and non-residential supports (such as respite, home support and personal assistance), although the dataset collected from the DSMAT tool excludes this data for day service provision. A number of limitations should be noted:

- DSMAT reflects demand from individuals who have come forward to services and been recorded, and therefore does not represent the full extent of unmet need within the population.

Data Review

- Data completeness is variable, as regional returns are not consistently submitted across all areas, leading to gaps in national coverage and reliance on partial datasets.
- The level of detail captured for non-residential services is inconsistent; in some cases, the specific type of support required is not fully specified due to variation in local recording practices.
- Regional breakdowns of waiting lists should be treated as indicative rather than definitive, as detailed geographic allocation is more robust for residential demand than for non-residential services.
- The dataset represents a point-in-time extract and therefore does not reflect changes made after the date of extraction. Classifications (e.g. priority levels) and record completeness may subsequently change as records are updated or validated.

Live National CDNT Data May 2026

The "Live National Data for May 2026" dataset provides a point-in-time snapshot of activity and demand within all 93 CDNTs across Ireland. It presents real-time, aggregated national figures on key operational metrics, including open caseloads, waiting lists across duration bands, service demand, and levels of activity such as interventions delivered. As such, it serves as a dynamic operational dataset that reflects current service pressure and throughput across CDNTs, offering insight into the scale and distribution of demand within children's disability services. Key limitations of this dataset:

- The dataset represents a single point-in-time snapshot and should be interpreted as indicative only. Monthly figures may fluctuate due to changes in referrals, discharges, caseload management and data entry practices.
- CDNT data is reported one month in arrears, meaning the latest available dataset reflects service activity from the previous month
- As CDNTIMS is a relatively new national reporting platform, differences in adoption and use across teams may result in variation in the recording of activity, interventions and service contacts.
- The dataset provides information on service volumes and activity but includes limited information on case complexity, intensity of support required, multidisciplinary input or service mix, constraining interpretation of workload and capacity pressures.
- Metrics such as waiting lists, IFSP coverage and missed appointments may be influenced by local operational practices, recording approaches and caseload characteristics and should therefore be interpreted with caution when comparing areas.

Assessment of Need Process 1st Quarter 2026 Management Report

This dataset presents administrative data from the HSE AON process, extracted from the AON database and compiled by the Disability Information Management Hub, providing a structured overview of application volumes, processing timelines and assessment outcomes for the period. This report is used within the analysis as a key source of evidence on AON activity and performance, including data on application volumes, stage progression and overdue cases, which enables the identification of assessment backlogs and regional variation in processing timelines. It also provides insight into the duration of assessments and supports cost-related considerations through analysis of processing timelines and throughput, alongside detailed breakdowns of completed assessment reports by disability category and the associated service requirements identified (e.g. therapy supports and multidisciplinary inputs). Collectively, the dataset offers a perspective on demand pressures within the statutory assessment system and the profile of needs being identified through completed AON reports. Limitations to consider:

- The dataset is drawn from the AON database at a single point in time and is therefore subject to ongoing updates, late data entry, and revisions that may affect reported totals and trends.
- The report reflects administrative process data rather than the full population of unmet need, capturing only those who have applied for an Assessment of Need.
- Backlog figures (e.g. overdue applications) exclude certain cases such as those on hold, closed, or deemed ineligible, which may limit the completeness of the overall demand .
- Reported timelines (e.g. time to complete assessments) may be influenced by "exceptional circumstances" or extensions, reducing comparability across cases and regions.
- Regional comparisons should be interpreted cautiously, as variation may reflect differences in administrative practices, data recording, or local resourcing rather than underlying demand alone.
- Disability categories and service requirements are based on completed assessment reports only and may not reflect the full profile of needs among those awaiting assessment.
- Individuals with multiple disabilities are grouped into a single category in reporting outputs, which can limit visibility of co-occurring needs and complicate detailed analysis of disability prevalence.

Data Review

Disabilities Employment Report May 2026 & Health Sector Workforce 2025 Turnover Report

These datasets are used in conjunction to provide an administrative snapshot of the disability workforce across HSE-funded services, capturing WTE staffing levels, workforce composition and changes over time. They are used in this analysis as a key source for understanding the current scale and structure of the disability workforce, including trends in workforce growth from 2020 to 2026, detailed breakdowns of staffing by discipline (e.g. nursing, health and social care, social care and patient care roles), and regional variation in workforce distribution across HSE health regions. The reports also enables comparison of service provision capacity between the HSE and Section 38 voluntary providers, highlighting differences in workforce scale and composition across provider types, and supports analysis of workforce dynamics such as growth patterns and indirect indicators of turnover through changes in WTE over time. However, it should be noted that the dataset does not include workforce data for Section 39 providers. Based on stakeholder feedback, no comprehensive dataset capturing the Section 39 workforce is currently available. Notable limitations:

- The dataset does not include workforce data for Section 39 organisations, limiting its completeness across the full disability service landscape.
- There is no data on Vacancy Rate or distinctions between funded versus filled WTE posts, restricting insight into workforce gaps or capacity pressures.
- Limited information is available on recruitment processes, pipeline activity, or persistently hard-to-fill roles, constraining analysis of workforce sustainability issues.
- Contract detail is restricted, with only full-time versus part-time breakdowns available. There is no visibility on permanent versus temporary contracts.
- The data represents a point-in-time administrative extract and may not fully reflect short-term fluctuations in staffing levels or recent recruitment activity.

CDNT National Workforce Report October 2025

This dataset presents the findings of a national workforce survey of Children's Disability Network Teams (CDNTs), based on a structured data capture exercise completed by managers across all 93 teams as of 8 October 2025. It is used in this analysis to provide a comprehensive overview of the CDNT workforce, including detailed WTE breakdowns across funded, filled and unfilled posts, Vacancy Rate, and the proportion of staff on leave. The report enables comparative analysis across provider types (HSE, Section 38 and Section 39), regional workforce distribution, and workforce composition by discipline and grade, alongside insights into recruitment activity, pipeline status, and the nature of hard-to-fill roles. It also provides an overview of workforce stability through contract type (e.g. permanent, part-time, temporary and agency staffing) and highlights the impact of leave on effective service capacity. While the report is based on an October 2025 survey, it includes estimated figures for the 1st quarter of 2026 and is used as a proxy for the most recent available position in the absence of more current national CDNT workforce data. Key limitations to consider:

- The dataset is based on a single point-in-time survey (8th October 2025), which limits its ability to capture short-term fluctuations in staffing, recruitment, or attrition.
- Data is self-reported by CDNT managers via a "Data Capture Template", introducing potential variability in interpretation and reporting consistency across teams and regions.
- Vacancy Rate data identifies volume and status but provides limited qualitative insight into recruitment barriers beyond classification of "unable to fill" roles.
- Although recruitment pipeline stages are included, the dataset does not track time-to-fill, duration of vacancies, or turnover rates, limiting longitudinal workforce planning analysis.
- Contract data provides a breakdown by type (e.g. permanent, agency, fixed-term) but does not link contract type to retention outcomes or staff stability over time.
- Workforce reconfiguration (e.g. shifting posts across disciplines) may affect comparability over time, as changes in WTE by discipline do not necessarily reflect net increases or decreases in service capacity.
- Regional comparisons should be interpreted with caution, as differences may reflect local reporting practices, service configuration, or workforce model variation rather than underlying differences in need or performance.

Data Review

Other sources included in this review include:

- Census 2022 (CSO) Disability Federation of Ireland
- (DFI) Region Disability Factsheets on Census 2022 data
- HIQA Designated Centre Registration Data and Inspection Reports
- National Day Services Office operational data
- Additional HSE management information reports and service activity datasets provided by national service leads
- Before We Die Survey March 2026

This data review brings these datasets together to triangulate a broad, but clear, view of key trends. This data review uses the terms “demand”, “identified need”, “enhancement required” and “access to services”. While similar terms, the distinction between the four is important.

- **Demand** refers to the measurable want and requirement of the population of Ireland for disability services, based on available sources
- **Future Identified need** refers to potential future demand for services based on the individuals identified as requiring a service in the 5 year period after reports publication (an indicative figure)
- **Enhancement required** refers to existing placements identified that are expected to require additional or altered supports within the next 12 months at the time of data publication.
- **Access to services** refers to availability of services, and the ability of service users to avail of those services.

The data review is structured into a number of categorised findings. These categories are:

- **National Overview of Population and Service Users (Page 44)**
- **Residential Services – Service Use and Demand (Page 51)**
- **Respite – Service Use and Demand (Page 60)**
- **Capacity – Residential and Respite (Page 73)**
- **Day Services (Page 80)**
- **Daily Living Services (Page 84)**
- **Children’s Disability Network Teams (Page 93)**
- **Assessment of Need (Page 96)**
- **Workforce (Page 100)**

Note: The figures presented throughout this section reflect need identified and recorded in the available administrative datasets and should not be interpreted as a complete measure of underlying population need. Differences between areas may reflect variation in reporting coverage, service availability, referral and assessment practices, and data maturity, as well as genuine differences in need. The findings should therefore be used to identify areas for further investigation and planning, rather than as a standalone basis for resource allocation.



Data Review: National Overview of Population and Service Users

Data Review Findings

National Overview - Population

The following tables provide an overview of responses from Ireland's population to the 2022 Census questions on disability, including prevalence and distribution across age, gender and region.

Census 2022: Prevalence of Disability by Region

Region	Region Population	People with 'at least 1 disability'	% of total population with at least 1 disability	People experiencing disability 'to a great extent'
HSE Dublin and North East	1,187,000	241,130	20.31%	86,860
HSE Dublin and Midlands	1,077,500	230,420	21.38%	84,168
HSE Dublin and South East	971,200	218,239	22.47%	78,356
HSE South West	740,500	162,399	21.93%	60,905
HSE Mid West	234,500	91,612	21.18%	34,974
HSE West and North West	759,700	165,757	21.82%	62,079
Total	4,970,400	1,109,557	22.32%	407,342

Source: DFI Regional Factsheets on Census 2022 data

Table 3.1

In the most recent available Census data (2022), a total of 1,109,557 people reported experiencing at least 1 long-lasting condition or difficulty accounting for 22% of the Irish population. Of these, 407,342 (8% of the population) reported experiencing at least 1 long-lasting condition or difficulty to "a great extent or a lot". Prevalence is broadly consistent across regions, ranging from 20.3% to 22.5%.

Census 2022: Age and Gender Breakdown of People with a Disability by Region

Region	People with a disability	Male	Female	0-19 years	20-64 years	>65 years
HSE Dublin and North East	241,130	114,172	126,958	35,124	135,513	70,493
HSE Dublin and Midlands	230,420	110,319	120,101	34,986	130,888	64,546
HSE Dublin and South East	218,239	103,893	114,346	28,863	116,350	73,026
HSE South West	162,399	78,107	84,292	22,906	87,319	52,174
HSE Mid West	91,612	44,656	47,047	12,867	48,027	30,718
HSE West and North West	165,757	80,151	85,606	21,691	85,348	58,718
Total	1,109,557	531,298	578,350	156,437	603,445	349,675

Source: DFI Regional Factsheets on Census 2022 data

Table 3.2

Of the total number of people with at least 1 reported disability, approximately 48% were male and 52% female. Prevalence among female respondents was 22.2%, and 20.9% among males. Approximately 14% of people with a reported disability were aged 0-19 years, 54% aged between 20-64 years, and 32% aged over 65. While specialist disability services are primarily targeted at those under 65, existing recipients may continue to receive disability-funded supports beyond age 65.

Data Review Findings

National Overview

Census 2022: Type of Disability by Region

Region	Difficulty with basic physical activities	Psychological or emotional condition or mental health issue	Blindness or visual impairment	Deafness or a hearing impairment	Difficult learning, remembering or concentrating	Intellectual Disability
HSE Dublin and North East	30,768	20,730	10,783	21,670	25,332	19,261
HSE Dublin and Midlands	90,065	73,946	24,815	55,745	65,098	48,318
HSE Dublin and South East	67,558	52,907	22,575	50,669	56,385	47,619
HSE South West	92,375	69,290	23,018	54,314	61,558	44,997
HSE Mid West	52,161	38,787	20,793	38,404	42,320	35,228
HSE West and North West	55,432	37,075	45,918	37,997	38,248	15,522
Total	388,359	292,735	147,902	258,799	288,941	210,945

Source: DFI Regional Factsheets on Census 2022 data

Table 3.3

The most commonly reported disability category was difficulty with basic physical activities, reported by 35% of people with a disability. This was followed by difficulty learning, remembering or concentrating, reported by 26%.

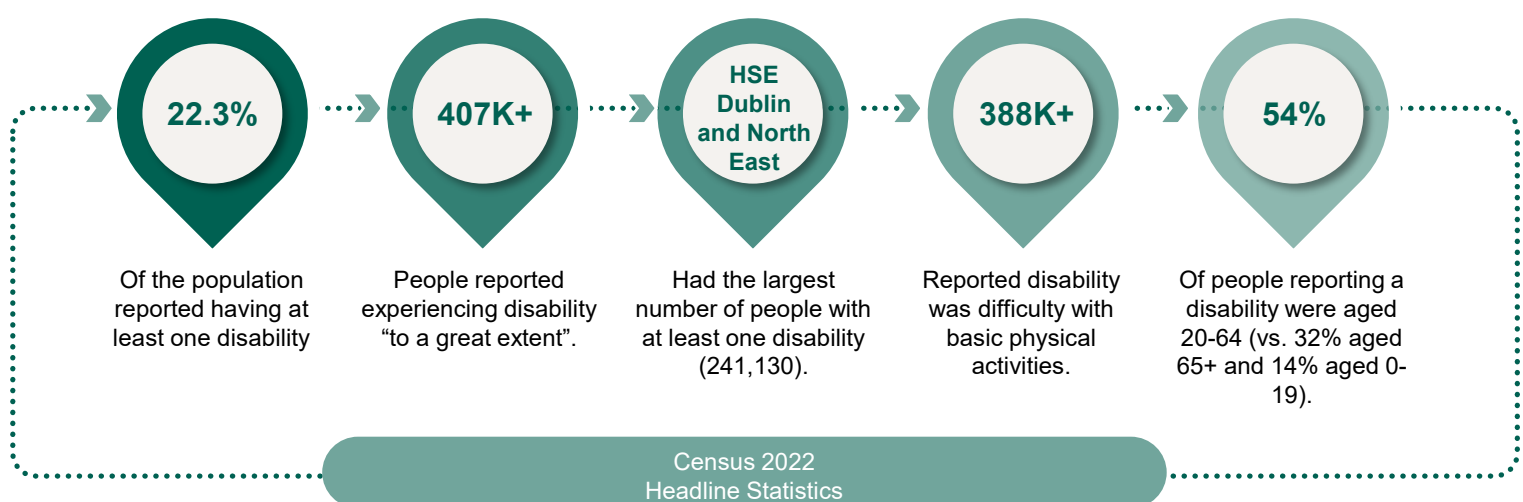


fig. 3.1

Data Review Findings

National Overview – Service Users

The following pages present analysis of adult service users based on the 2025 NASS dataset, supplemented by trend comparisons with previous years.

Primary Disability among adults 2025

	Male		Female		Total	
	n	%	n	%	n	%
Intellectual	10,947	56.2	8,543	43.8	19,490	50.9
Neurological	4,225	50.6	4,125	49.4	8,351	21.8
Autism	2,753	74.3	950	25.7	3,703	9.7
Physical	1,658	48.9	1,731	51.1	3,389	8.9
Visual	869	48.9	909	51.1	1,778	4.6
Hearing loss/deafness	397	47.6	437	52.4	834	2.2
Mental health	262	56.7	200	43.3	462	1.2
Specific learning difficulty (other than intellectual)	38	48.1	41	51.9	79	0.2
Deaf Blind (dual sensory)	28	46.7	32	53.3	60	0.2
Speech and/or language	18	62.1	11	37.9	29	0.1
Not verified	40	46.5	46	53.5	86	0.2
Primary disability type not recorded	12	44.4	13	48.1	27	0.1
Total	21,247	55.5	17,038	44.5	38,288	100.0

Source: NASS 2025

Table 3.4

This profile indicates that intellectual disability represents the largest primary disability category among adults in the dataset, with neurological disability as the second-largest component, while autism and physical disability form meaningful but smaller shares.

The gender profile varies across primary disability categories, most notably in autism, where 74.3% of adults recorded are male and 25.7% are female.

Additional Disability among adults 2025

Additional disability	Primary disability categories									
	Intellectual disability		Physical or sensory		Autism		Other**		Total population	
	n	%	n	%	n	%	n	%	n	%
Total population	19,490	100.0	14,441	100.0	3,703	100.0	627	100.0	38,261	100.0
Physical	3,508	18.0	3,457	23.9	70	1.9	31	4.9	7,066	18.5
Speech and/or language	3,009	15.4	323	2.2	104	2.8	7	1.1	3,443	9.0
Autism	2,363	12.1	71	0.5	0	0.0	29	4.6	2,463	6.4
Mental Health	1,334	6.8	293	2.0	282	7.6	6	1.0	1,915	5.0
Neurological	1,004	5.2	623	4.3	89	2.4	18	2.9	1,734	4.5
Visual	1,303	6.7	330	2.3	29	0.8	9	1.4	1,671	4.4
Intellectual	0	0.0	410	2.8	953	25.7	80	12.8	1,443	3.8
Hard of hearing and/or deafness	950	4.9	122	0.8	25	0.7	9	1.4	1,106	2.9
Specific learning difficulty (other than intellectual)	137	0.7	53	0.4	83	2.2	~	~	277	0.7
Deaf Blind (dual sensory)	33	0.2	12	0.1	~	~	0	0	46	0.1
No additional disability	5,849	30.0	8,747	60.6	2,067	55.8	434	69.2	17,097	44.7

Note more than one additional disability may be recorded for a person and as a result, total percentages add up to more than 100.

Source: NASS 2025

Table 3.5

Within the NASS 2025 dataset, a majority of individuals have at least one additional recorded disability. Further, people with primary intellectual disability are much more likely to have additional disabilities recorded than those in other primary categories. Across the total cohort, the most frequently recorded additional disabilities are physical (18.5%) and speech/language (9.0%), followed by autism (6.4%) and mental health (5.0%). Among adults with autism as a primary disability, intellectual disability is the most commonly recorded additional disability (25.7%). This pattern of co-occurring disabilities is explored further on the following page.

Data Review Findings

National Overview – Service Users

Autism and Increasing Complexity of Need

	Male		Female		Total (Primary Disability)*		No additional Disability		Additional Disability		Total Autism (Primary or addition-al)
Year	n	%	n	%	n	%	n	%	n	%	n
2023	2,267	76.7	682	23.1	2,955	8.4	1,815	61.4	1,140	38.6	5,160
2024	3,179	75.7	1,019	24.3	4,198	10.4	2,411	57.4	1,787	42.6	6,804
2025	2,753	74.3	950	25.7	3,703	9.7	2,067	55.8	1,636	44.2	6,166

Source: NASS 2025, NASS 2024, NASS 2023

Table 3.6

The proportion of individuals with autism as a primary disability who also have an additional recorded disability increased from 38.6% in 2023 to 44.2% in 2025. A similar pattern is reflected in the growing proportion of individuals with additional recorded disabilities.

Population Proportion Accessing Specialist Services 2025

NASS 2025 Population Reference	
Total NASS Population	101,373
Children	63,085
Adults	38,288

Specialist support represents a substantial component of service delivery within the NASS 2025 service user dataset. 86,871 specialist service engagements are currently being delivered across 35 service types. This is equivalent to 85.7% of the NASS population, noting that individuals may access more than one service. Significantly, adults account for 92.7% of additional services required despite representing only 38% of the NASS population.

Source: NASS 2025

Table 3.7

Specialist Service Engagement Summary				
	Children	Adults	Total	% of NASS Pop.
Currently Accessing Specialist Services	62,644	24,227	86,871	85.7%
Additional Services Required (2025-2030)	369	4,669	5,038	5.0%
Total Service Demand	63,013	28,896	91,909	90.7%

Source: NASS 2025

Table 3.8

Of the 62,644 children currently accessing specialist support, 61,570 access these services through CDNTs.

Specialist Service Engagements

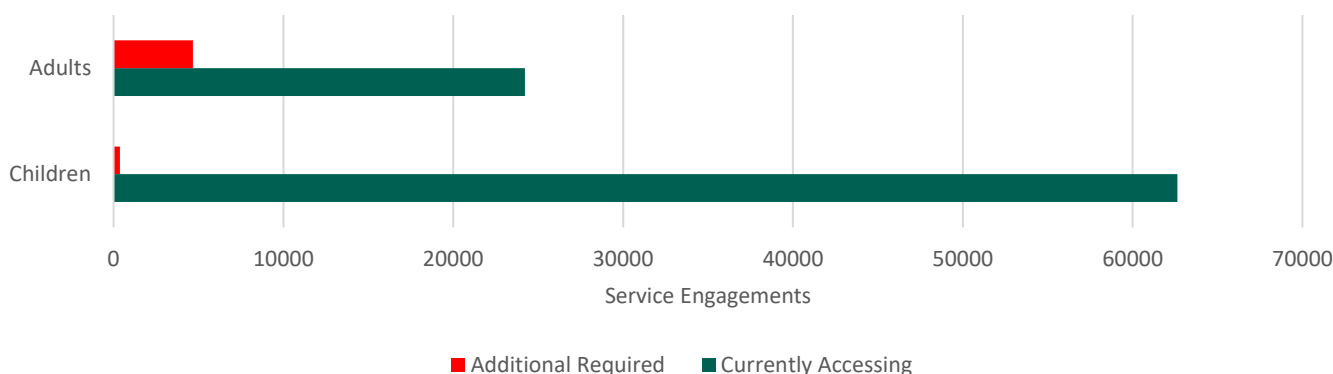


fig. 3.2

Notable Unmet Need:			
Service	Currently Accessing	Additional Required	Gap %
Occupational Therapy	5,733	1,263	22.0%
Physiotherapy	5,467	1,134	20.7%

Source: NASS 2025

Table 3.9

Occupational Therapy and Physiotherapy show service gaps, with additional demand equivalent to approximately 20% of current delivery.

Data Review Findings

National Overview – Underlying Demand

Adults with Disabilities Living with Ageing Primary Carers

Census 2022 data indicates that 6% of people provide regular unpaid care. A growing cohort of adults with disabilities are living with ageing primary carers.

Adults with Disabilities Living with Ageing Primary Carers (60+ years), NASS 2023-2025

Primary Carer Age Group	2023	2024	2025
Between 60 and 69 years	2,774	3,006	3,202
Between 70 and 79 years	1,494	1,565	1,623
80 years or over	471	500	516
TOTAL (Carers 60+)	4,739	5,071	5,341

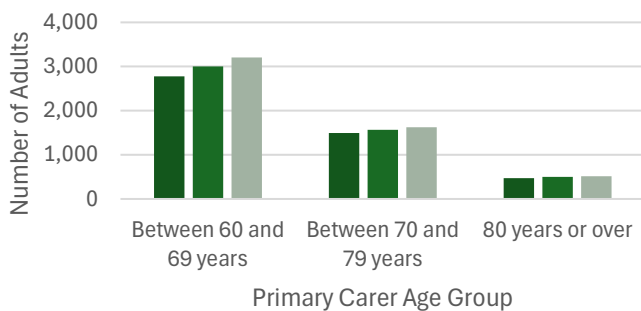
Source: NASS 2025

Table 3.10

Primary Carer Age Group	Growth (2023-2025)
Between 60 and 69 years	+428
Between 70 and 79 years	+129
80 years or over	+45
TOTAL (Carers 60+)	+602

Table 3.11

Adults with Disabilities by Ageing Carer Age Group (60+)

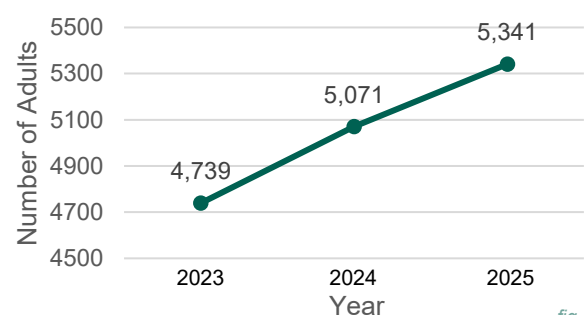


Source: NASS 2025

fig. 3.4

■ 2023 ■ 2024 ■ 2025

Adults with Ageing Carers (60+), 2023-2025



Source: NASS 2025

fig. 3.3

NASS 2025 data highlights an upward trend, with an increase of 602 individuals (+12.7%) living with primary carers aged 60 years and over between 2023 and 2025. The 60-69 age group shows the largest absolute increase (+428 people) but growth is consistent across all three age brackets.

Growth Trajectory: Adults with Ageing Carers (60+)

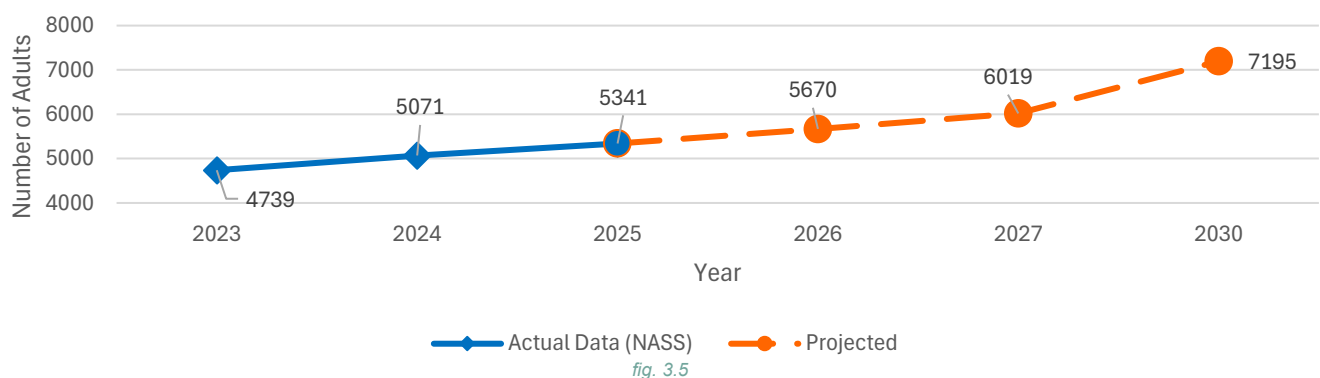


fig. 3.5

If current growth continues		
Year	Projected Adults with Carers 60+	Calculation
2026	5670	$2025 \times (1 + \text{growth rate})$
2027	6019	$2026 \times (1 + \text{growth rate})$
2030	7195	5-year compound growth

*Note: Annual growth rate = 0.0616

Table 3.12

Using the existing NASS data as a baseline, the orange dotted line demonstrates an identical compound annual growth rate (CAGR) of 6.16% (from 2023-2025). Projections show a figure of 7,195 individuals with primary carers aged 60 years and over by 2030.

Interpretation Note: These findings should be interpreted as directional rather than definitive. NASS values below five are suppressed, and totals may vary across data extracts owing to differences in regional assignment, service classification, or the inclusion of provision delivered outside the State.

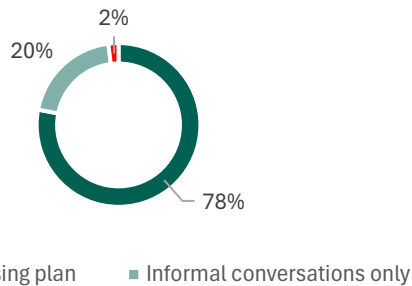
Data Review Findings

National Overview – Underlying Demand

Adults with Disabilities Living with Ageing Primary Carers

Data from the 'Before We Die' (BWD) Survey (March 2026) highlights a growing crisis in ageing carers. This survey had 1,000 respondents. From those surveyed respondents; 48% of primary carers are aged 60+, and 92% of individuals with intellectual disabilities continue to rely on a parent as their primary carer.

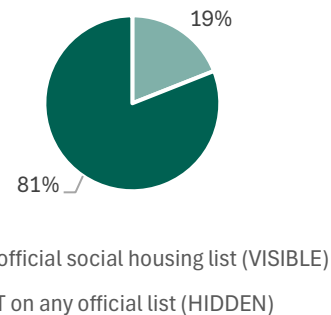
Housing Planning Status



Before We Die Survey March 2026

fig. 3.6

The Invisible Queue: 81% n Demand

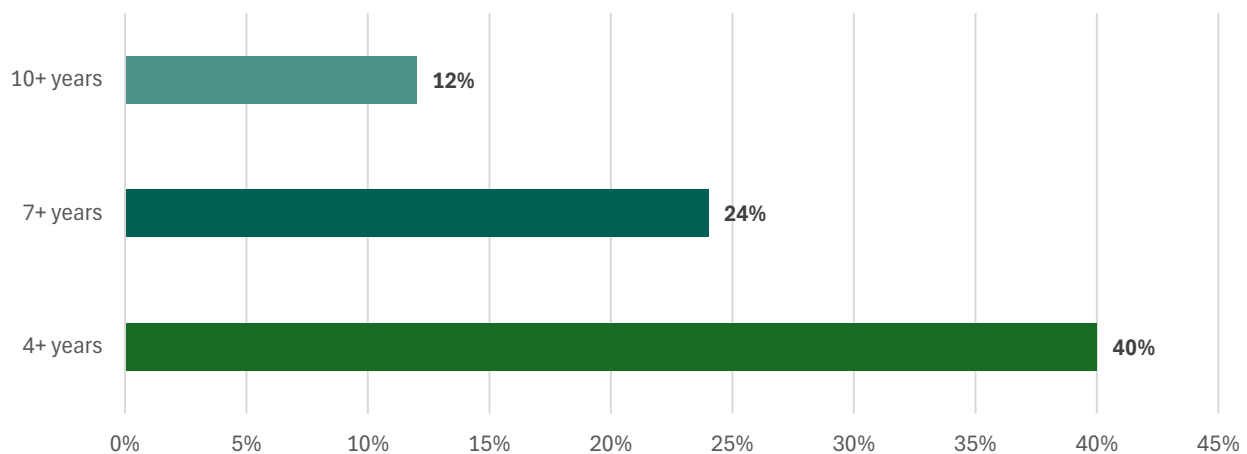


Before We Die Survey March 2026

fig. 3.7

The BWD respondents indicate that a significant proportion of future housing need is both unplanned and not formally captured. The majority of families have no formal housing plan in place (78%), with only a minority having documented arrangements. At the same time, 81% of individuals are not recorded on any official housing list. It is not specified if respondents require specialist residential services or independent living supports in social housing.

Housing Wait Times (% of Families)



Before We Die Survey March 2026

fig. 3.8

The BWD survey findings variably align the existing evidence base within the Intellectual Disability Supplement to the Irish Longitudinal Study on Ageing (IDS-TILDA). The IDS-TILDA Wave 5 (2023) shows alignment on carer age but divergence on planning and living arrangements. IDS-TILDA found that 62.9% of carers were aged over 66, all 38 parent carers were over 66 and four were over 86, exceeding the comparative BWD finding.⁸⁰ Alignment weakens on future planning with 64.4% of IDS-TILDA carers reporting they had thought about where their family member would live in five years and 55.6% of parent carers reporting a discussion on such with a professional.⁸⁰ Living arrangements also diverge with only 22.6% of IDS-TILDA participants reporting living independently or with family, against 92% of BWD respondents relying on a parent as primary carer, reflecting that IDS-TILDA follows an older cohort already largely transitioned into residential or community group settings.⁸⁰ IDS-TILDA's carer sample is small (n=73, and several analyses were based on smaller numbers of respondents due to item non-response or question-specific eligibility.), so its percentages carry wide uncertainty, and BWD's self-selecting sample should likewise be read as directional.



Data Review: Residential Services – Service Use and Demand

Data Review Findings

Residential Services

Residential Service Use

This section leverages data from NASS, DSMAT and HSE datasets, which are outlined on pages 40-43.

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Number in Residential 2025 (NASS)	8,318	1,733	2,013	1,442	1,005	770	1,355
Number in Residential 2025 (HSE Internal data)	8,911	~	~	~	~	~	~
New or supplemental Placements 2025	330	100	83	49	21	37	40

Sources: NASS 2025; HSE Achievements Document; DSMAT Activity Outturn 2025. *Note: Regional NASS data may not match national service use as seen in subsequent breakdown tables due to unassigned regions or services provided outside the State.

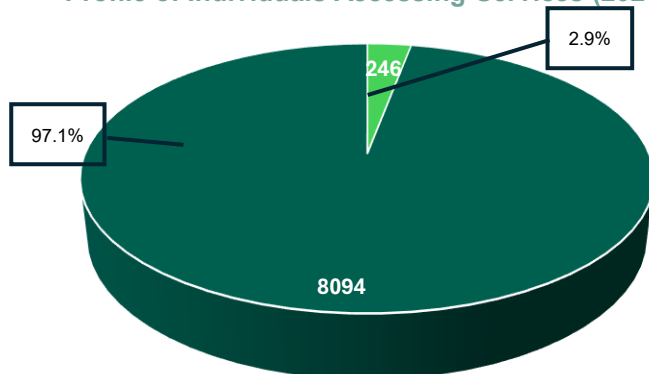
Table 3.13

According to the HSE Disability achievement report, a total of **8,911** placements were provided nationally in 2025 (with **330** new or supplemental placements provided (DSMAT). Based on 2025 NASS data, HSE Dublin & North East (2,013) and HSE Dublin & Midlands (1,733) together account for approximately 45% of residential occupancy. When adjusted for population size, however, the Mid West region records the highest rate of service users accessing residential services (20.0 per 10,000 population), while South West records the lowest (14.6 per 10,000 population). This highlights that absolute service volumes are concentrated in larger population centres, while utilisation rates vary across regions. New or supplemental placements account for 3.7% of total residential placements in 2025, indicating that most residential activity reflects ongoing occupancy.

RHA	NASS residential users	Population	NASS users per 10,000 population
Dublin & Midlands	1,733	1,000,042	17.33
Dublin & North East	2,013	1,081,727	18.61
Dublin & South East	1,442	893,502	16.14
South West	1,005	690,575	14.55
Mid West	770	384,998	20
West & North West	1,355	711,048	19.06

Table 3.14

Profile of Individuals Accessing Services (2025)

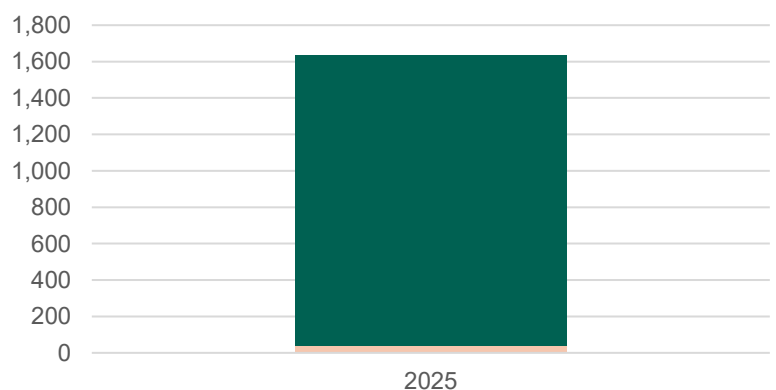


Source: NASS 2025

■ Children ■ Adult

fig. 3.10

Identified Enhancement to Residential Services Required



■ Children ■ Adult

fig. 3.9

Adults make up the vast majority of NASS registered users at 8,094 (97.1%) compared to 246 children (2.9%). Of those currently in residential services, 1,635 individuals have been identified as requiring service enhancements, 38 children and 1,597 adults. In this context, enhancement refers to existing placements that are expected to require additional or altered supports within the next 12 months and is explored in a later section.

Data Review Findings

Number awaiting services

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Number awaiting Residential Services – New Provision	1,486	89	73	423	242	324	335
Priority 1 (emergency)	291	34	40	39	47	10	121
Priority 2 (contingency)	142	15	9	58	4	9	47
Priority 3 (future needs / TBC)	1,053	40	24	326	191	305	167
Number awaiting Residential Services – Supplemental Provision	163	33	5	19	25	32	49
Priority 1 (emergency)	39	12	1	2	13	2	9
Priority 2 (contingency)	32	13	1	3	6	6	3
Priority 3 (future needs / TBC)	92	8	3	14	6	24	37
Total	1,649	122	78	442	267	356	384

Source: DSMAT Q1 2026 report

Table 3.15

Supplementary provision in this context refers to additional funded supports required for individuals already in residential services whose needs have changed (e.g. due to ageing, behavioural or health factors). Demand is primarily driven by longer-term future need (Priority 3) making up **69%** of national total. There remains a material cohort of Priority 1 cases, totalling 330 with over one-third located in the HSE West and North West region. The Mid West region records the highest residential waiting list relative to population size, followed by West & North West and Dublin South East. The extent to which existing residential capacity aligns with this demand is examined separately in the subsequent Capacity Analysis section.

RHA	Total Waiting List	Population	Per 10,000 Population
Dublin & Midlands	122	1,000,042	1.22
Dublin & North East	78	1,081,727	0.72
Dublin & South East	442	893,502	4.95
South West	267	690,575	3.87
Mid West	356	384,998	9.25
West & North West	384	711,048	5.4
National	1,649	4,761,892	3.46

Table 3.16

Future Identified Need

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Future identified needs for Residential (NASS 2025)	2,197	471	432	532	275	102	384

Sources: NASS 2025 *Note: Regional NASS data may not match national service use as seen in subsequent breakdown tables due to unassigned regions or services provided outside the State.

Table 3.17

Identified as Requiring Residential Services 2025-2030

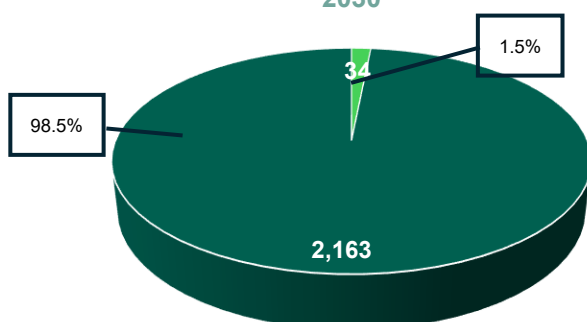


fig. 3.11

■ Children ■ Adults

RHA	Future Identified Need	Population	Per 10,000 Population
Dublin & Midlands	471	1,000,042	4.71
Dublin & North East	432	1,081,727	3.99
Dublin & South East	532	893,502	5.95
South West	275	690,575	3.98
Mid West	102	384,998	2.65
West & North West	384	711,048	5.4
National	2,196	4,761,892	4.61

Table 3.18

Data Review Findings

Residential Services

Looking ahead to the 2025-2030 period, 2,197 individuals have been identified as requiring residential services. Similar to the split of current provision, adults account for the majority of the cohort with 34 children and 2,163 adults. Children account for 1.5% of this future need, though additional demand has grown substantially since 2023 as explored below. The majority of future residential demand (98.5%) relates to adults, with community-based accommodation representing the primary service type required across both cohorts.

Dublin & South East has the highest future Identified need : Population ratio, while Mid West has the lowest.

Comparison of NASS identified need and DSMAT waiting list data highlights regional variation in how future demand presents. Dublin & Midlands and Dublin & North East record relatively high levels of identified need but lower waiting list rates, whereas Mid West records the highest waiting list rate but comparatively lower identified future need. This may reflect differences in local demand profiles, service pathways or how identified future need progresses to active residential applications.

Multi-year Trends

There is a significant divergence in demographic trends within residential services. The following table illustrates the breakdown of children and adults using residential services as outlined in NASS data from 2023-2025.

	Children	Adults	Total	Children (%)	Adults (%)	Children YoY Change	Children YoY Change (%)
2023	93	7,799	7,892	1.2%	98.8%	~	~
2024	192	7,844	8,036	2.4%	97.6%	99	106.5%
2025	246	8,094	8,340	1.9%	97.1%	54	28.1%
2023-2025 Change	153	295	448	~	~	153	164.5%

Sources: NASS 2025, NASS 2024, NASS 2023

Table 3.19

% Growth in Residential Service use 2023 - 2025 (%)

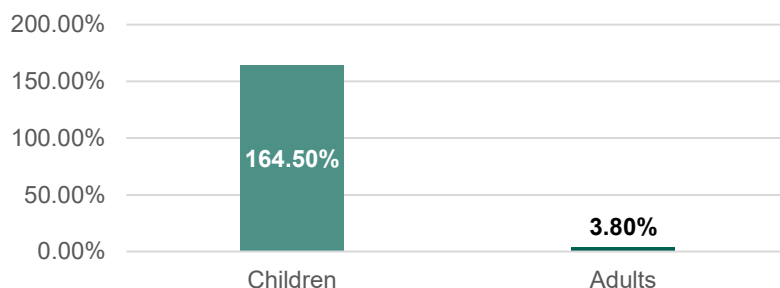


fig. 3.12

While the number of adults accessing residential services increased by 3.8% between 2023 and 2025, the number of children increased by 164.5% over the same period. Much of this growth occurred in 2024, when the number of children increased by 106.5% year-on-year. Although adults continue to account for majority of the cohort, the data indicates a clear upward trend in the number of children accessing residential services.

The below table illustrates the future identified need for residential services as recorded in NASS from 2023-2025.

Year	Children	Adults	Total	Children (%)	Adults (%)
2023	20	1,932	1,952	1.0%	99.0%
2024	9	2,044	2,053	0.4%	99.6%
2025	34	2,163	2,197	1.5%	98.5%

Sources: NASS 2025, NASS 2024, NASS 2023

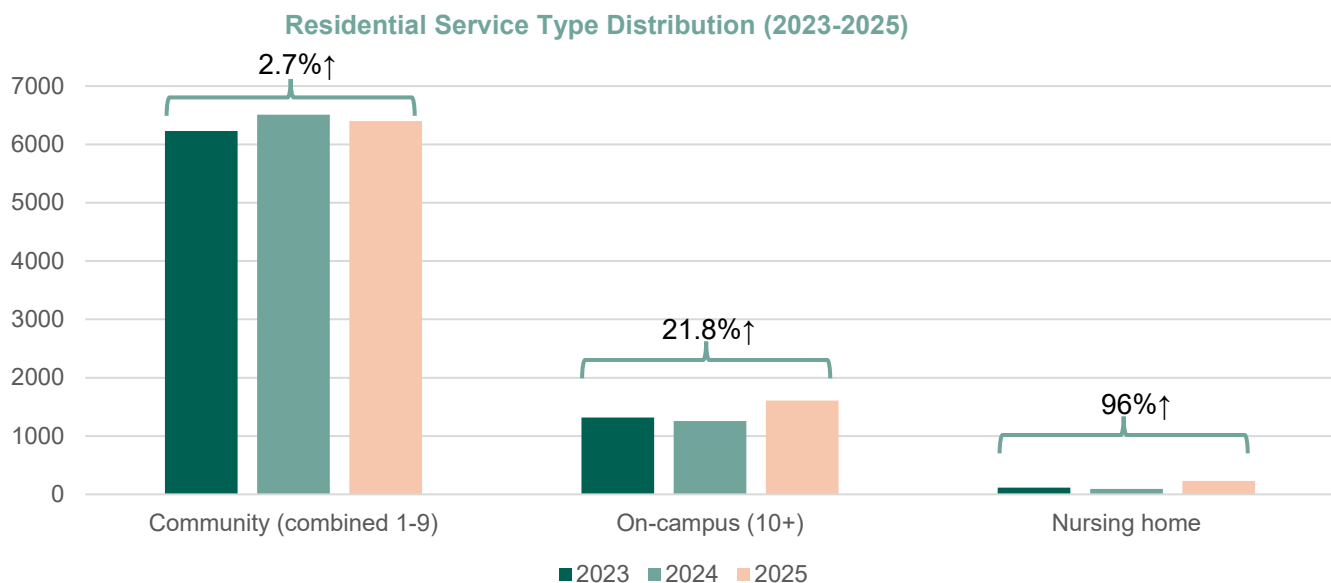
Table 3.20

As with current residential use, future identified need is primarily concentrated in the adult cohort. However, over the two-year period, the number of children identified as requiring residential services increased by approximately 70%, compared with a 12% increase among adults.

Data Review Findings

Residential Services

Multi-year Trends



Source: NASS 2025

fig. 3.13

Nursing home placements almost doubled (+96%), rising from 117 to 229, though absolute numbers remain relatively small. On-campus residential centres (10+ residents) grew 22% from 1,319 to 1,606 following dip in 2024. The majority of provision is in community services, totalling 6,339 or approximately 77% of total number accessing services. The continued predominance of community-based residential settings is broadly aligned with national policy objectives supporting deinstitutionalisation and community inclusion.

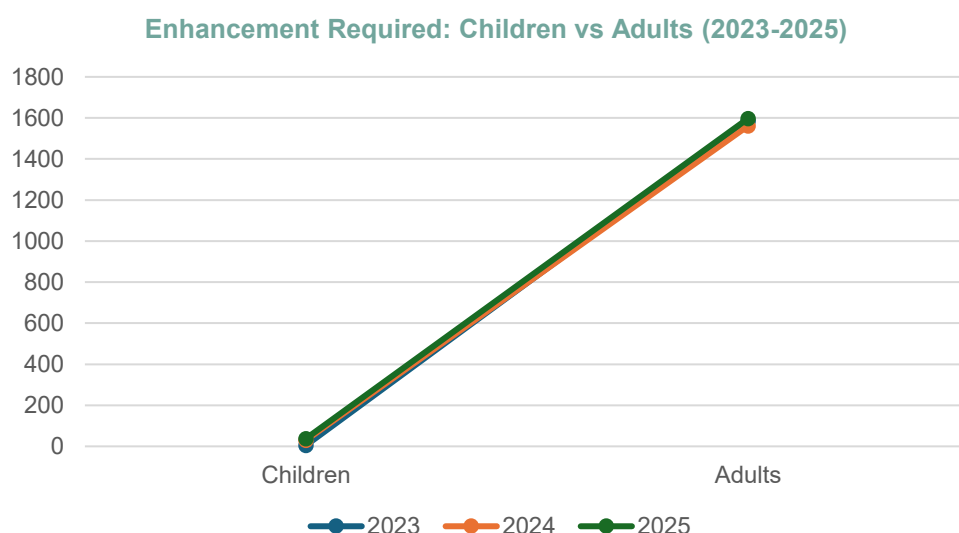


fig. 3.14

Approximately 20% of service users accessing residential services require service enhancement each year, with this proportion remaining broadly stable over the period. However, the number of children requiring enhancement increased from 5 to 38 (+660%). This may reflect increasing complexity of need among a subset of children, greater demand for intensive support arrangements, and situations where families and community-based supports are no longer able to safely meet support needs.

Data Review Findings

Geographic Distribution of Residential Need – County Level

County	No. Residential Service Users 2025	No. identified Need Residential Services 2025-2030	DSMAT Applications Q2 2026	County Population (2022)	Service Users per 10,000 population	Unmet Need per 10,000 population	DSMAT applications per 10,000
Co. Carlow	89	16	15	61968	14.20	2.26	2.42
Co. Cavan	52	12	7	81704	6.12	6.12	0.86
Co. Clare	179	18	89	127938	13.76	1.02	6.96
Co. Cork	784	197	115	584156	13.32	3.18	1.97
Co. Donegal	186	96	59	167084	11.13	5.63	3.53
Co. Dublin	1,833	740	396	1458154	12.31	5.07	2.72
Co. Galway	492	153	43	277737	17.35	5.36	1.55
Co. Kerry	228	66	77	156458	14.51	3.96	4.92
Co. Kildare	593	55	26	247774	23.57	2.14	1.05
Co. Kilkenny	340	24	(included in Carlow)	104160	32.35	2.11	N/A
Co. Laois	148	18	15	91877	16.11	1.31	1.63
Co. Leitrim	34	18	16	35199	8.81	3.13	4.55
Co. Limerick	487	57	81	209536	22.62	2.62	3.87
Co. Longford	77	32	4	46751	15.19	5.56	0.86
Co. Louth	388	17	35	139703	27.13	1.00	2.51
Co. Mayo	249	50	46	137970	17.25	3.19	3.33
Co. Meath	371	129	29	220826	16.21	5.75	1.31
Co. Monaghan	136	11	3	65288	20.83	1.38	0.46
Co. Offaly	125	33	(Included in Laois)	83150	15.03	3.97	N/A
Co. Roscommon	118	41	14	70259	16.80	5.69	1.99
Co. Sligo	284	26	49	70198	40.03	2.85	6.98
Co. Tipperary	275	74	42	167895	16.14	4.23	2.50
Co. Waterford	207	39	7	127363	16.10	2.83	0.55
Co. Westmeath	240	37	15	96221	24.63	3.53	1.56
Co. Wexford	198	56	10	163919	11.23	3.11	0.61
Co. Wicklow	241	135	128	155851	15.27	8.21	8.21

Sources: NASS 2025; DSMAT; Census 2022. Figures should be taken as directional rather than exact.

Table 3.21

Current Residential Service Use and Identified Need

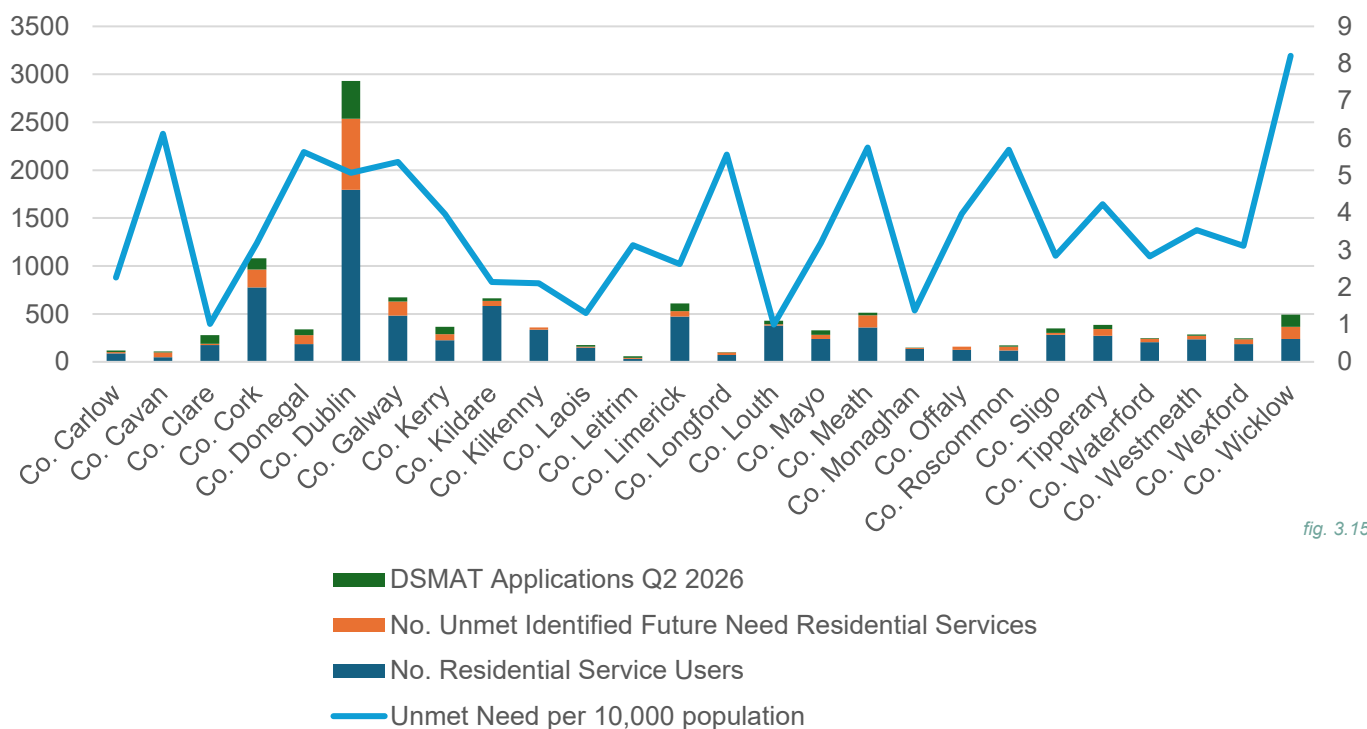


fig. 3.15

Data Review Findings

Geographic Distribution of Residential Need – County Level

- County-level analysis highlights variation in both current residential service use and future residential demand across Ireland. Dublin and Cork account for the largest absolute numbers of service users accessing residential services, identified future need and DSMAT residential applications. While these metrics are not directly additive and should be interpreted with caution, they provide an indicator of residential need across counties.
- Identified future residential need is concentrated in a number of counties, particularly Dublin, Cork, Galway, Meath and Wicklow. Similarly, high levels of DSMAT residential applications are recorded in Dublin, Wicklow, Cork and Clare, indicating ongoing demand for additional residential provision across several parts of the country.
- When adjusted for population, the highest rates of identified unmet need are evident in Wicklow, Cavan, Donegal, Roscommon and Meath, while Sligo, Louth, Westmeath and Kildare record the highest rates of current residential service use.
- These findings suggest that future residential demand is not evenly distributed geographically and should be considered alongside local demographic profiles, service utilisation patterns and other indicators of need when planning future service development. **The relationship between identified demand and available residential capacity is explored in a later section.**

Age Profile of Identified Future Residential Need by County

County (of Residence)	0-17 years	18-24 years	25-39 years	40-59 years	60-69 years	70+ years
Co. Carlow	<5	8	6	<5	0	0
Co. Cavan	0	6	5	<5	0	0
Co. Clare	0	7	6	<5	<5	0
Co. Cork	16	88	66	6	<5	10
Co. Donegal	23	31	25	9	0	<5
Co. Dublin	83	316	248	49	27	17
Co. Galway	26	78	45	<5	<5	0
Co. Kerry	<5	20	34	8	<5	0
Co. Kildare	7	27	19	<5	0	0
Co. Kilkenny	9	8	5	<5	0	0
Co. Laois	<5	12	<5	0	0	0
Co. Leitrim	0	11	<5	<5	0	0
Co. Limerick	<5	27	28	0	0	0
Co. Longford	<5	16	10	<5	<5	0
Co. Louth	0	9	5	<5	0	0
Co. Mayo	0	16	28	<5	<5	0
Co. Meath	25	49	53	<5	0	0
Co. Monaghan	0	<5	9	0	0	0
Co. Offaly	9	16	8	0	0	0
Co. Roscommon	7	19	14	<5	0	0
Co. Sligo	<5	8	12	<5	<5	0
Co. Tipperary	11	34	26	<5	0	<5
Co. Waterford	<5	15	13	8	0	0
Co. Westmeath	8	18	8	<5	<5	0
Co. Wexford	<5	20	23	8	<5	0
Co. Wicklow	17	60	46	5	<5	0

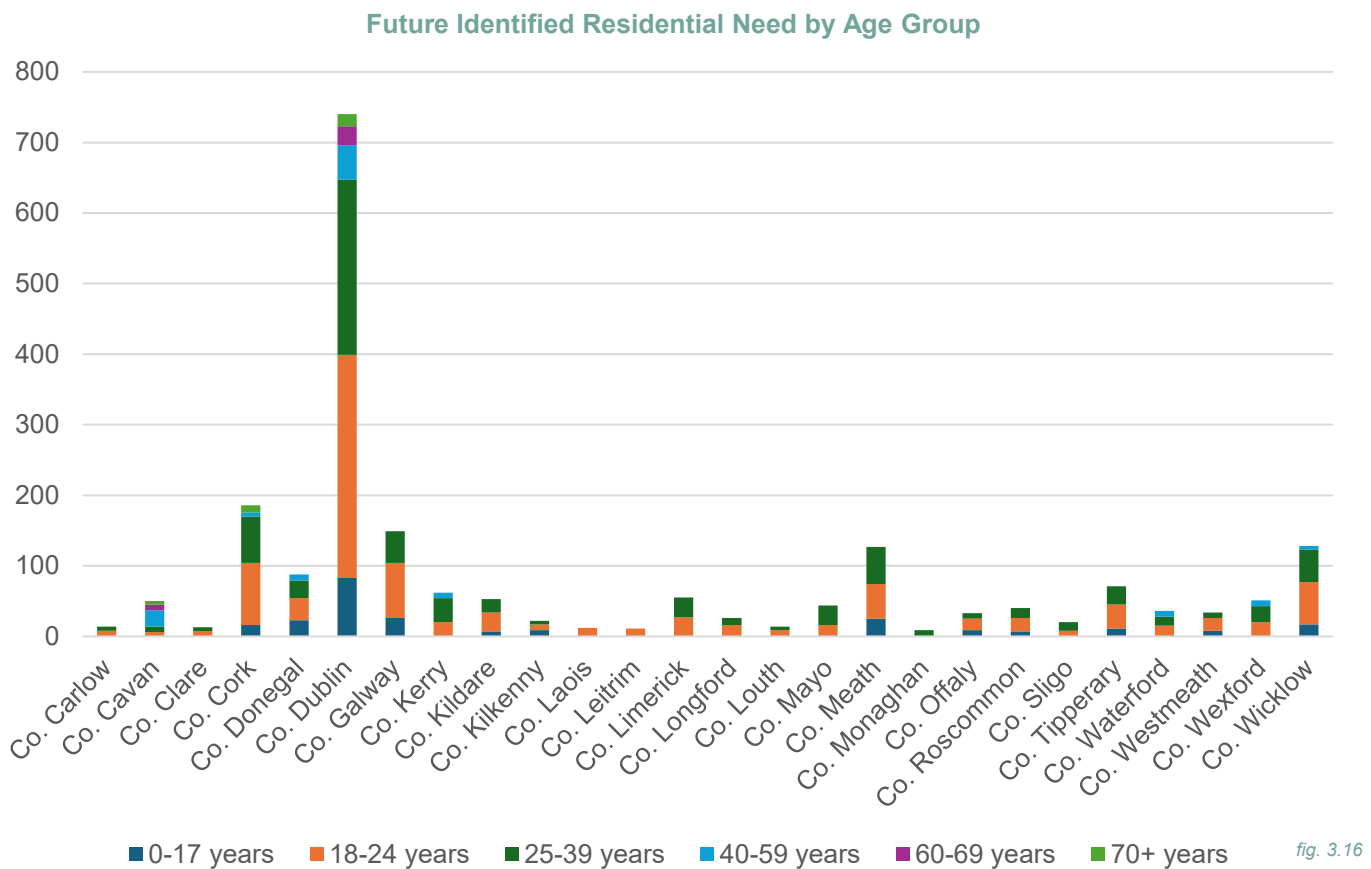
Sources: NASS 2025, Numbers less than 5 were suppressed from NASS reporting. These figures should be interpreted as directional, not exact.

Table 3.22

Interpretation Note: The table above refers to the identified unmet need for **accommodation in the community**. The numbers reported for unmet need for other residential service types, such as specialist facilities, campus accommodation, or nursing home were suppressed as the numbers were fewer than five across all counties and age groups. The only exception is the 6 people who reported an unmet need for a specialist facility for a neurological disorder in Donegal (age group 25–39), which is included.

Data Review Findings

Age Profile of Identified Future Residential Need by County



- The age profile of identified future residential need varies across counties, but is predominantly concentrated among adults aged 18–39 years, particularly in Dublin, Cork, Galway, Meath and Wicklow.
- While identified need among children is comparatively lower, a number of counties, including Dublin, Donegal, Galway and Meath, record notable levels of need among the 0–17 age group, consistent with wider trends showing increasing demand for residential supports among children and young people with complex needs.
- Need among older age groups is less prevalent overall but is evident in a number of counties, particularly Dublin and Cavan. This may reflect both the impact of ageing carers and increasing support needs among older disability service users.

Data Review Findings

Residential Services

Section Summary

- **Scale of provision:** HSE data recorded 8,911 residential placements in 2025, of which 330 (3.7%) were new or supplemental placements, suggesting that most activity reflects ongoing occupancy.
- **Adult-dominated cohort:** Adults represent 97.1% (8,094) of service users accessing residential services in 2025 vs. 2.9% children (246), with the same split echoed in future identified need (98.5% adult).
- **Future demand:** 2,197 individuals have been identified as requiring residential services between 2025–2030, while 1,649 individuals were recorded on the DSMAT residential waiting list in Q1 2026, indicating continued demand for additional residential provision. The majority of demand relates to community-based accommodation.
- **Total estimated demand:** Combining current service users (8,911), with NASS-reported future demand (2,197) and active DSMAT applications (1,649), it gives a total estimated demand for residential services of 12,757. This should be interpreted with caution as NASS and DSMAT figures are not directly additive and may contain cross-over of individuals counted in both. It should be interpreted as indicative of the level of demand, and not an exact figure.
- **Growth in the child cohort:** Children in residential services rose 164.5% from 2023–2025 (vs. 3.8% for adults). This was at a rate ~43x faster than adults, with enhancement need for children up 660% (5 to 38) and future identified need similarly growing quickly at 70% in the same period. Although children remain a small proportion of the overall cohort, the sustained growth may indicate increasing complexity of need and greater demand for intensive supports.
- **Priority 1:** 1,649 individuals are awaiting residential support, including 330 Priority 1 (emergency) cases, with over a third of Priority 1 cases in HSE West & North West.
- **Geographic variation:** Residential service use and future demand vary considerably across counties. Dublin, Cork, Galway, Meath and Wicklow record the highest absolute levels of future identified need and residential demand.
- **Population-adjusted demand:** When adjusted for population size, the highest rates of identified unmet residential need are evident in Wicklow, Cavan, Donegal, Roscommon and Meath, highlighting areas where demand is disproportionately high relative to population.
- **Waiting list pressures:** The Mid West records the highest residential waiting list relative to population size (9.25 per 10,000 population), followed by West & North West (5.40) and Dublin & South East (4.95), demonstrating regional variation in active demand for residential provision.
- **Service model:** Community-based accommodation remains the dominant model of residential provision, accounting for approximately 77% of service users accessing residential services, broadly aligning with national policy objectives supporting community inclusion and deinstitutionalisation. However on-campus centres grew 22% and nursing-home placements nearly doubled (+96%) from 117 to 229, between 2023 and 2025.
- **Capacity planning:** The extent to which existing residential and respite capacity aligns with current and future demand is examined separately in the Capacity Analysis section.

Interpretation Note: These findings should be interpreted as directional rather than definitive. NASS values below five are suppressed, and totals may vary across data extracts owing to differences in regional assignment, service classification, or the inclusion of provision delivered outside the State.



Data Review: Respite – Service Use and Demand

Data Review Findings

Respite

Respite Service Use

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Number accessing Respite (Overnight)	6,021	1,413	1,637	1,117	619	441	794
Number accessing Respite (Day only)	1,978	480	632	335	131	201	199

Source: NASS 2025 *Note: Regional NASS data may not match national service use as seen in subsequent breakdown tables due to unassigned regions or services provided outside the State. Table 3.23

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Total Overnights	165,593	28,521	36,917	23,000	18,348	17,167	41,640
Total days (day only)	68,874	2,875	22,738	13,385	5,315	2,833	21,728

Source: DSMAT 2025 Activity Outturn

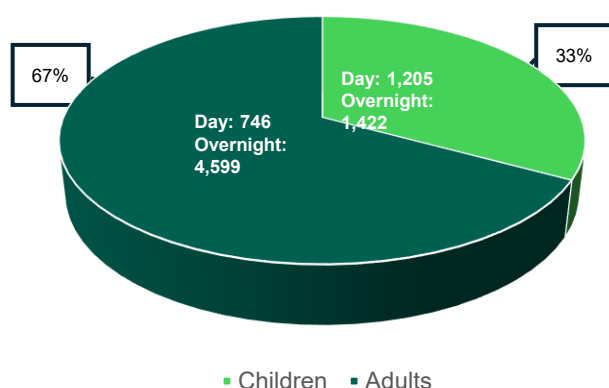
An estimated 165,593 respite overnights were provided in 2025, with approximately 25% delivered in HSE West and North West and 22% in HSE Dublin and North East. A further 68,874 day-only respite sessions were provided, with the majority concentrated in these same regions (64%). Dublin & North East has the highest rate of overnight respite users per 10,000 population, while South West has the lowest. Day respite utilisation is considerably lower than overnight respite across all regions, with national rates of 12.64 overnight users and 4.15 day users per 10,000 population.

RHA	NASS Overnight Respite users	NASS Day Respite users	Population	Overnight users per 10,000 population	Day users per 10,000 population
Dublin & Midlands	1,413	480	1,000,042	14.12	4.8
Dublin & North East	1,637	632	1,081,727	15.13	5.84
Dublin & South East	1,117	335	893,502	12.5	3.75
South West	619	131	690,575	8.96	1.9
Mid West	441	201	384,998	11.45	5.22
West & North West	794	199	711,048	11.17	2.8
National	6,021	1,978	4,761,892	12.64	4.15

Table 3.24

Table 3.25

Profile of Individuals Accessing Respite (Day & Overnight)



Source: NASS 2025

fig. 3.18

Identified Enhancement to Respite Services Required

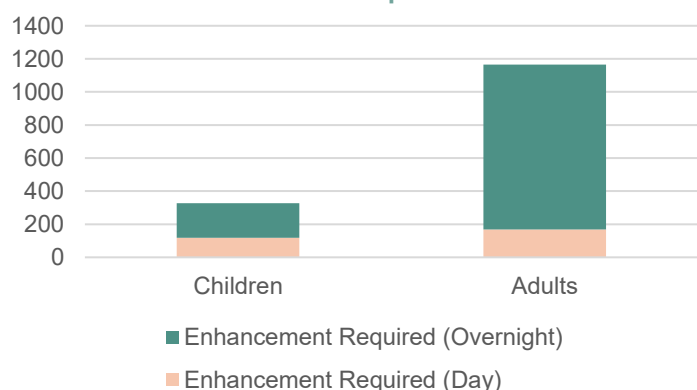


fig. 3.17

Respite service use reflects distinct patterns across day and overnight provision. Enhancement in this scenario refers to places accessed which require an alteration in the next 12 months; for example, additional hours/days or additional support. Day respite appears relatively balanced between children and adults in terms of enhancement need (169 adults vs 118 children), suggesting that while current utilisation is somewhat children oriented, additional demand is more evenly distributed across age groups. In contrast, overnight respite demonstrates a clear concentration among adults, with enhancement requirements predominantly concentrated in adult provision (997 adults vs 209 children). This divergence indicates that, while both service types experience demand across the lifespan, the most acute capacity gap is within adult overnight respite. Totals may vary slightly due to differences in NASS extracts and classification across service types.

Data Review Findings

Respite

Number Awaiting Services

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Estimate awaiting Respite (DSMAT Q1 2026)	920	174	50	185	177	163	171
Priority 1 (emergency)	124	33	17	12	12	23	27
Priority 2 (contingency)	97	12	9	31	1	18	26
Priority 3 (future needs / TBC)	699	129	24	142	147	139	118

Source: DSMAT Q1 2026 (*Regional figures estimated using proxy percentages derived from a subset of DSMAT non-residential applications with identified service type - respite, home support and PA. Proportions have been applied to total and regional non-residential demand data as indicative estimates.)

Table 3.26

Demand is concentrated in longer term need (Priority 3), which comprises **three quarters** of the national total. The regional spread sees relatively similar volumes, with the exception of HSE Dublin and North East, suggesting that demand is broadly distributed rather than concentrated in specific regions. While the national average is 1.93 per 10,000 population, rates are notably higher in the Mid West, South West, West & North West, and Dublin & South East. In contrast, Dublin & Midlands (1.74) and particularly Dublin & North East (0.46) report lower rates of unmet demand relative to population size.

RHA	Total Waiting List	Population	Per 10,000 Population
Dublin & Midlands	174	1,000,042	1.74
Dublin & North East	50	1,081,727	0.46
Dublin & South East	185	893,502	2.07
South West	177	690,575	2.56
Mid West	163	384,998	4.23
West & North West	171	711,048	2.40
National	920	4,761,892	1.93

Table 3.27

Future Identified need

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Future identified needs for Respite (overnights)	1,316	215	362	369	216	63	237
Future identified needs for Respite (day only)	222	~	~	~	~	~	~

Source: NASS 2025 *Note: Regional NASS data may not match national service use as seen in subsequent breakdown tables due to unassigned regions or services provided outside the State.

Table 3.28

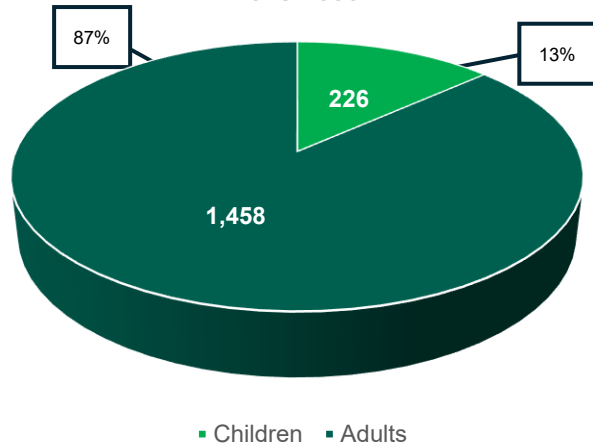
Nationally, 1,316 individuals have been identified as requiring overnight respite services in the 2025-2030 period. HSE Dublin & South East accounts for the largest share at 369, followed closely by Dublin & North East (362). The West & North West region shows the third highest demand at 237, while Mid West reports the lowest at 63. Data on day-only respite needs is limited, with a national figure of 222.

Data Review Findings

Respite

Future Identified Need

Profile of Individuals Requiring Respite Services 2025-2030



Source: NASS 2025

fig. 3.19

Identified as Requiring Respite Services 2025-2030

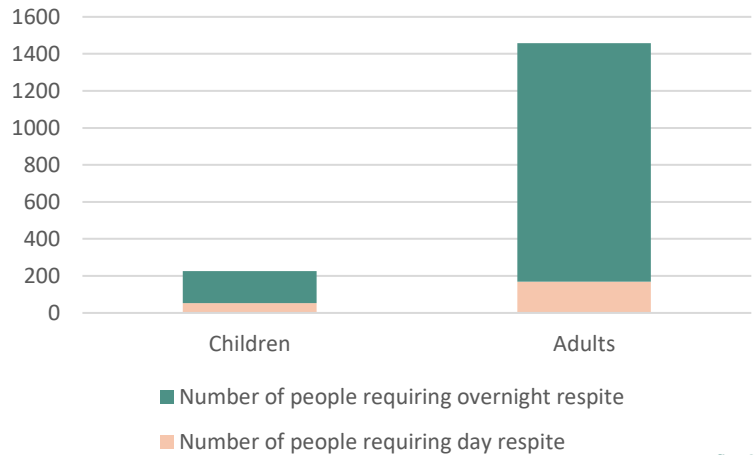


fig. 3.20

The identified need for future respite services broadly aligns with the trends observed in required enhancements to current provision. Adult need accounts for the majority of the cohort (1,458 individuals), including 1,289 requiring overnight respite and 169 requiring day respite. Overnight respite represents the primary area of demand and is largely concentrated among adults (1,289 compared with 173 children). Day respite demand is also predominantly adult-led (169 compared with 53 children), although the gap is less pronounced. The aligning demand structures paint a clear of need for expansion and enhancement of capacity of adult respite services, particularly in the area of overnight respite. The extent to which existing respite capacity aligns with this demand is examined separately in the subsequent Capacity Analysis section.

Nationally, there are 1,316 people identified as having a future overnight respite need, equivalent to 2.76 people per 10,000 population. Rates vary considerably across RHAs. Dublin & South East, Dublin & North East, and West & North West report the highest rates of future identified respite need relative to population, while Dublin & Midlands and Mid West show comparatively lower rates. Notably, the Midwest region has highest ratio of waiting list to population for residential and respite, and the lowest identified future need to population ratio for both.

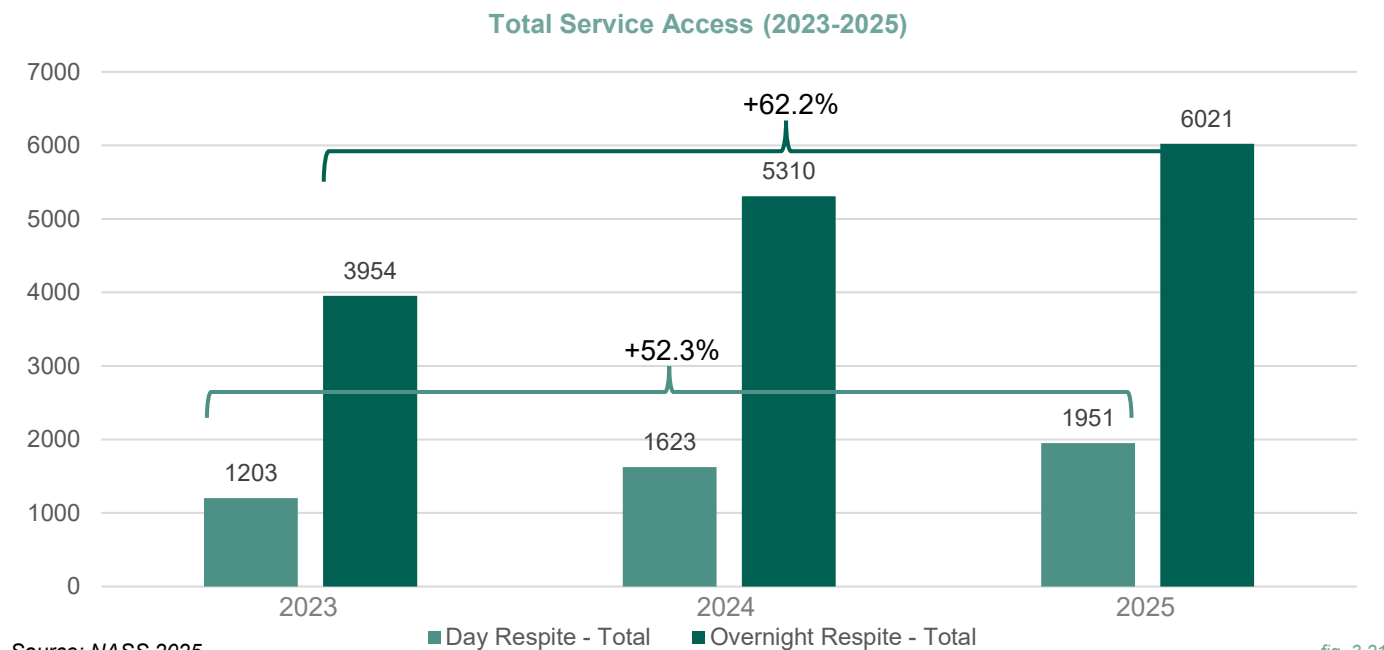
RHA	Future Identified Need Respite	Population	Per 10,000 Population
Dublin & Midlands	215	1,000,042	2.15
Dublin & North East	362	1,081,727	3.35
Dublin & South East	369	893,502	4.13
South West	216	690,575	3.13
Mid West	63	384,998	1.64
West & North West	237	711,048	3.33
National	1316	4,761,892	2.76

Table 3.29

Data Review Findings

Respite

Multi-year Trends

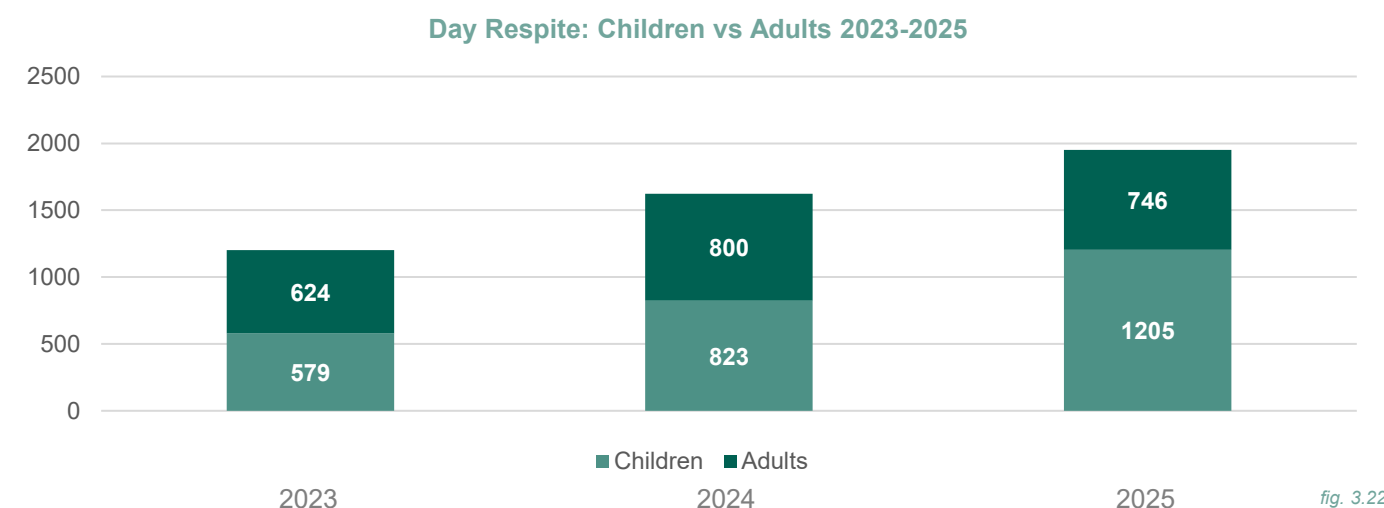


Both service types show strong sustained growth. Overnight respite remains the dominant service (>3x larger than day respite), but day respite is growing faster. The growth observed highlights divergence across age groups and service types when comparing provision for children and adults. The below table shows the breakdown of children and adult service provision between 2023-2025.

	Children	Adults	Total	Children (%)	Adults (%)
2023	1,391	3,766	5,157	26.97	73.3
2024	1,931	5,002	6,933	38.60	61.4
2025	2,627	5,345	7,972	32.95	67.05
2023-2025 Change	1,236	1,579	2,815	43.9	56.1

Source: NASS 2025, NASS 2024, NASS 2023

Table 3.30

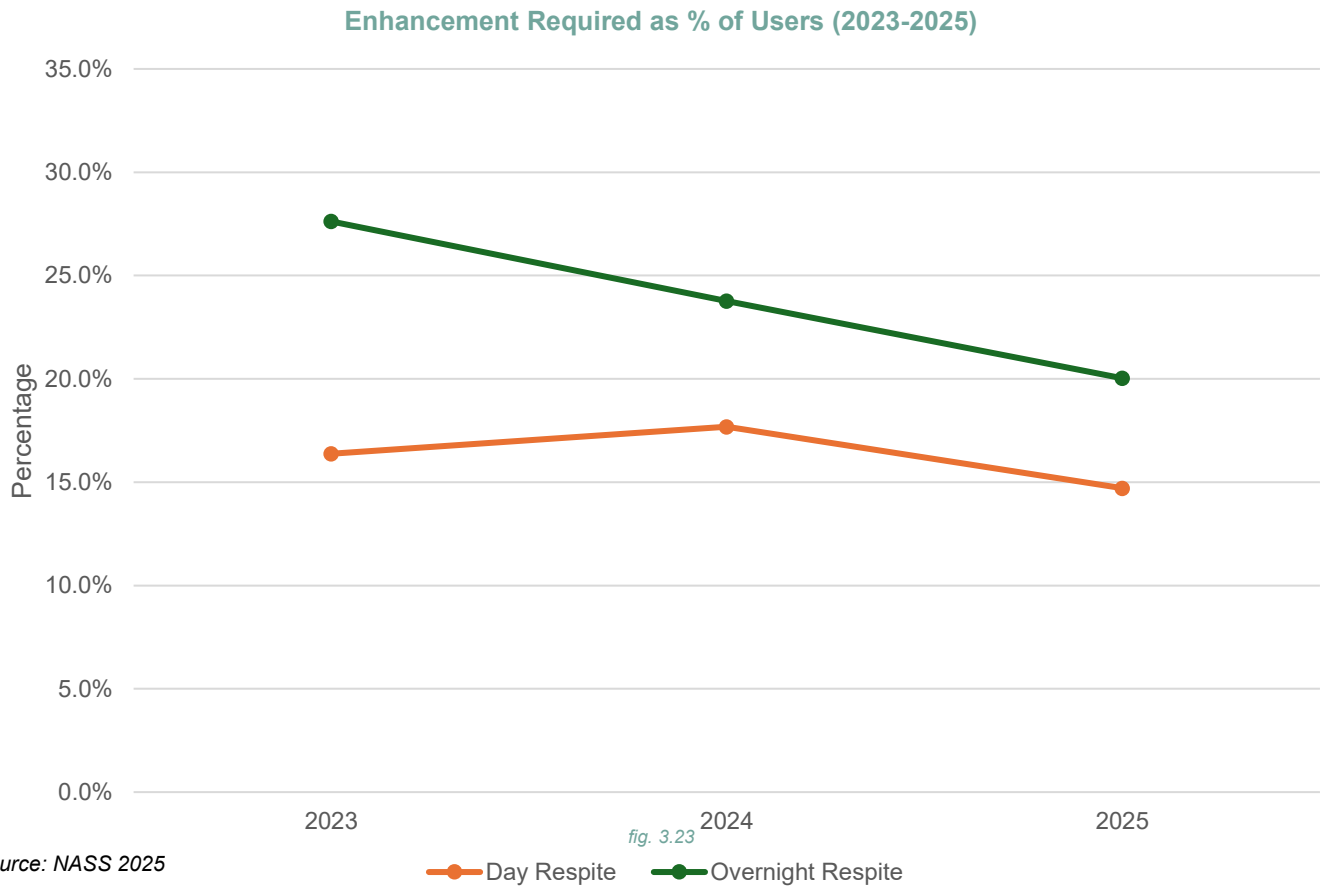


There is evidence of a shifting balance in day respite provision towards children's services. Children grew from 48% to 62% of day respite users, a 108% increase versus only 20% for adults.

Data Review Findings

Respite

Multi-year Trends



There is a decline in the proportion of service users who access respite requiring enhancement to their current provision. Day respite shows a decrease from 16.4% to 14.7% of service users, where overnight reduces from 27.6% to 20.0%. This indicates a decline in the proportion of users requiring.

Data Review Findings

Geographic Distribution of Day Respite Need – County Level

County	No. Service Users	No. Unmet Identified Future Need Day Respite Services	County Population	Service Users per 10,000 population	Unmet Need per 10,000 population
Co. Carlow	<5	<5	61968	<5	~
Co. Cavan	25	<5	81704	3.1	~
Co. Clare	95	<5	127938	7.4	~
Co. Cork	97	16	584156	1.7	0.3
Co. Donegal	82	5	167084	4.9	0.3
Co. Dublin	644	105	1458154	4.4	0.7
Co. Galway	20	<5	277737	0.7	~
Co. Kerry	27	<5	156458	1.7	~
Co. Kildare	65	<5	247774	2.6	~
Co. Kilkenny	5	<5	104160	0.5	~
Co. Laois	73	<5	91877	7.9	~
Co. Leitrim	<5	<5	35199	~	~
Co. Limerick	92	0	209536	4.4	0.0
Co. Longford	55	9	46751	11.8	1.9
Co. Louth	94	<5	139703	6.7	~
Co. Mayo	18	<5	137970	1.3	~
Co. Meath	22	12	220826	1.0	0.5
Co. Monaghan	22	<5	65288	3.4	~
Co. Offaly	83	<5	83150	10.0	~
Co. Roscommon	43	6	70259	6.1	0.9
Co. Sligo	25	10	70198	3.6	1.4
Co. Tipperary	49	6	167895	2.9	0.4
Co. Waterford	41	<5	127363	3.2	~
Co. Westmeath	127	6	96221	13.2	0.6
Co. Wexford	<5	0	163919	~	0.0
Co. Wicklow	112	7	155851	7.2	0.4

Sources: NASS 2025; HIQA; Census 2022. NASS figures across age groups and residential service types that were less than 5 were suppressed from reporting, so total figures may be marginally lower than real figures. Figures should be taken as directional rather than exact.

Table 3.31

Service Users and Identified Need by County

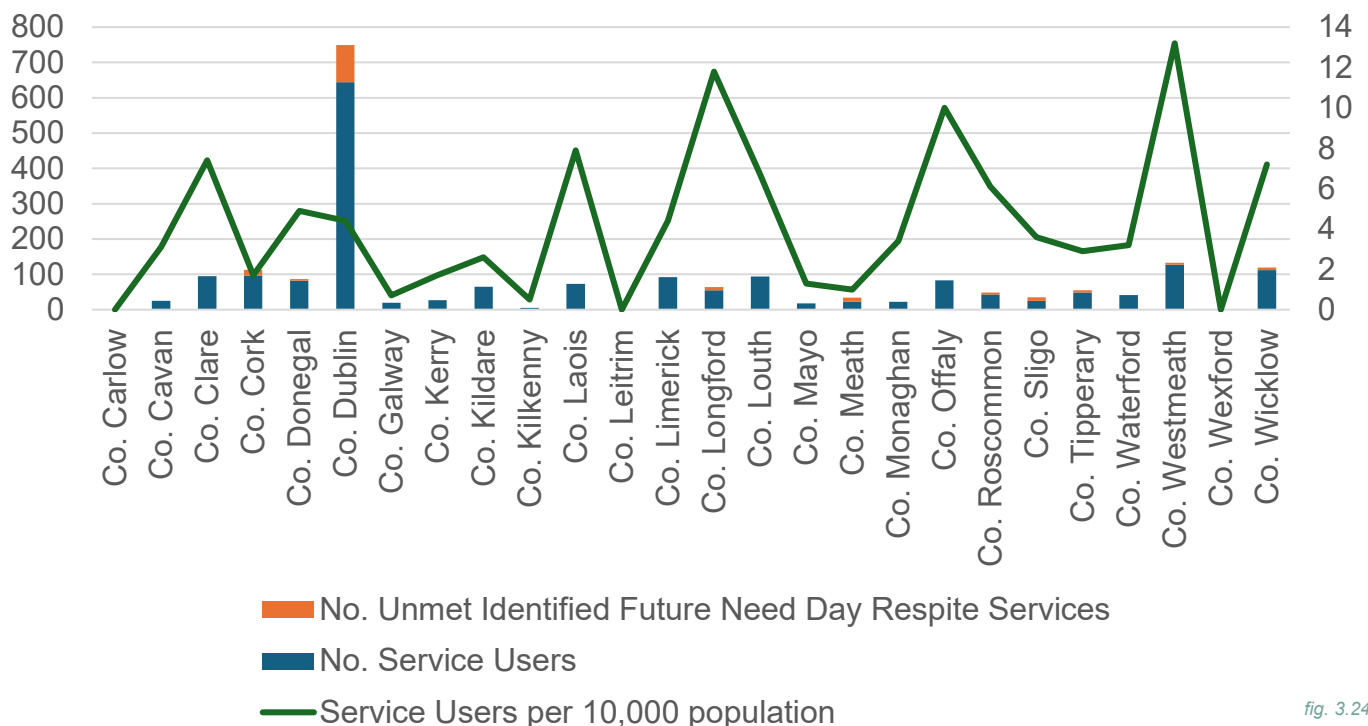


fig. 3.24

Data Review Findings

Geographic Distribution of Day Respite Need – County Level

- County-level analysis highlights variation in the distribution of day respite service users across Ireland. While Dublin and Cork account for the largest absolute numbers of users, population-adjusted analysis indicates that Westmeath, Longford, Offaly, Laois, Clare and Wicklow record the highest rates of day respite service utilisation relative to their populations. Conversely, a number of counties, including Galway, Meath, Mayo, Cork and Kerry, record comparatively low rates of service use.
- Identified future day respite need is concentrated in a small number of counties, particularly Dublin, Cork, Meath, Sligo, Longford, Wicklow, Roscommon and Tipperary. When adjusted for population, the highest rates of unmet identified future need is evident in Longford, Sligo, Roscommon, Dublin, Westmeath and Meath, suggesting comparatively greater future demand pressures in these areas.
- These findings indicate that future day respite demand is not evenly distributed geographically and should be considered alongside local demographic profiles and existing patterns of day respite utilisation when planning future service development. The relationship between identified demand and available respite capacity is explored separately in the Capacity Analysis section.

Age Profile of Identified Future Day Respite Need by County

County (of Residence)	0-17 years	18-24 years	25-39 years	40-59 years	60-69 years	70+ years
Co. Carlow	<5	0	0	0	0	0
Co. Cavan	<5	<5	<5	0	0	0
Co. Clare	0	<5	0	0	0	0
Co. Cork	<5	5	0	<5	<5	<5
Co. Donegal	0	<5	<5	0	<5	<5
Co. Dublin	7	32	<5	9	29	20
Co. Galway	0	<5	0	0	0	<5
Co. Kerry	<5	<5	0	0	0	0
Co. Kildare	0	0	0	<5	0	0
Co. Kilkenny	0	<5	0	0	0	<5
Co. Laois	0	0	0	0	0	<5
Co. Leitrim	0	0	0	<5	0	0
Co. Limerick	0	0	0	0	0	0
Co. Longford	0	0	0	7	0	<5
Co. Louth	0	0	0	<5	0	0
Co. Mayo	0	0	0	<5	0	<5
Co. Meath	<5	<5	0	5	<5	<5
Co. Monaghan	0	0	0	0	<5	0
Co. Offaly	0	<5	0	0	<5	0
Co. Roscommon	0	0	0	0	0	6
Co. Sligo	0	<5	0	8	0	<5
Co. Tipperary	<5	<5	<5	0	<5	<5
Co. Waterford	0	0	0	<5	0	<5
Co. Westmeath	0	0	0	<5	0	<5
Co. Wexford	0	0	0	0	0	0
Co. Wicklow	0	<5	0	5	<5	<5

Sources: NASS 2025, Numbers less than 5 were suppressed from NASS reporting. These figures should be interpreted as directional, not exact.

Table 3.32

Data Review Findings

Age Profile of Identified Future Day Respite Need by County

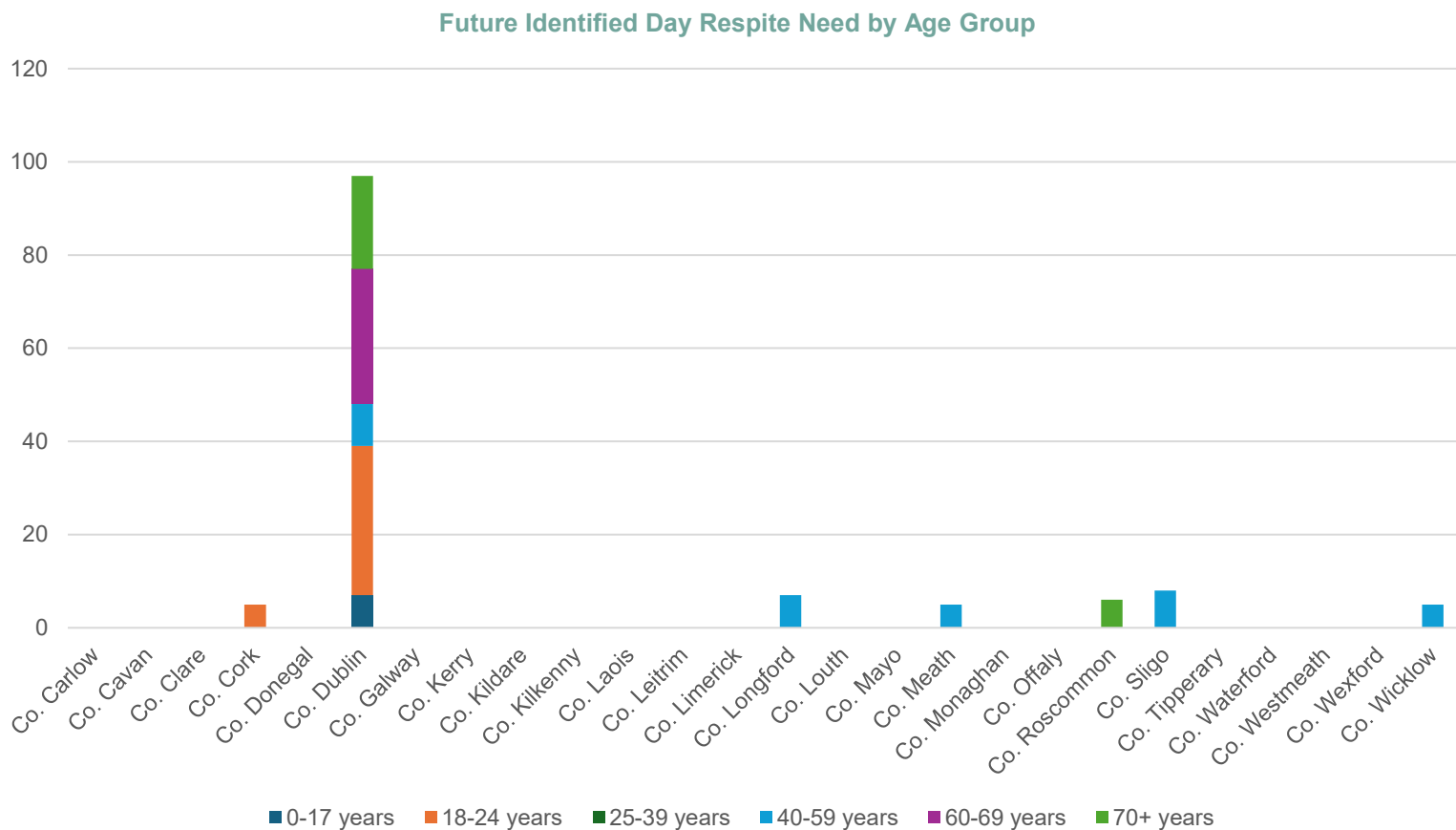


fig. 3.25

- The age profile of identified future day respite need is concentrated among adults, particularly those aged 18–24 years and older adults aged 60+ years. Need among children aged 0–17 years is comparatively low, with only a small number of recorded cases across the dataset.
- Co. Dublin accounts for the majority of identified future need across all age cohorts, recording the highest values in the 18–24 and 60+ age groups. Outside Dublin, recorded need is generally low, with only a small number of counties showing values above suppression thresholds, dominated mostly in the 40–59 cohort.
- While requirements are evident across the adult life course, the highest levels of identified need is concentrated among younger adults aged 18–24 years and older adults aged 60 years and over.
- Need among adults aged 40–59 years is present but more limited geographically, with notable recorded values in Dublin, Longford, Sligo, Meath and Wicklow.
- The strongest concentration of identified future need among older adults is observed in the 60–69 and 70+ age groups, particularly in Co. Dublin.

Data Review Findings

Geographic Distribution of Overnight Respite Need – County Level

County	No. Service Users	No. Unmet Identified Future Need Overnight Respite Services	County Population	Service Users per 10,000 population	Unmet Need per 10,000 population
Co. Carlow	70	10	61968	11.29	1.6
Co. Cavan	115	21	81704	14.1	2.6
Co. Clare	213	5	127938	16.6	0.4
Co. Cork	488	163	584156	8.4	2.8
Co. Donegal	225	44	167084	13.5	2.6
Co. Dublin	1743	433	1458154	12.0	3.0
Co. Galway	257	106	277737	9.3	3.8
Co. Kerry	139	52	156458	8.9	3.3
Co. Kildare	345	19	247774	13.9	0.8
Co. Kilkenny	105	102	104160	10.1	9.8
Co. Laois	120	6	91877	13.1	0.7
Co. Leitrim	44	<5	35199	12.5	~
Co. Limerick	204	23	209536	9.7	1.1
Co. Longford	50	20	46751	10.7	4.3
Co. Louth	278	50	139703	19.9	3.6
Co. Mayo	114	42	137970	8.3	3.0
Co. Meath	301	77	220826	13.6	3.5
Co. Monaghan	109	8	65288	16.7	1.2
Co. Offaly	120	<5	83150	14.4	~
Co. Roscommon	78	34	70259	11.1	4.8
Co. Sligo	98	17	70198	14.0	2.4
Co. Tipperary	161	68	167895	9.6	4.1
Co. Waterford	182	11	127363	14.3	0.9
Co. Westmeath	164	16	96221	17.0	1.7
Co. Wexford	226	81	163919	13.8	4.9
Co. Wicklow	202	50	155851	13.0	3.2

Sources: NASS 2025; HIQA; Census 2022. NASS figures across age groups and residential service types that were less than 5 were suppressed from reporting, so total figures may be marginally lower than real figures. Figures should be taken as directional rather than exact. Table 3.33

Service Use and Identified Need Overnight Respite by County

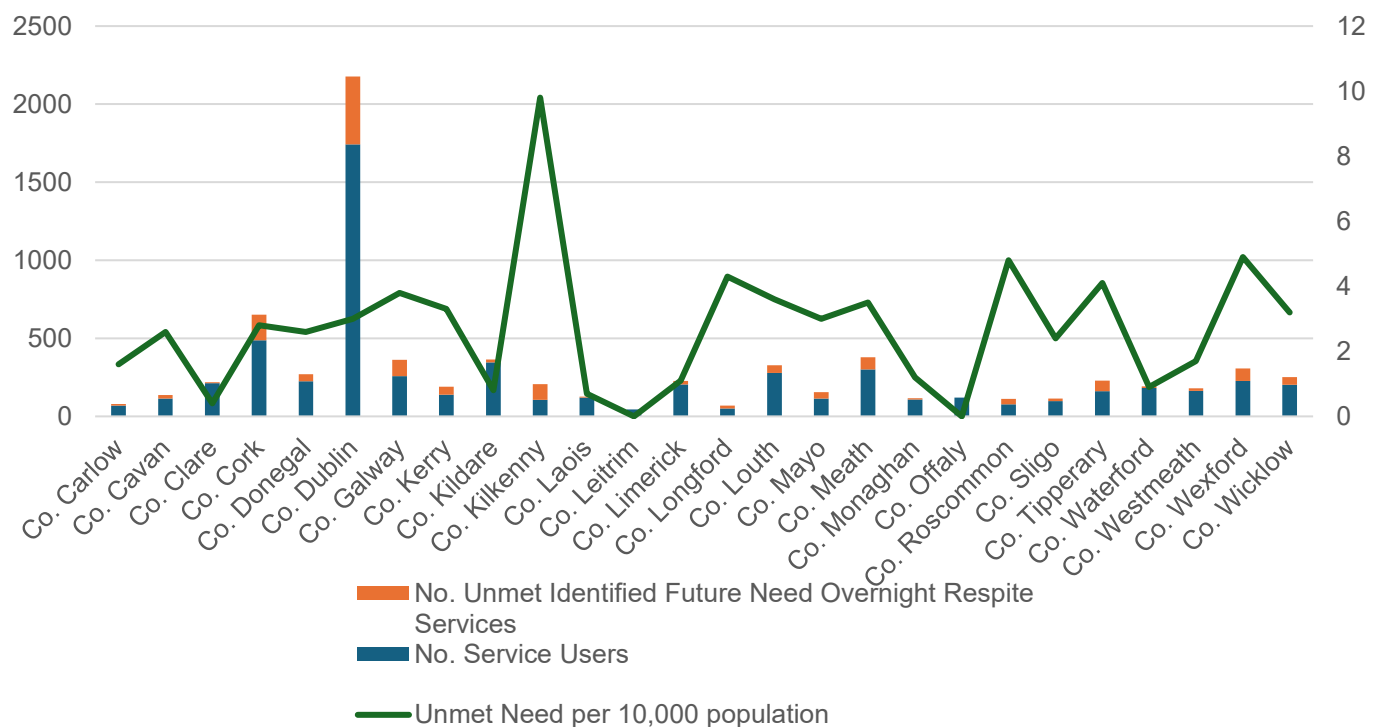


fig. 3.26

Data Review Findings

Geographic Distribution of Overnight Respite Need – County Level

- County-level analysis highlights substantial variation in the distribution of service users who access over night respite across Ireland. While Dublin and Cork account for the largest absolute numbers of service users, population-adjusted analysis indicates that Louth, Westmeath, Monaghan, Clare and Cavan record the highest rates of overnight respite service utilisation relative to their population. Conversely, a number of counties, including Mayo, Cork, Kerry, Galway and Limerick, record comparatively low rates of service use.
- Identified future need for overnight respite services is concentrated in a small number of counties, particularly Dublin, Cork, Galway, Kilkenny, Wexford and Meath, which record the highest absolute numbers of unmet identified future need. When adjusted for population, the highest rates of unmet identified future need are evident in Kilkenny, Wexford, Roscommon, Longford and Tipperary, suggesting comparatively greater future demand pressures in these areas.
- These findings suggest that future overnight respite demand is not evenly distributed geographically and should be considered alongside local demographic profiles, current utilisation patterns and carer support needs when planning future service development. The relationship between identified demand and available respite capacity is examined separately in the Capacity Analysis section.

Age Profile of Identified Future Overnight Respite Need by County

County (of Residence)	0-17 years	18-24 years	25-39 years	40-59 years	60-69 years	70+ years
Co. Carlow	<5	<5	5	0	0	0
Co. Cavan	<5	<5	5	5	<5	<5
Co. Clare	<5	0	<5	0	0	0
Co. Cork	31	33	69	<5	11	<5
Co. Donegal	9	8	19	0	<5	<5
Co. Dublin	83	118	116	<5	75	21
Co. Galway	11	31	58	0	<5	<5
Co. Kerry	11	7	24	0	<5	<5
Co. Kildare	<5	<5	5	<5	<5	0
Co. Kilkenny	50	16	21	<5	0	14
Co. Laois	<5	<5	<5	0	0	0
Co. Leitrim	<5	<5	<5	0	<5	0
Co. Limerick	9	<5	5	<5	0	0
Co. Longford	<5	8	<5	<5	7	<5
Co. Louth	<5	26	<5	<5	13	<5
Co. Mayo	12	<5	19	0	<5	0
Co. Meath	<5	37	21	<5	14	<5
Co. Monaghan	<5	<5	<5	0	<5	<5
Co. Offaly	<5	0	<5	0	0	<5
Co. Roscommon	5	17	11	0	0	<5
Co. Sligo	<5	<5	<5	0	<5	<5
Co. Tipperary	10	13	28	<5	<5	<5
Co. Waterford	<5	8	<5	0	<5	0
Co. Westmeath	<5	<5	<5	0	6	0
Co. Wexford	24	11	35	<5	0	<5
Co. Wicklow	6	7	24	<5	<5	<5

Sources: NASS 2025, Numbers less than 5 were suppressed from NASS reporting. These figures should be interpreted as directional, not exact. Table 3.34

Data Review Findings

Age Profile of Identified Future Overnight Day Respite Need by County

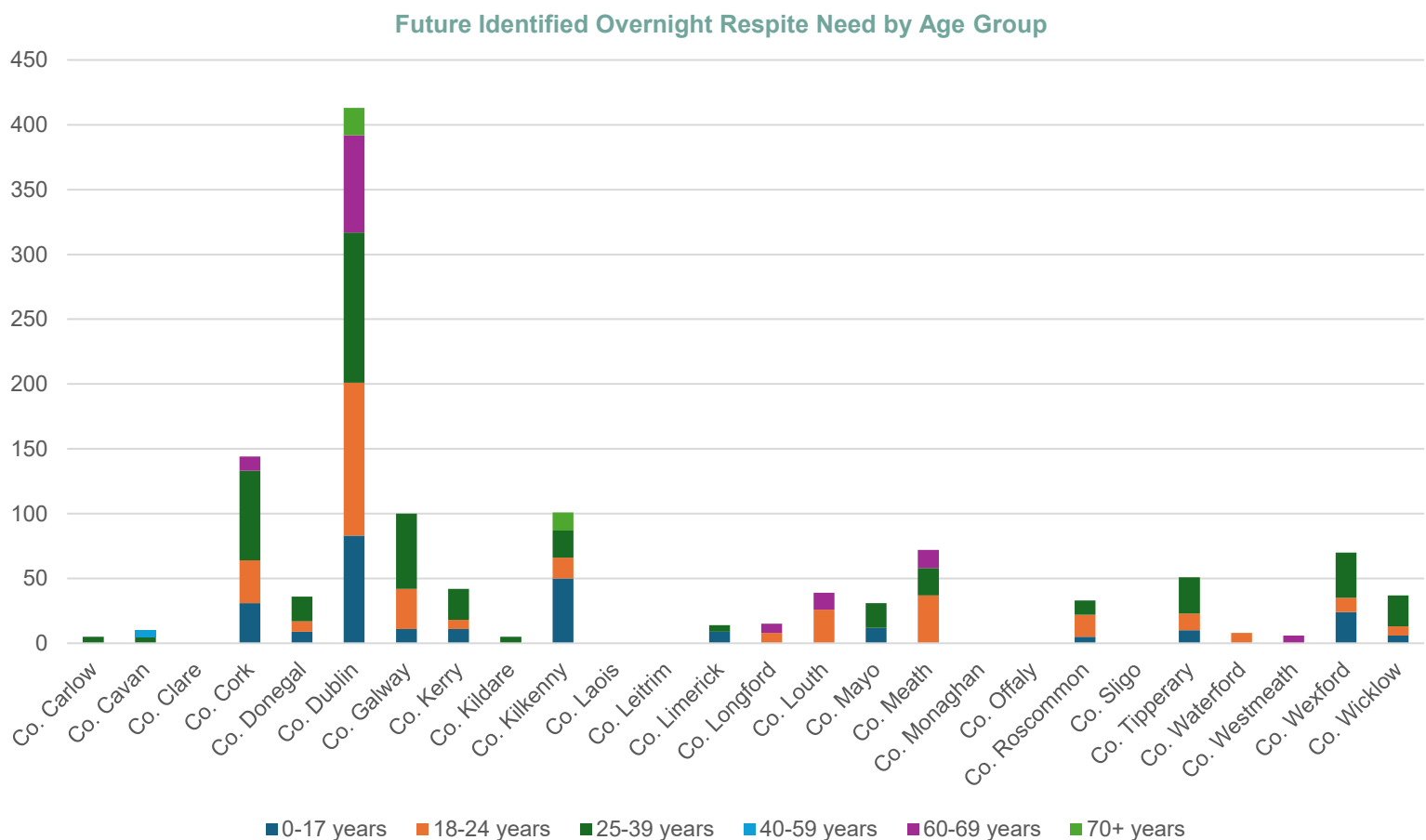


fig. 3.27

- The age profile of identified future overnight respite need is concentrated among children, young people and younger adults, particularly those aged 25–39 years, followed by the 18–24 and 0–17 cohorts. Demand among older age groups is comparatively lower, with relatively few recorded cases among those aged 40 years and over.
- Co. Dublin records the highest level of identified future need across most age cohorts, particularly among those aged 18–24 years (118), 25–39 years (116) and 0–17 years (83). Other counties with notable levels of recorded need include Cork, Galway, Kilkenny, Wexford and Meath, although at considerably lower levels.
- Future need is evident across all stages of the life course, with the strongest concentration among younger adults aged 18–39 years.
- Need among older adults is more limited geographically. While Dublin records the highest numbers in the 60–69 and 70+ cohorts, smaller levels of need are also evident in counties such as Meath, Louth, Kilkenny, Longford and Cork. Many other counties report only suppressed values.
- Overall, the findings indicate that future overnight respite need is primarily driven by younger age groups, while the presence of identified need among older cohorts reinforces the importance of maintaining age-appropriate and flexible respite options as service users and family carers age.

Data Review Findings

Respite

Section Summary

- **Scale of provision in 2025:** 6,021 people accessed overnight respite, accounting for 165,593 overnights, while 1,978 people accessed day-only respite, accounting for 68,874 days. Overnight respite remains the larger service type nationally, although both forms of respite represent important components of current provision.
- **Adult overnight respite shows the greatest need for service enhancement:** 997 adults vs 209 children require alterations to their current places in the next 12 months (e.g. additional hours/days or additional support), while day respite need is more evenly split (169 adults vs 118 children).
- **Enhancement requirement is declining but still elevated for overnight:** Day respite enhancement requirement fell from 16.4% to 14.7% and overnight from 27.6% to 20.0%, indicating improving service fit but more complex needs in overnight provision.
- **Current waiting list:** An estimated 920 people are awaiting respite, with ~75% in Priority 3 (future need) and pressure spread system-wide rather than confined to one region.
- **Future identified need:** Regional NASS data identifies 1,316 people with future overnight respite need and a further 222 with future day-only respite need. Age-profile analysis indicates that future overnight respite need is predominantly adult-led, with adults accounting for the majority of recorded need; however, totals should be interpreted with caution due to differences between NASS extracts, regional assignment and classification approaches.
- **Future identified need (county lens):** Future day respite need is concentrated in a smaller number of counties, particularly Dublin, Cork, Meath, Sligo, Longford, Wicklow, Roscommon and Tipperary. Future overnight respite need is more substantial and is concentrated in Dublin, Cork, Galway, Kilkenny, Wexford and Meath in absolute terms, with the highest population-adjusted rates in Kilkenny, Wexford, Roscommon, Longford and Tipperary.
- **Population adjusted future need:** Nationally, future overnight respite need equates to 2.76 people per 10,000 population. Dublin & South East, Dublin & North East, and West & North West record the highest rates, while Dublin & Midlands and Mid West show comparatively lower rates.
- **Total estimated demand:** Combining current service users (7,999), with NASS-reported future demand (1,538) and active DSMAT applications (920), it gives a total estimated demand for respite services of 10,457. This should be interpreted with caution as NASS and DSMAT figures are not directly additive and may contain cross-over of individuals counted in both. It should be interpreted as indicative of the level of demand, and not an exact figure.
- **Age Profiles:** Future day respite need is concentrated among adults, particularly younger adults aged 18–24 and older adults aged 60+, with comparatively low recorded need among children. Future overnight respite need is more strongly concentrated among children, young people and younger adults, particularly the 25–39, 18–24 and 0–17 age groups.
- **County-level patterns:** County-level patterns show uneven geographic distribution. Day respite service use is highest in absolute terms in Dublin and Cork, but population-adjusted rates are highest in Westmeath, Longford, Offaly, Laois, Clare and Wicklow. For overnight respite, Dublin and Cork again record the largest absolute numbers, while Louth, Westmeath, Monaghan, Clare and Cavan record the highest population-adjusted utilisation rates.
- **Consistent multi-year growth (2023–2025):** Overnight respite up 52.3% and day respite up 62.2%; overnight is ~3x larger but day is growing faster, indicating rising demand for shorter, more flexible respite.
- **Shift in day respite toward children:** Children grew from 48% to 62% of day respite users (+108% in volume) vs +20% for adults, suggesting expansion or improved identification of children's needs.

Interpretation note: Findings should be interpreted as directional rather than exact, as NASS values below 5 are suppressed and some totals may vary across extracts due to regional assignment, service classification or provision outside the State.



Data Review: Capacity Analysis – Residential and Respite

Data Review Findings

Capacity - Residential and Respite

The preceding sections examined current service utilisation, identified need and waiting list demand for residential and respite services. This section examines the distribution of registered bed capacity using HIQA registration data and considers how this aligns with current and projected demand.

County	Number Centres	Total Beds	Number Beds (Adult)	Number Beds (Children)	Number Beds (used for both)	Total Capacity by 10,000 pop.
National	1,732	9,322	8,695	485	142	
Co. Carlow	22	113	109	4	0	18.24
Co. Cavan	17	78	66	7	5	9.55
Co. Clare	55	174	162	8	8	13.60
Co. Cork	108	771	750	13	8	13.20
Co. Donegal	50	240	223		17	14.36
Co. Dublin	282	1848	1,730	75	43	12.67
Co. Galway	84	504	472	30	28	18.15
Co. Kerry	42	293	291		2	18.73
Co. Kildare	135	685	641	35	14	27.65
Co. Kilkenny	61	319	306	8	5	30.63
Co. Laois	47	196	151	36	9	21.33
Co. Leitrim	12	45	37	3	5	12.78
Co. Limerick	78	550	531	19	0	26.25
Co. Longford	23	97	92	4	1	20.75
Co. Louth	96	457	438	13	6	32.71
Co. Mayo	71	270	262	8	0	19.57
Co. Meath	90	458	384	74	0	20.74
Co. Monaghan	30	171	154	17	0	26.19
Co. Offaly	41	145	124	17	4	17.44
Co. Roscommon	29	156	140	16	0	22.20
Co. Sligo	62	312	305	7	0	44.45
Co. Tipperary	70	370	312	40	18	22.10
Co. Waterford	43	259	257	2	0	20.34
Co. Westmeath	70	298	279	15	4	30.97
Co. Wexford	44	234	230	4	0	14.28
Co. Wicklow	70	279	249	30	0	17.90

Source: HIQA registrations

Table 3.35

Based on current HIQA registrations, approximately 9,322 beds are registered nationally across residential and overnight respite settings. Adult provision accounts for the vast majority of capacity (8,695 beds; 93%), while dedicated children's capacity accounts for just 463 beds (5%) and a further 177 beds are recorded within mixed-use facilities serving both adults and children (in separate services within the same facility).

Capacity distribution varies considerably across counties. Dublin contains the largest volume of registered capacity, while population-adjusted capacity is highest in counties including Sligo, Louth, Kilkenny, Westmeath and Kildare, reflecting substantial variation in the distribution of registered services nationally.

Of the 1,735 centres registered nationally, approximately **70% are run by not-for-profit organisations, 20% are run by private organisations, and 10% are run by the HSE**. When broken down by service type, approximately 76% of respite facilities, 69% of residential facilities, and 90% of those facilities providing both residential and respite services, are run by not-for profits.

Data Review Findings

Capacity - Residential and Respite

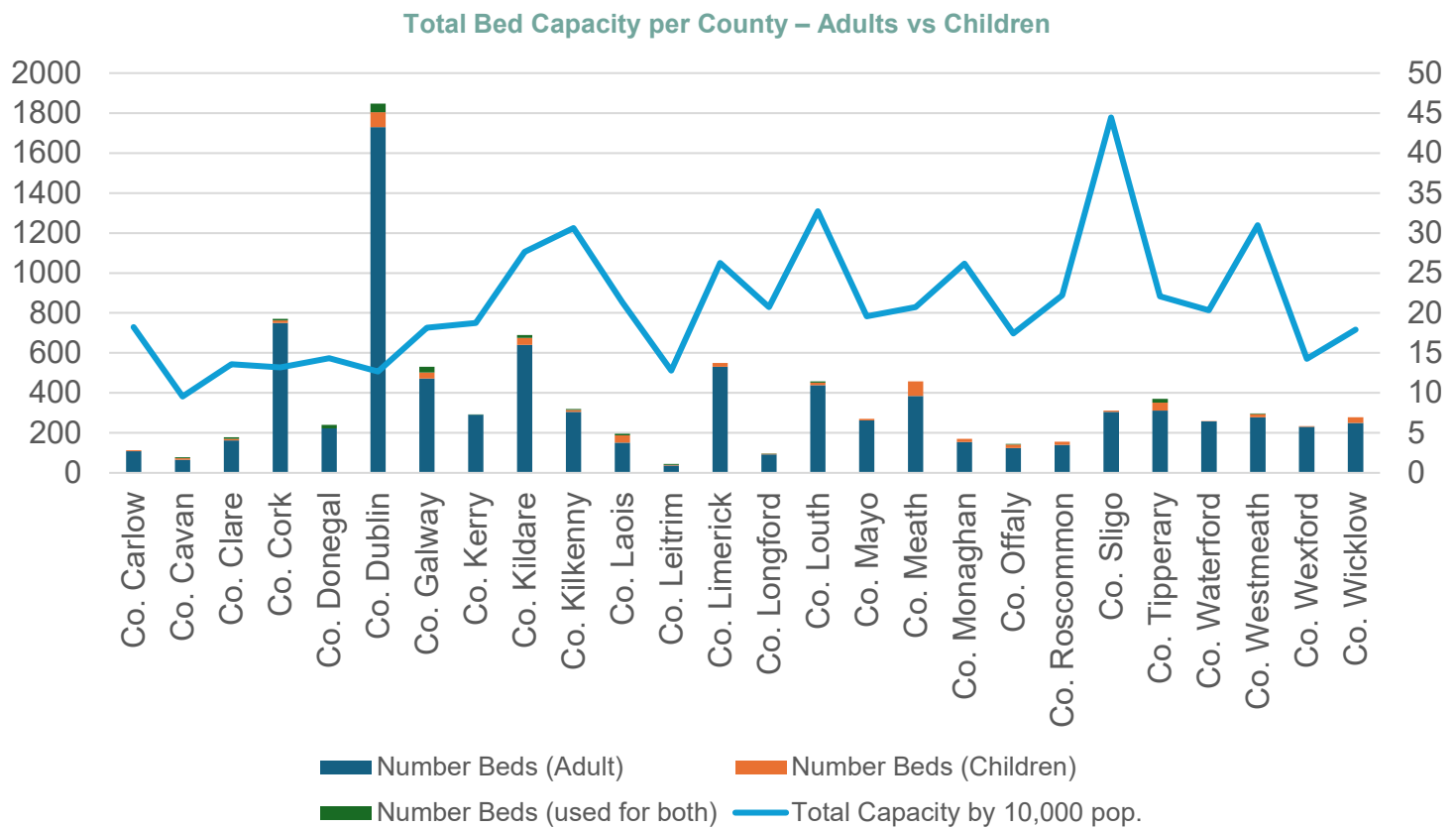


fig. 3.28

Counties with the largest absolute capacity do not necessarily record the highest population-adjusted capacity, highlighting the importance of considering local population size alongside bed numbers.

Data Review Findings

Capacity - Residential and Overnight Respite

The table below provides an overview of the capacity of registered HIQA premises for Residential, Respite, and premises with shared-service capacity. Figures reflect approximate number of places (beds) across registered premises.

County	Residential			Respite (overnight)			Shared Residential and Respite		
	Residential			Respite (overnight)			Shared Residential and Respite		
	Adult	Children	Both	Adult	Children	Both	Adult	Children	Both
National	8,145	285	39	443	205	85	128	0	7
Co. Carlow	104	0	0	5	4	0	0	0	0
Co. Cavan	62	4	0	4	3	5	0	0	0
Co. Clare	146	0	0	16	8	4	0	0	0
Co. Cork	660	4	8	31	9	0	59	0	0
Co. Donegal	220	0	0	3	0	17	0	0	0
Co. Dublin	1637	35	23	99	45	9	0	0	0
Co. Galway	418	13	2	54	17		15	0	0
Co. Kerry	286	0	0	5	0	2	0	0	0
Co. Kildare	602	30	0	32	5	9	7	0	0
Co. Kilkenny	306	8	5	0	0	0	0	0	0
Co. Laois	151	29	0	0	7	9	0	0	0
Co. Leitrim	33	0	0	0	3	5	4	0	0
Co. Limerick	504	8	0	17	11	0	10	0	0
Co. Longford	86	0	1	6	4	0	0	0	0
Co. Louth	407	13	0	12	0	6	19	0	0
Co. Mayo	229	1	0	24	7	0	9	0	0
Co. Meath	368	57	0	16	17	0	0	0	0
Co. Monaghan	146	8	0	8	9	0	0	0	0
Co. Offaly	118	17	0	6	0	4	0	0	0
Co. Roscommon	120	12	0	15	4	0	5	0	0
Co. Sligo	305	4	0	0	3	0	0	0	0
Co. Tipperary	304	18	0	8	22	11	0	0	7
Co. Waterford	240	2	0	17	0	0	0	0	0
Co. Westmeath	256	3	0	23	12	4	0	0	0
Co. Wexford	224	4	0	6	0	0	0	0	0

Source: HIQA Registrations and Inspection Reports

Table 3.36

- Capacity is distributed across residential-only, respite-only, and shared residential and respite services.
- Approximately 90% of all identified capacity is contained within residential-only services, while approximately 7.8% relates to respite-only services. A further proportion of beds are located within mixed-use facilities. Where mixed-use facilities specified the number of beds for respite and the number of beds for residential, this was accounted for in the respite and residential categories.
- Capacity figures represent registered beds rather than service throughput. In particular, overnight respite beds may support multiple individuals over the course of a year and are therefore not directly comparable with respite service user numbers.
- Those facilities providing for both adults and children facilitate separate adult and children services, not shared services.

Data Review Findings

Capacity - Residential and Overnight Respite

Total Bed Capacity by Service Type (Residential, Respite, both)

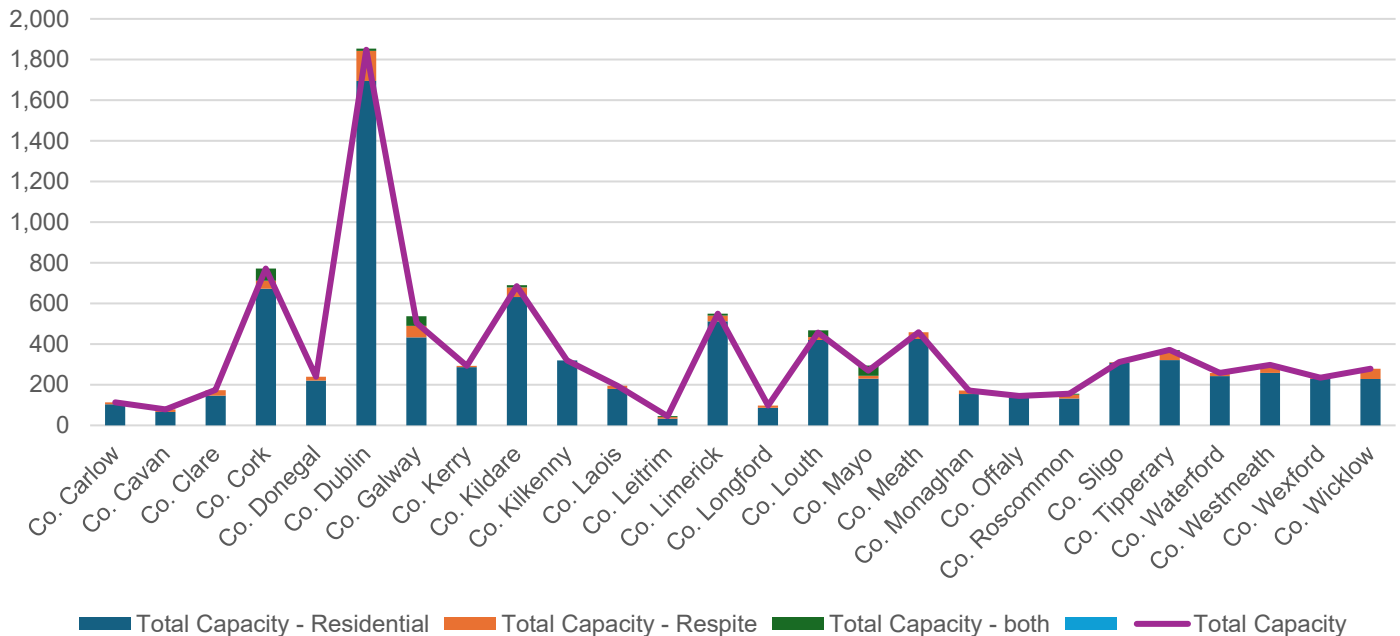


fig. 3.29

Residential capacity accounts for the majority of registered bed capacity in every county, with comparatively small levels of dedicated respite capacity nationally.

Residential Capacity by County

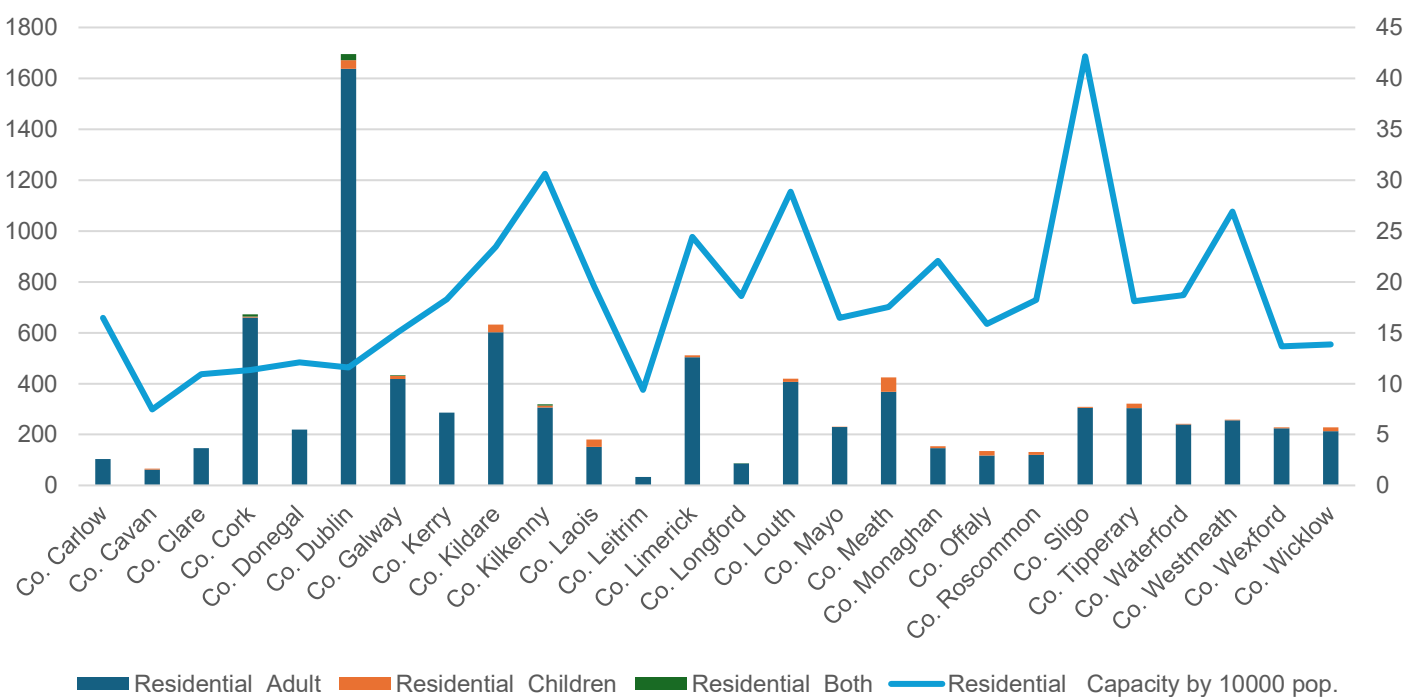


fig. 3.30

Residential capacity refers to known residential capacity and does not include premises where beds are used for both residential and respite. Residential capacity appears concentrated in Dublin, Cork, Kildare, Limerick, Galway, though substantial variation exists when adjusted for population, with counties such as Sligo, Kilkenny, Louth and Westmeath having the highest ratio of residential capacity to population. This should be interpreted alongside service catchments and cross-county utilisation patterns.

Data Review Findings

Capacity – Residential

Service Users Accessing Residential Services by Total Residential Capacity

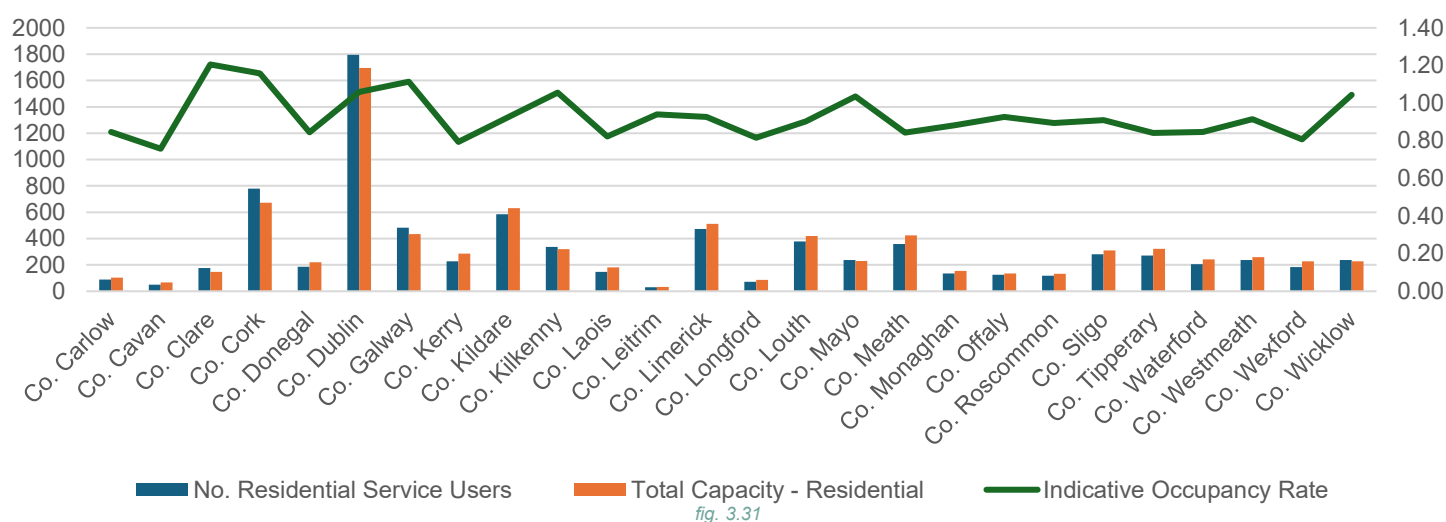


fig. 3.31

Indicative occupancy rates appear high across most counties, with current service user numbers accessing residential services broadly equivalent to or exceeding known residential capacity in several locations. Counties including Galway, Cork, Mayo, Dublin and Wicklow report occupancy rates above 100%, while Kerry, Cavan, Longford and Wexford exhibit comparatively lower utilisation relative to known registered capacity. This should be interpreted as a directional indicator of the relationship between service use and capacity rather than a measure of actual bed occupancy or vacancy rates, and should be interpreted alongside service catchments and cross-county utilisation patterns.

Current Residential Service Use, Future Demand and Capacity by County

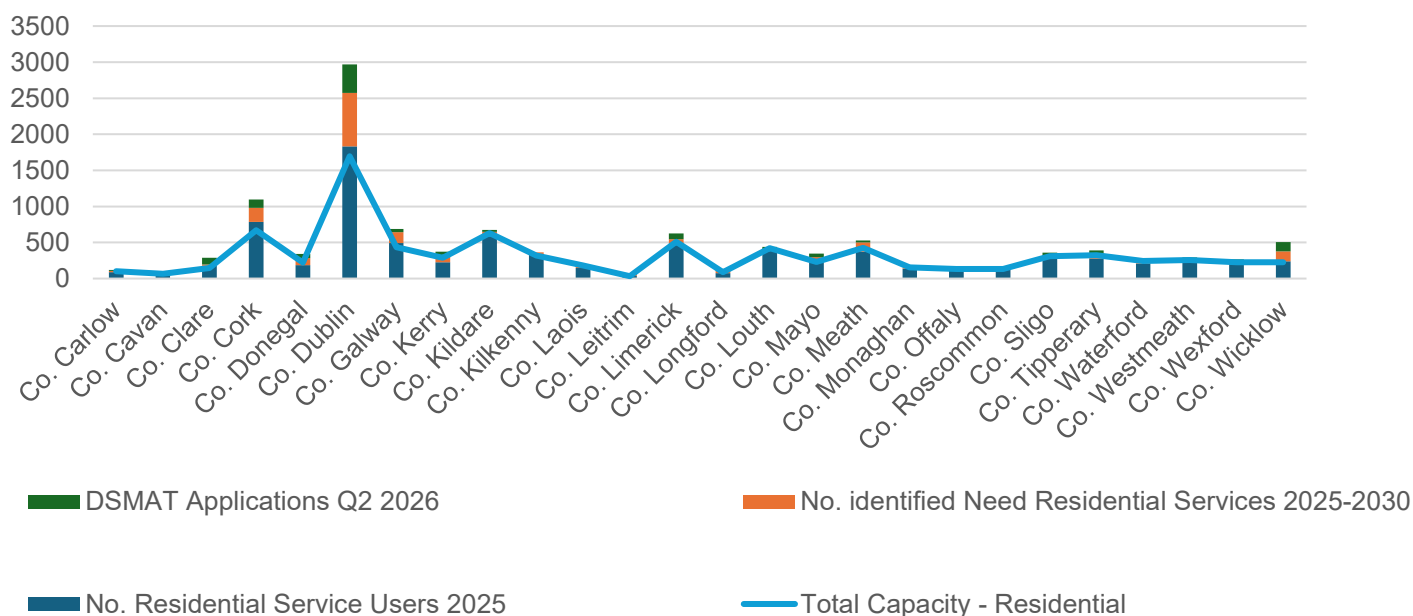


fig. 3.32

Comparison of current residential service use, DSMAT residential applications, identified future need and known residential capacity highlights substantial geographic variation in the relationship between demand and capacity. While counties such as Dublin, Cork, Kildare and Limerick appear to have the largest residential service infrastructure and capacity, these counties also record some of the highest overall levels of current and future demand.

Counties including Wicklow, Meath, Galway, Cork and Dublin demonstrate particularly high levels of combined current use, identified future need and DSMAT demand, reinforcing findings from the Residential Services section that future residential demand is concentrated in a relatively small number of locations.

Across many counties, combined current service use, identified future need and DSMAT demand considerably exceed known residential capacity. While these metrics are not directly additive and should be interpreted with caution and alongside cross-county utilisation, they indicate significant pressure on existing residential provision and the need for targeted capacity planning in a number of locations.

Data Review Findings

Capacity – Residential and Respite

Section Summary and Key Findings

Residential and Respite Capacity:

- Based on current HIQA registrations, approximately 9,322 beds are registered nationally across residential and overnight respite settings.
- Capacity is heavily concentrated within adult residential services, with dedicated children's capacity accounting for a relatively small proportion of overall provision (less than 5%).
- Residential-only premises make up the majority of registered premises, with residential capacity accounting for approximately 8,469 beds, 90% of total capacity.

Geographic Variation:

- Bed capacity is unevenly distributed across counties, reflecting historical service development patterns and population distribution.
- Dublin contains the largest absolute volume of registered capacity, while counties including Sligo, Louth, Kilkenny, Westmeath and Kildare record the highest rates of registered capacity relative to population size.
- Significant variation is evident between counties when capacity is considered alongside current service utilisation and identified future need.

Alignment with Demand:

- As identified in the Residential and Respite sections, future demand is concentrated in a relatively small number of counties rather than being evenly distributed across the country.
- Counties such as Dublin, Cork, Galway, Meath and Wicklow consistently emerge as areas of comparatively high current utilisation, identified future need and residential demand.
- Population-adjusted analysis highlights additional pressures in counties including Wicklow, Cavan, Donegal, Roscommon and Meath, where identified need is high relative to population size.
- Residential service capacity comprises approximately 8,469 places, excluding premises with shared respite/residential beds. This compares with identified demand of approximately 12,757 places, encompassing current service users, active applications, and future identified need, and indicates a difference of approximately 4,288 places (33%) between current capacity and identified demand nationally.
- Respite beds may support multiple individuals over the course of a year and are therefore not directly comparable with respite service user numbers.

Planning Implications:

- The findings suggest that future residential and respite demand is unlikely to be addressed through a uniform expansion of capacity across all counties.
- Instead, future planning should consider both the geographic distribution of current capacity and the concentration of identified demand and waiting-list pressures.
- Areas exhibiting high current utilisation, elevated levels of identified future need and sustained demand may warrant further review as part of future estates, capital and service planning processes.

Interpretation note: Findings should be interpreted as directional rather than exact, as NASS values below 5 are suppressed and some totals may vary across extracts due to regional assignment, service classification or provision outside the State.



Data Review: Day Services

Data Review Findings

Day Services

Day Service Use – Current Provision and Service Scale

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Day Service users at end of 2025 (excluding RT)	20621	3574	3954	4005	4316	1765	3007
Day Service users at end of 2024 (excluding RT)	19524	3479	3792	3685	4055	1645	2868

Source: HSE Day Service Database

Table 3.37

Service Type	2025
Total Number in Day Services	22,754
Day Programme	20,621
Rehabilitative Training	2,133

Source: HSE Achievements in Disabilities 2025 report. *Excludes 4000 in residential services not in a New Directions Day Service

Table 3.38

Day service provision has continued to expand, with 20,621 people recorded in day services, excluding rehabilitative training, at end-2025. This represents an increase from 19,524 in 2024 and 18,963 in 2022, indicating continued growth in the scale of adult day service provision. Growth is visible across all regions, with South West, Dublin South East and Dublin North East recording the highest end-2025 volumes.

Demand, Referrals and School Leaver Inflow

New Referrals to Day opportunities teams

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
2025	2922	611	563	433	617	266	432
2024	3028	631	543	456	710	260	428
2023	2700	496	548	392	545	269	450

Table 3.39

Day Service data shows 8,650 new referrals to Day Opportunities Teams between 2023 and 2025, with referrals increasing from 2,700 in 2023 to 3,028 in 2024, before reducing slightly to 2,922 in 2025.

School Leaver/RT Summary 2024/2025	Referrals (total)	Completed Supports Needs Process	Required RT/Day Service	Availed of Deferral processes	Required no HSE supports	Previously Deferred, Returned	Total Entering (New and Returned)	Funding Provided	Used Vacant RT/day places
Persons (n)	2,309	2,112	1,790	441	78	43	1,833	1,340	493

Source: HSE Day Service Database

Table 3.40

Demand for day services remains shaped by the annual school leaver and rehabilitative training transition process. In 2025, 2,309 people leaving school or RT were referred nationally, of whom 2,112 completed the Supports Needs Process and 1,790 were identified as requiring RT/day service supports. 441 availed of the deferral process, of which 182 were post-guidance deferrals. By June 2026, 95% of people that left school/RT in 2025 and required day service supports have commenced in day services and placement funding has been agreed and allocated to providers. Funding was required for 1,340 spaces, while 493 commenced through the Management of Vacant Places protocol.

Data Review Findings

Day Services

Day Service Capacity, Utilisations and Staffing Constraints

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Utilisations Rate at end 2025	99%	97%	95%	98%	105%	103%	96%

Table 3.41

Source: HSE Day Service Database

Utilisation rates indicate that day service capacity is highly utilised across regions, with reported end-2025 utilisation ranging from 95% to 105%. Mid West and South West reported utilisation above 100%, suggesting that provision is operating at or above planned capacity in some areas.

However, funded capacity does not automatically translate into operational capacity. Providers report ongoing challenges in filling posts, and the March 2026 workforce update for the 2025 RT/school leaver process recorded 282 primary notifications requested from Workforce Planning, of which 219 had been onboarded, with further posts at offer or recruitment stage. Where necessary, providers have engaged agency staff to provide support whilst awaiting completion of the recruitment processes. Providers in all regions have reported challenges in filling vacant posts.

Complexity of Need and Service Model Implications

Disability Category	2024	2025
Physical & Sensory	578	516
Mental Health	327	297
Intellectual	1461	1358
Autism	1348	1323

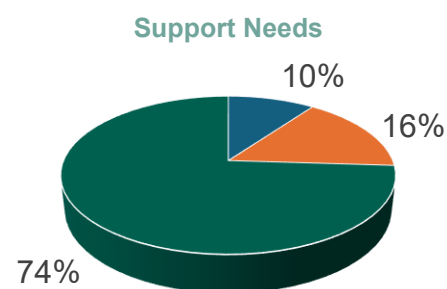
Table 3.42

Source: HSE Day Service Database

Age Group	2024
18 to 25	26.84%
26 to 35	23.92%
36 to 55	30.84%
Over 55	18.40%

Table 3.43

Source: HSE Day Service Database



- High support (1:1 or greater support)
- Medium support (greater than 1:2)
- Low support (less than 1:2)

fig. 3.33

The day service cohort includes a range of support needs, from lower-intensity supports to high-support arrangements requiring 1:1 or greater staffing. The average frontline staff-to-person support ratio is currently reported at 1:2.5, indicating that day service planning must consider not only the number of places required, but also the intensity of support required to operationalise those places. Complexity is also reflected in diagnostic profile, with 60% of people reported as having multiple diagnoses. Support needs are also reported to increase significantly for people aged 55 and over, which has implications for future staffing, programme design, transport, health supports and the sustainability of existing day service models.

Data Review Findings

Day Services

Section Summary

Scale of provision: Day services continue to represent one of the largest areas of disability service provision, with 22,754 people recorded in day services at the end of 2025, including 20,621 in Day Programs and 2,133 in Rehabilitative Training

Sustained referral demand: New referrals to Day Opportunities Teams remained high across 2023–2025, with 8,650 referrals recorded over the three-year period.

School leaver / RT pathway: In 2025, 1,790 people leaving school or RT required RT/day service supports, with 1,719 commenced by June 2026 and funding agreed and allocated to providers.

High utilisation: End-2025 utilisation rates ranged from 95% to 105% across regions, indicating limited spare operational capacity in parts of the system.

Workforce constraint: Staffing remains a key operational bottleneck, with recruitment delays affecting the pace at which funded places can become operational.

Increasing complexity: Support needs vary significantly, with 60% of people reported as having multiple diagnoses and support needs increasing among people aged 55 and over.



Data Review: Daily Living Supports

Data Review Findings

Daily Living Supports

Daily Living Supports Service Use

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Number accessing home support	6,595	1,060	2,211	1,526	406	345	1,046
Home support users per 10k pop.		10.6	20.44	17.08	5.88	8.96	14.71
Number accessing Personal Assistance (PA)	2,255	301	97	171	573	393	720
PA Users per 10k pop.		3.01	0.90	1.91	8.30	10.21	10.13

Source: NASS 2025. *Note: Regional NASS data may not match national service use breakdown tables due to unassigned regions or services provided outside the State.

Table 3.44

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Home support (hrs)	4,249,992	639,942	1,333,397	801,748	340,339	356,359	778,207
Personal Assistance (hrs)	1,870,938	330,477	291,320	215,667	177,181	413,025	443,268

Source: DSMAT 2025 Activity Outturn

Table 3.45

Profiles of Individuals Accessing Daily Living Services (All types)

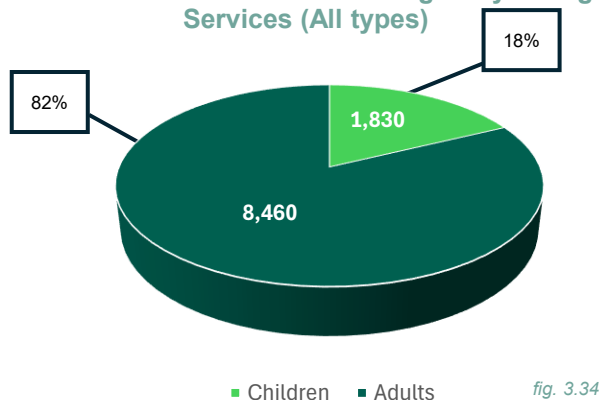


fig. 3.34

Enhancement Required by Service Type (Children vs Adults)

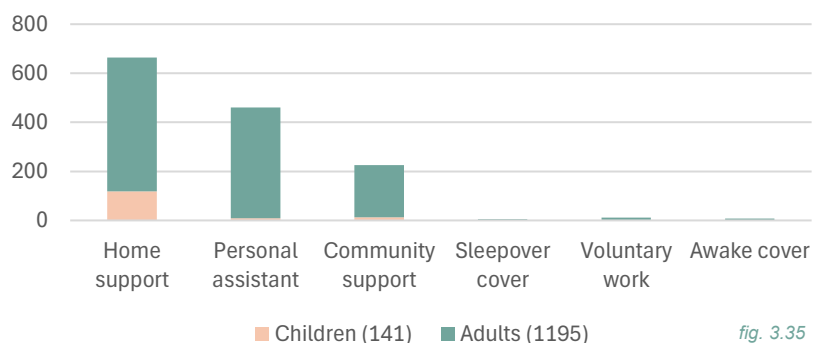


fig. 3.35

Current Service Use by Type (Children vs Adults)

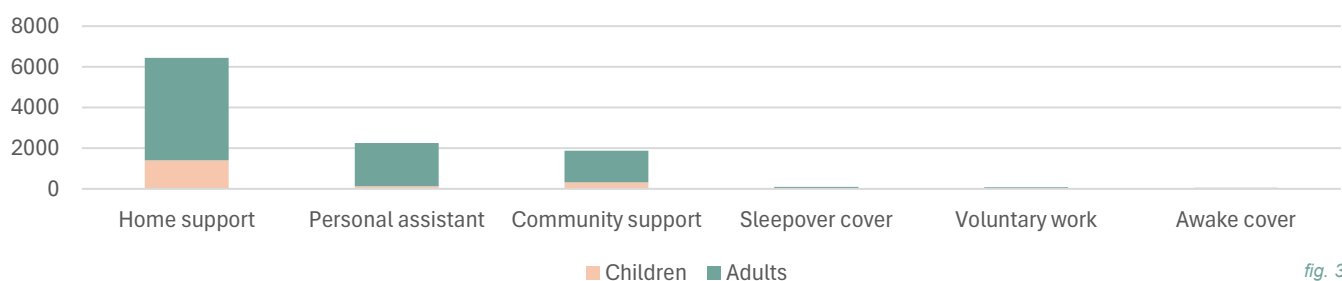


fig. 3.36

Adults account for the majority of service usage across all categories. Adults account for 82% of total people accessing daily living supports (8,460 out of 10,290). Children represent only 18% (1,830 out of 10,290).

Home Support is the most utilised service accounting for a total of 6,446 people, approx. 63% of total daily support service users. This reflects that home-based care remains the primary support model. Community support makes up a lesser but nevertheless material proportion of current service provision at 1,883 current service users. It is worth noting that home support may support community participation and the undertaking of activities outside the home, therefore not confined to a home-based model of support.

All service categories are weighted towards adults. In both service use and identified enhancement need, some values for children are suppressed where there are fewer than five users, in order to protect confidentiality. However, these services remain predominantly adult-focused.

Data Review Findings

Daily Living Supports

Number awaiting services

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Estimate awaiting Home Support (DSMAT Q1 2026)	997	189	54	200	191	178	185
Priority 1 (emergency)	135	36	19	13	13	25	29
Priority 2 (contingency)	105	13	10	34	20	1	27
Priority 3 (future needs / TBC)	757	140	26	154	159	150	128
Estimate awaiting Personal Assistance (DSMAT Q1 2026)	665	126	36	134	128	118	123
Priority 1 (emergency)	90	24	12	8	9	17	20
Priority 2 (contingency)	70	9	7	22	13	1	18
Priority 3 (future needs / TBC)	505	93	17	103	106	100	86
Total	1,662	315	90	334	319	296	308

Source: DSMAT Q1 2026 (*Regional figures estimated using proxy percentages derived from a subset of DSMAT non-residential applications with identified service type - respite, home support and Personal Assistance (PA). Proportions have been applied to total and regional non-residential demand data as indicative estimates.)

Table 3.46

Demand is concentrated in longer-term need (Priority 3), which accounts for approximately three quarters of the national total. The regional spread sees relatively similar volumes indicating system-wide pressure rather than isolated regional difficulties.

Future Identified Need

Region	National	HSE Dublin & Midlands	HSE Dublin & North East	HSE Dublin & South East	HSE South West	HSE Mid West	HSE West & North West
Future identified needs for Home Support	706	86	155	273	96	20	76
Future identified needs for Personal Assistance	200	46	17	45	42	13	37
Total	906	132	172	318	138	33	113

Source: NASS 2025 *Note: Regional NASS data may not match national service use breakdown tables due to unassigned regions or services provided outside the State.

Table 3.47

Future Identified Need by Region

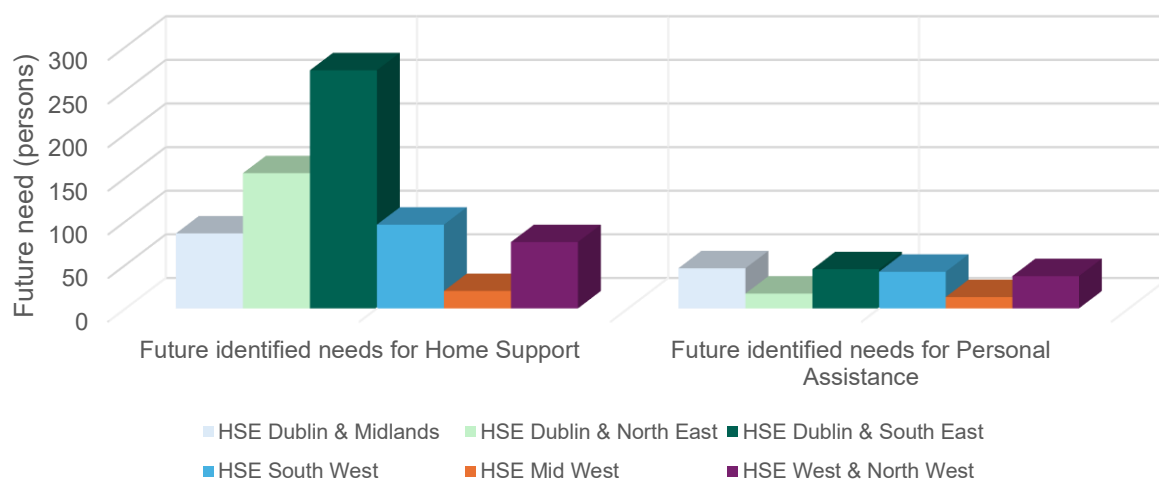


fig. 3.37

This indicates that current unmet demand exceeds future identified need.

Data Review Findings

Daily Living Supports

Future Identified need

Identified as Requiring Daily Living Services 2025-2030

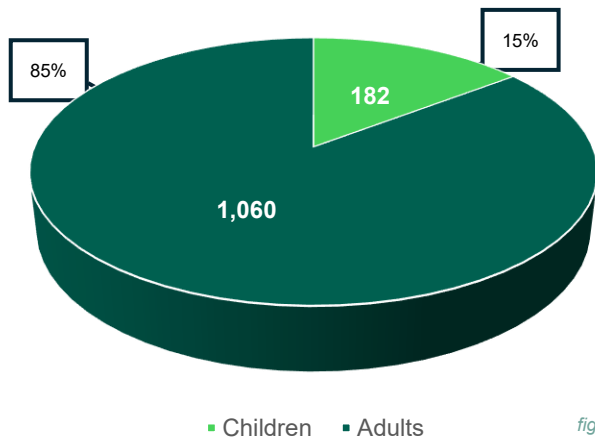


fig. 3.38

Identified as Requiring Respite Services 2025-2030

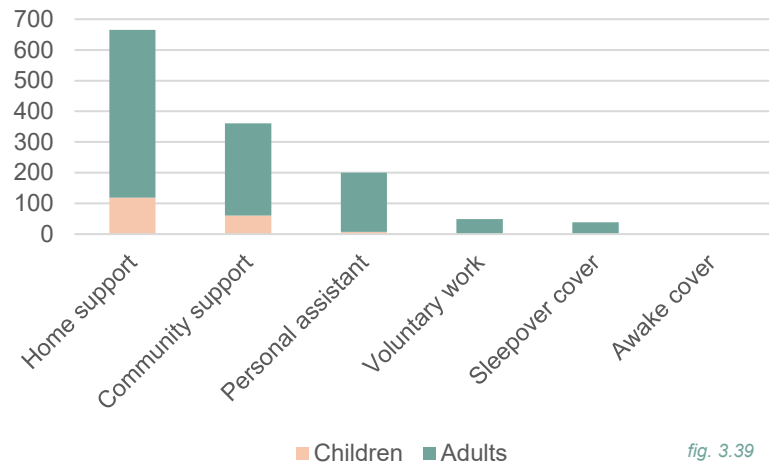


fig. 3.39

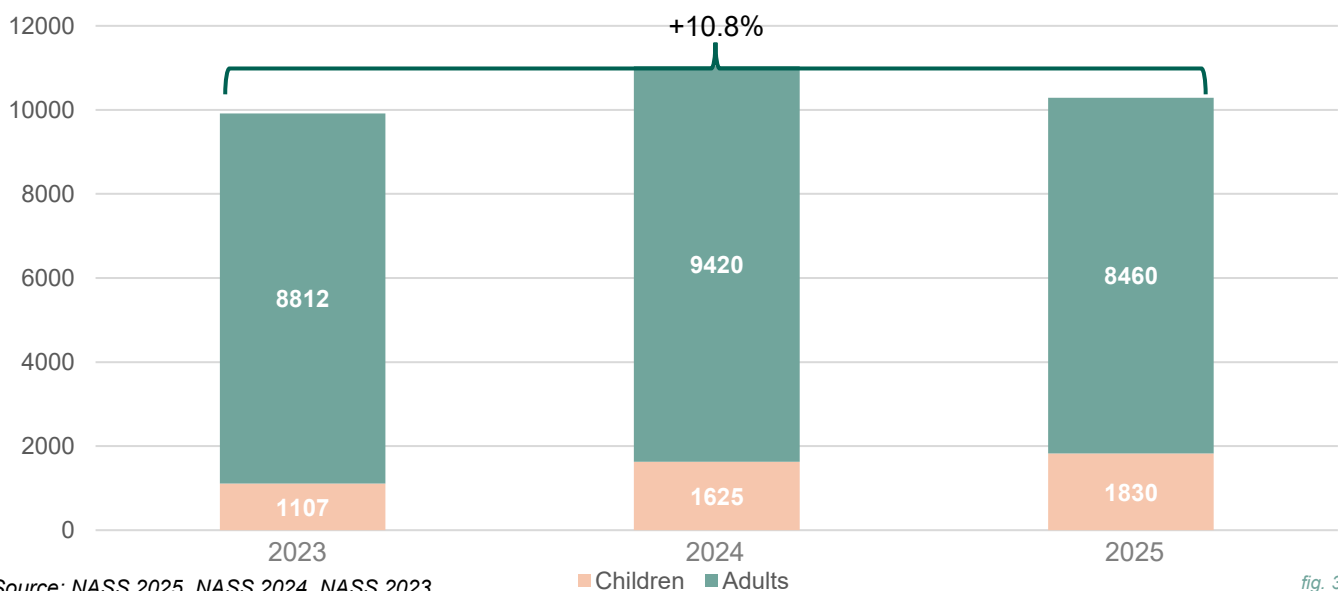
Source: NASS 2025

Similar to current provision patterns, home support remains the most significant future identified need, accounting for 665 of 1,242 people (54%) requiring future supports.

A notable shift emerges in future requirements: Community support (361 people) surpasses Personal Assistant services (200 people) as the second highest need. This contrasts with current provision where Personal Assistant (2,255) exceeds Community Support (1,883), suggesting a strategic pivot toward community-based integration models.

Multi-year Trends

Total Service Use by Year (Children vs Adults)



Source: NASS 2025, NASS 2024, NASS 2023

fig. 3.40

Total number of people accessing daily living supports grew from 9,289 (2023) to 10,290 (2025), an increase of 1,001 people (+10.8%).

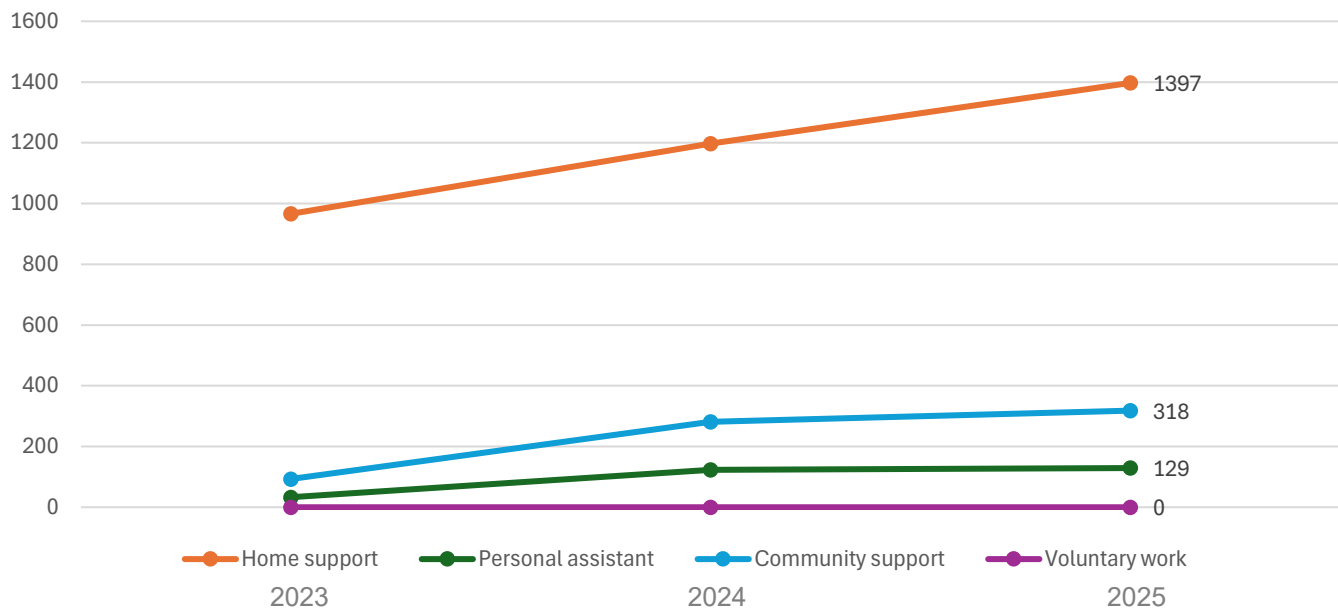
However, 2024 peak level were observed at 11,045, with a decline in 2025 primarily driven by reduced adult numbers.

Data Review Findings

Daily Living Supports

Multi-year Trends

Children: Service Use Trends 2023-2025

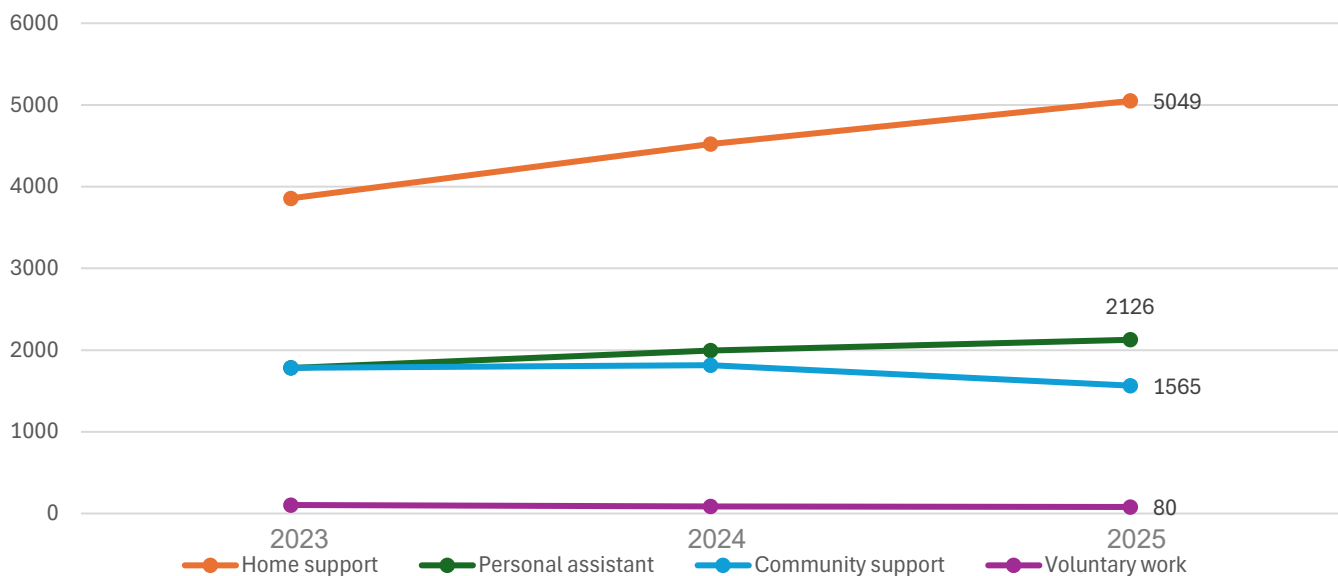


Source: NASS 2025, NASS 2024, NASS 2023

fig. 3.41

Children accessing services increased by 65% from 1,107 (2023) to 1,830 (2025). Home support for children grew by 431 (+45%), Personal Assistant by 96 (+291%), and Community support by 225 (+242%).

Adults: Service Use Trends 2023-2025



Source: NASS 2025, NASS 2024, NASS 2023

fig. 3.42

Home support grew consistently: 3,857 (2023) to 4,523 (2024) and to 5,049 (2025), up 1,192 (+31%). Personal Assistant also grew: 1,781 (2023) to 1,993 (2024) and to 2,126 (2025), up 345 (+19%). However, Community support declined significantly: 1,782 (2023) to 1,565 (2025), down 217 (-12%).

Data Review Findings

Geographic Distribution of Need for Home Support and Personal Assistance – County Level

County	Number accessing Home Support	Identified Need for Home Support	Number Accessing Personal Assistance	Identified Need for Personal Assistance	Home Support users per 10,000 pop.	Home Support Unmet Need per 10,000 pop.	PA users per 10,000 pop.	PA Unmet Need per 10,000 pop.
Co. Carlow	158	11	10	<5	25.50	1.78	1.61	N/A
Co. Cavan	152	23	13	0	18.60	2.82	1.59	0.00
Co. Clare	84	9	89	<5	6.57	0.70	6.96	N/A
Co. Cork	314	70	396	36	5.38	1.20	6.78	0.62
Co. Donegal	429	12	138	9	25.68	0.72	8.26	0.54
Co. Dublin	2203	181	184	52	15.11	1.24	1.26	0.36
Co. Galway	168	17	130	<5	6.05	0.61	4.68	N/A
Co. Kerry	69	16	177	7	4.41	1.02	11.31	0.45
Co. Kildare	284	5	48	8	11.46	0.20	1.94	0.32
Co. Kilkenney	224	24	12	5	21.51	2.30	1.15	0.48
Co. Laois	54	7	74	5	5.88	0.76	8.05	0.54
Co. Leitrim	103	5	46	0	29.26	1.42	13.07	0.00
Co. Limerick	223	9	179	<5	10.64	0.43	8.54	N/A
Co. Longford	22	8	5	<5	4.71	1.71	1.07	N/A
Co. Louth	320	32	<5	<5	22.91	2.29	N/A	N/A
Co. Mayo	35	9	253	20	2.54	0.65	18.34	1.45
Co. Meath	322	56	11	<5	14.58	2.54	0.50	N/A
Co. Monaghan	108	7	<5	<5	16.54	1.07	N/A	N/A
Co. Offaly	69	8	83	5	8.30	0.96	9.98	0.60
Co. Roscommon	117	22	72	<5	16.65	3.13	10.25	N/A
Co. Sligo	189	10	80	<5	26.92	1.42	11.40	N/A
Co. Tipperary	83	10	159	7	4.94	0.60	9.47	0.42
Co. Waterford	148	0	12	0	11.62	0.00	0.94	0.00
Co. Westmeath	100	9	29	<5	10.39	0.94	3.01	N/A
Co. Wexford	341	64	5	<5	20.80	3.90	0.31	N/A
Co. Wicklow	225	50	45	12	14.44	3.21	2.89	0.77

Sources: NASS 2025; Census 2022.

Table 3.48

- Home support is utilised more widely than personal assistance, with Dublin accounting for the highest absolute number of home support users, followed by Donegal, Wexford, Meath and Louth.
- Identified future need for home support is concentrated in Dublin, Cork, Wexford, Meath and Wicklow, while identified future need for personal assistance remains comparatively low across most counties.
- When adjusted for population, the highest rates of unmet home support need are evident in Wexford, Wicklow, Roscommon, Meath and Louth, indicating comparatively greater demand relative to local population size.
- Personal assistance utilisation is highest in Mayo, Leitrim, Sligo, Kerry and Roscommon on a population-adjusted basis, reflecting variation in service models and local patterns of support provision.

Current Use and Identified Need Home Support and PA

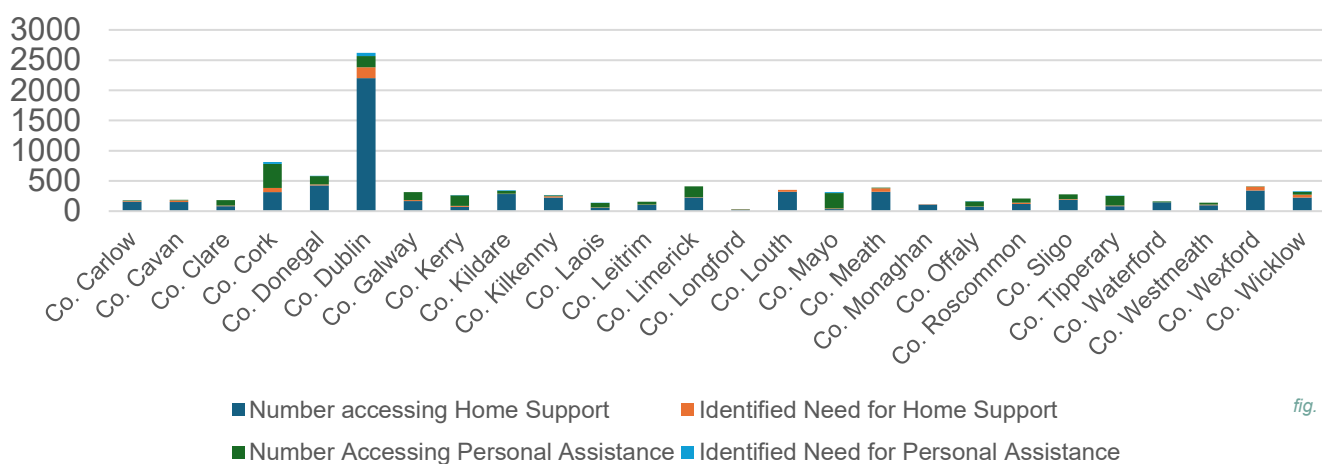


fig. 3.43

Data Review Findings

Age Profile of Identified Future Home Support Need by County

County (of Residence)	0-17 years	18-24 years	25-39 years	40-59 years	60-69 years	70+ years
Co. Carlow	<5	<5	<5	<5	0	0
Co. Cavan	9	<5	<5	7	<5	<5
Co. Clare	0	<5	<5	<5	<5	<5
Co. Cork	<5	35	26	<5	5	<5
Co. Donegal	0	<5	6	0	<5	0
Co. Dublin	27	41	63	37	7	6
Co. Galway	0	7	6	<5	<5	<5
Co. Kerry	<5	<5	8	<5	0	0
Co. Kildare	<5	<5	<5	<5	0	<5
Co. Kilkenny	0	7	<5	<5	6	<5
Co. Laois	<5	<5	<5	0	0	<5
Co. Leitrim	0	<5	<5	0	0	0
Co. Limerick	0	<5	<5	<5	<5	<5
Co. Longford	<5	<5	<5	0	0	0
Co. Louth	13	<5	6	<5	9	<5
Co. Mayo	0	<5	<5	<5	0	<5
Co. Meath	29	<5	10	<5	9	<5
Co. Monaghan	<5	<5	0	<5	<5	<5
Co. Offaly	<5	<5	<5	0	<5	0
Co. Roscommon	0	<5	5	<5	9	0
Co. Sligo	0	<5	<5	<5	<5	<5
Co. Tipperary	0	<5	<5	<5	<5	0
Co. Waterford	0	0	<5	<5	0	<5
Co. Westmeath	<5	<5	0	0	6	<5
Co. Wexford	0	19	13	12	11	<5
Co. Wicklow	19	5	10	12	<5	0

Table 3.49

- Future identified home support need is concentrated primarily among adults aged 18–39 years, particularly in Dublin, Cork, Wexford, Meath and Wicklow.
- Notable levels of identified home support need are also evident among children and young people in Dublin, Meath, Wicklow and Louth, indicating that unmet need is present across multiple stages of the life course.
- Need is recorded across all age groups, including older adults aged 60 years and over, highlighting the role of home support in sustaining independence and supporting individuals and families as support needs evolve over time.

Identified Unmet Need for Home Support by Age Group

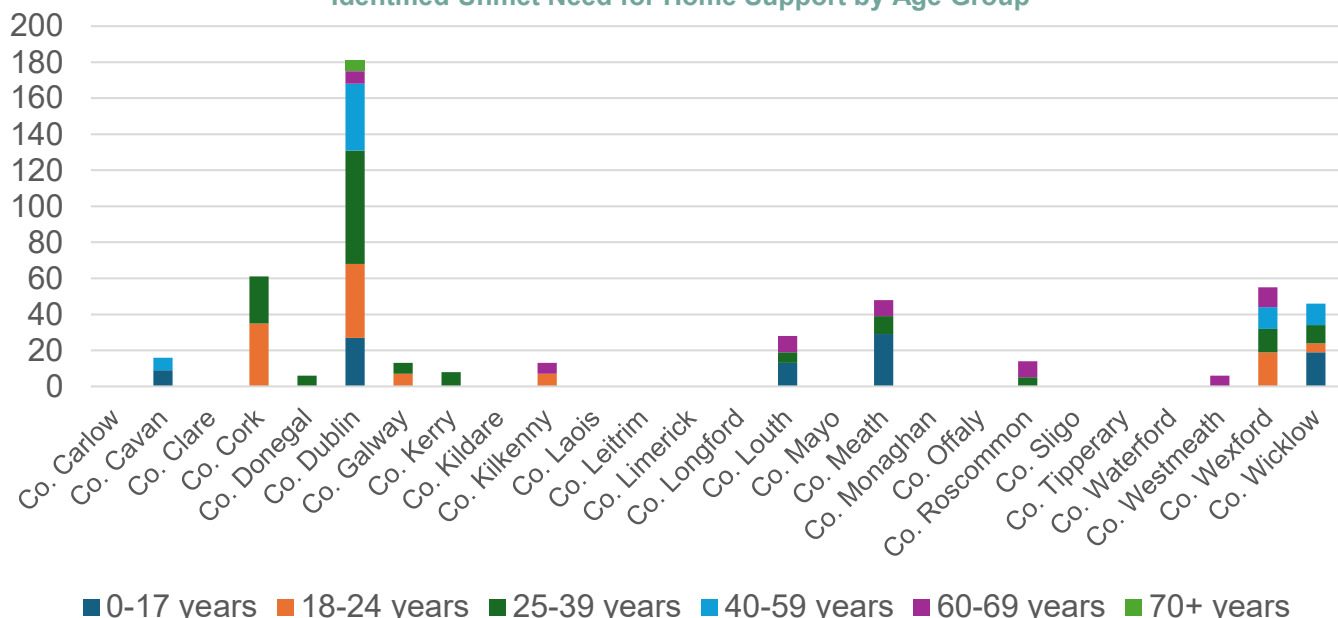


fig. 3.44

Data Review Findings

Age Profile of Identified Future Personal Assistance Need by County

County (of Residence)	0-17 years	18-24 years	25-39 years	40-59 years	60-69 years	70+ years
Co. Carlow	~	~	0	0	0	0
Co. Cavan	0	0	0	0	0	0
Co. Clare	0	~	~	0	0	0
Co. Cork	8	16	6	5	~	0
Co. Donegal	5	~	~	0	0	0
Co. Dublin	12	29	5	~	~	~
Co. Galway	0	~	0	0	~	0
Co. Kerry	~	~	0	0	0	~
Co. Kildare	~	~	~	0	~	~
Co. Kilkenny	~	~	0	~	0	0
Co. Laois	0	~	~	~	0	0
Co. Leitrim	0	0	0	0	0	0
Co. Limerick	~	~	~	0	0	0
Co. Longford	~	0	0	0	0	0
Co. Louth	~	~	0	0	0	0
Co. Mayo	~	9	~	~	~	0
Co. Meath	~	0	0	0	0	0
Co. Monaghan	0	~	~	0	0	0
Co. Offaly	0	~	0	~	0	0
Co. Roscommon	0	~	~	0	0	0
Co. Sligo	0	0	~	0	0	0
Co. Tipperary	0	6	~	0	0	0
Co. Waterford	0	0	0	0	0	0
Co. Westmeath	0	~	~	0	0	0
Co. Wexford	~	0	~	0	0	0
Co. Wicklow	~	7	~	0	~	~

Table 3.50

- Identified future need for personal assistance is lower than for home support services and is concentrated in a small number of counties, most notably Dublin, Cork, Galway, Wexford and Tipperary.
- The largest proportion of identified need relates to people aged 18–39 years, indicating the importance of personal assistance in supporting independence, community participation and self-directed living among working-age adults.
- Only limited levels of identified need are recorded among children and older age groups, although this may partly reflect the relatively small size of the overall cohort and the effect of NASS reporting thresholds.

Identified Unmet Need for PA by Age Group

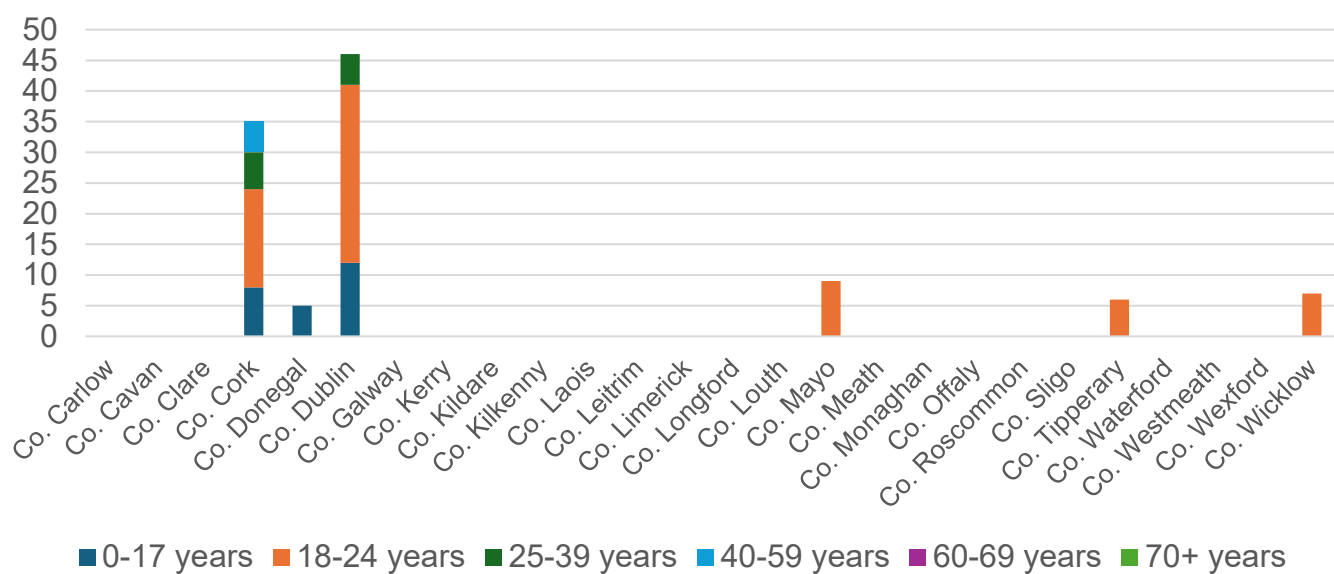


fig. 3.45

Data Review Findings

Daily Living Supports

Section Summary

- **Scale of provision in 2025:** Daily living supports are provided to a cohort nationally, with 10,290 people accessing supports in 2025. Home support is the most widely utilised service (6,446 users), followed by personal assistance (2,255 users) and community support (1,883 users), highlighting the importance of community-based and home-based supports within the overall service model.
- **Adult-led service use:** Adults account for the majority of people accessing daily living supports, representing 82% of total users, while children account for 18%.
- **Age Profile:** Future home support need is concentrated among adults aged 18–39 in several counties, while personal assistance need is lower overall and concentrated in a smaller number of counties.
- **Daily living support categories:** Home support is the most widely used service nationally and remains the largest element of both current provision and future identified need. Personal assistance and community support also represent important components of the overall support mix, although their relative use varies by region and county.
- **Regional variation:** County-level patterns vary depending on whether need is viewed in absolute or population-adjusted terms. Dublin, Cork, Wexford, Meath and Wicklow account for substantial identified future home support need, while the highest population-adjusted rates of unmet home support need are seen in Wexford, Wicklow, Roscommon, Meath and Louth. Personal assistance shows a different pattern, with higher population-adjusted use in Mayo, Leitrim, Sligo, Kerry and Roscommon, suggesting variation in local service models and the balance of supports available.
- **Current waiting list:** DSMAT estimates indicate that most people awaiting home support or personal assistance are categorised as Priority 3, suggesting that a significant proportion of unmet demand relates to future or longer-term support requirements rather than emergency need alone.
- **Future identified need:** Future identified need is highest for home support, with community support emerging as a notable area of future requirement. This may indicate increasing emphasis on supports that enable people to remain at home and participate in community life.

Interpretation Note: Findings should be interpreted as directional rather than exact, as NASS values below 5 are suppressed and some totals may vary across extracts due to regional assignment, service classification or provision outside the State.



Data Review: Children's Disability Network Teams

Data Review Findings

Children's Disability Network Teams (CDNT)

Current Service Provision Summary

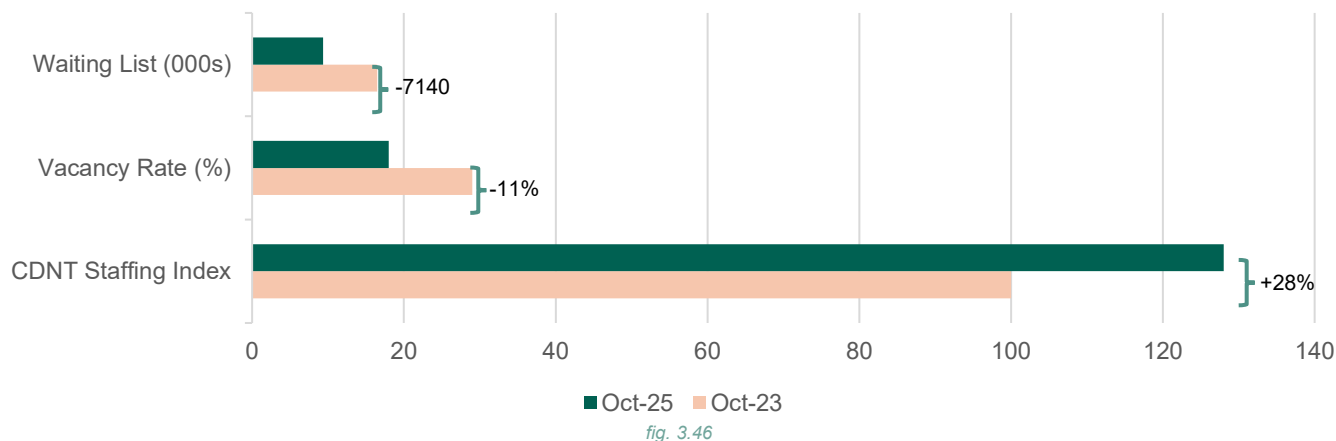
Region	National
Total Children Accessing CDNT (Dec 2025)	44,739
2024 – 2025 Increase	2,700
Percentage Increase	6.40%
Waiting List (End 2025)	9,363
Open Caseload (May 2026)	45,746
Total Waitlist (May 2026)	7,234
Total Service Demand (May 2026)	52,980
Children Receiving Support/Intervention (May 2026)	19,000

Source: HSE Achievements in disabilities document, Live National CDNT Data May 2026

Table 3.51

The most recent CDNT data highlights the scale of current service provision, with nearly 45,000 children accessing CDNT services and total demand exceeding 52,000. Whilst 19,000 children received direct support in May 2026, this represents only 36% of total demand - highlighting ongoing capacity challenges. However, these figures must be viewed in the context of the significant progress made over the past two years.

Key Improvements (Oct 2023 - Oct 2025)



AON Assessments: 43% Increase YoY



Source: HSE Achievements in disabilities document, Live National CDNT Data May 2026

The period October 2023 to October 2025 demonstrates substantial progress in addressing historic capacity constraints within children's disability services. The 28% increase in CDNT staffing, coupled with a reduction in the gap between funded and filled WTE from 29% to 18%, has directly contributed to a 43% reduction in waiting lists from 16,500 to 9,363 children. AON activity, while separate from CDNT service delivery, increased by 43% year-on-year, from 4,162 assessments in 2024 to 5,949 in 2025. Increased AON activity should not be interpreted as a direct measure of growth in disability service demand, however this improvement may reflect workforce investment, targeted waiting list initiatives, commissioned assessments, and activity across disability, primary care and mental health services, indicating improved accessibility and capacity despite sustained demand pressures.

Data Review Findings

Children's Disability Network Teams (CDNT)

Regional Comparison

Region / IHA	Open Caseload	Waitlist	Children with IFSP %	Missed Appt %	New Referrals	Discharges
Dublin South City and West	1604	523	57.0	24.0	48	67
Dublin South West	2039	1098	42.1	31.6	65	56
Kildare and West Wicklow	2119	433	58.6	28.6	46	57
Midlands	3431	105	78.1	37.0	98	101
HSE Dublin and Midlands Total	9193	2159	61.9	31.8	257	281
Cavan and Monaghan	1030	277	56.4	23.5	19	27
Dublin North City and West	2455	792	75.2	33.6	87	65
Dublin North County	2326	279	57.3	31.9	29	88
Louth Meath	3651	272	58.2	25.8	81	98
HSE Dublin & North East Total	9462	1620	62.2	29.5	216	278
Carlow, Kilkenny and Tipperary South	2102	307	52.9	31.9	39	43
Dublin South and Wicklow	2935	970	68.0	21.3	61	47
Waterford and Wexford	2170	439	40.5	40.6	31	21
HSE Dublin & South East Total	7207	1716	55.3	30.1	131	111
Clare and Limerick County	2928	342	46.5	27.6	48	42
Limerick City and North Tipperary	3125	700	50.4	30.5	69	53
HSE Midwest Total	6053	1042	48.5	29.1	117	95
Cork North and East	3122	202	91.7	33.0	78	38
Cork South and West	3210	120	66.4	19.4	45	46
Kerry	1412	39	94.2	33.5	24	37
HSE South West Total	7744	361	81.7	28.7	147	121
Donegal	859	29	85.9	44.4	25	26
Galway and Roscommon	3602	289	77.7	37.1	86	58
Mayo	956	12	68.4	37.9	26	25
Sligo, Leitrim, South Donegal and West Cavan	670	6	61.3	31.1	19	27
HSE West & North West Total	6087	336	75.6	38.1	156	136
National Total	45746	7234	64.3	31.4	1024	1022

Source: Live National CDNT Data May 2026

Table 3.52

The table above highlights variation in caseload, waiting lists, IFSP coverage, missed appointment rates and referral activity across IHAs and HSE regions. As the data represents a point-in-time snapshot (May 2026), figures should be interpreted as indicative and may vary over time.

- Significant variation is evident across IHAs in both caseload size and waiting list volumes. The largest open caseloads are reported in Louth Meath (3,651), Galway and Roscommon (3,602), Midlands (3,431), Limerick City and North Tipperary (3,125) and Cork North and East (3,122).
- Waiting lists are concentrated within a relatively small number of IHAs, with Dublin South West (1,098) and Dublin South and Wicklow (970) accounting for the highest volumes. Lower waiting list volumes are reported in Mayo (12), Donegal (29) and Kerry (39).
- IFSP coverage varies considerably between IHAs, ranging from approximately 40% to over 90%. This should be interpreted with caution, as children may continue to receive supports despite not having a recently reviewed IFSP recorded on the system.
- Missed appointment rates range from approximately 19% to 44%, indicating variation in engagement, attendance and operational factors across local areas.
- Referral and discharge activity is broadly balanced nationally (1,024 referrals and 1,022 discharges), although variation is evident between IHAs, reflecting different levels of demand and service activity at local level.
- Consistent with the broader findings of this review, the data suggests that demand and service pressures are not evenly distributed geographically and that local context should be considered when interpreting CDNT activity and access metrics.



Data Review: Assessment of Needs (AON)

Data Review Findings

Assessment of Needs (AON)

The AON process provides a statutory mechanism for identifying the health and education needs of eligible individuals with disabilities and determining the services required to support those needs. The analysis presented in this section examines AON activity, backlog and timeliness metrics, disability profiles identified through completed assessments, and the resulting service requirements. While most applications relate to children and young people, AON data should not be interpreted as representing children's needs exclusively.

Assessment of Needs Current Backlog

AON Backlog Overview (31/03/26)

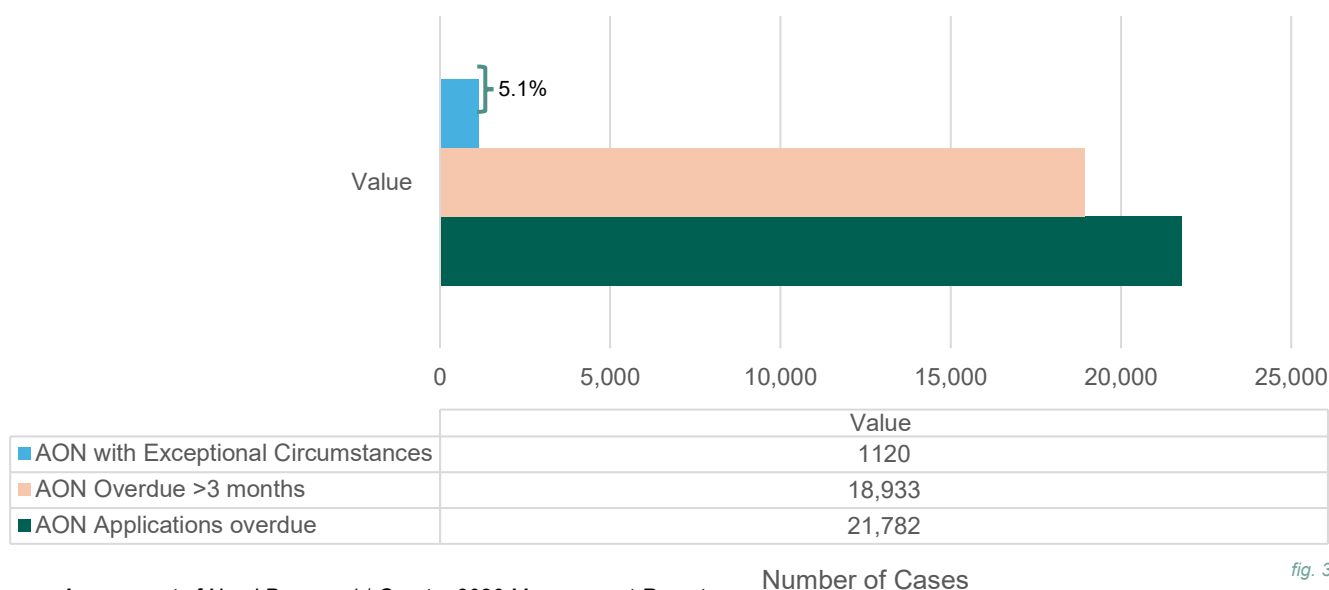


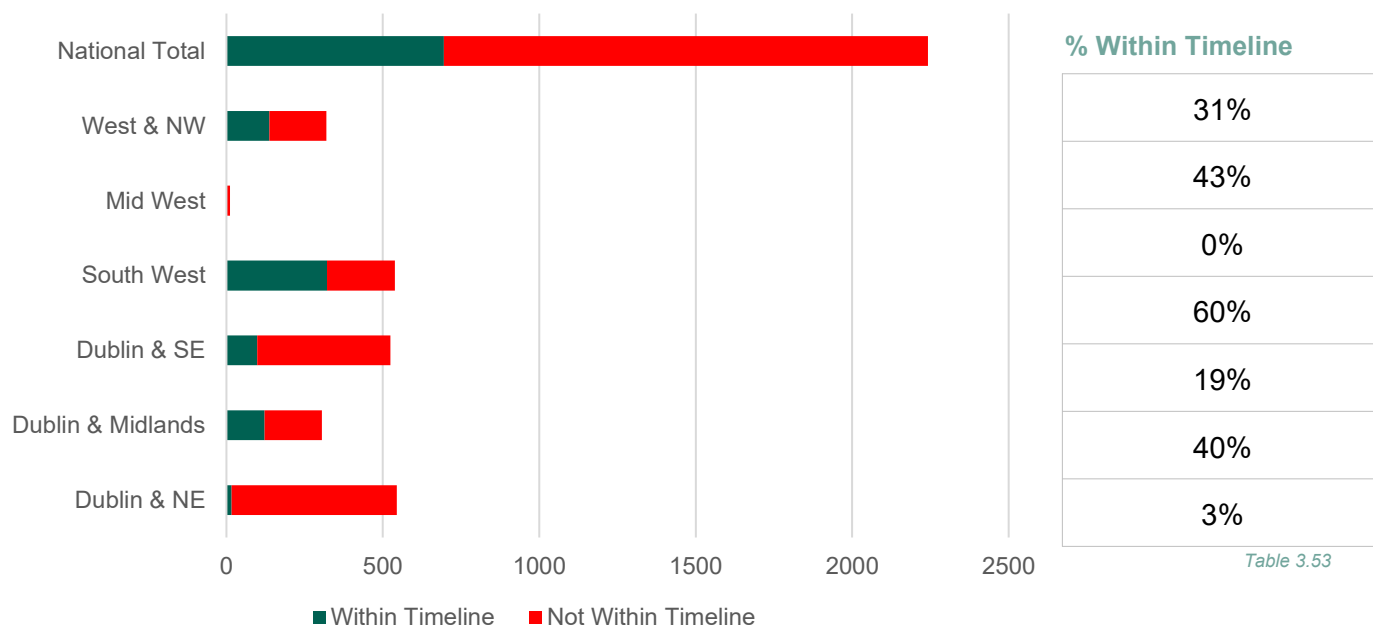
fig. 3.48

Source: Assessment of Need Process 1st Quarter 2026 Management Report

The AON backlog includes 21,782 assessments overdue for completion as of 31 March 2026. Of these, 18,933 (87%) have been overdue for more than 3 months. Notably, only 1,120 of the total overdue assessments have exceptional circumstances recorded. This means the vast majority (95%) are standard cases awaiting processing without mitigating factors.

Regional AON

AON Stage 2 Commencements: Timeline Compliance (Q1 2026)



Source: Assessment of Need Process 1st Quarter 2026 Management Report

fig. 3.49

Data Review Findings

Assessment of Needs (AON)

Categories Of Disability in Completed Reports

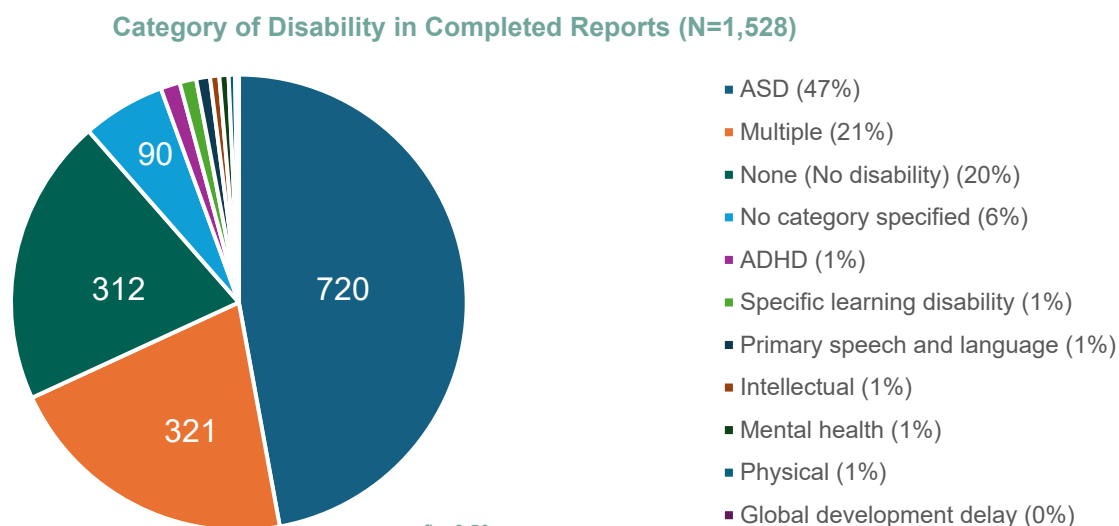
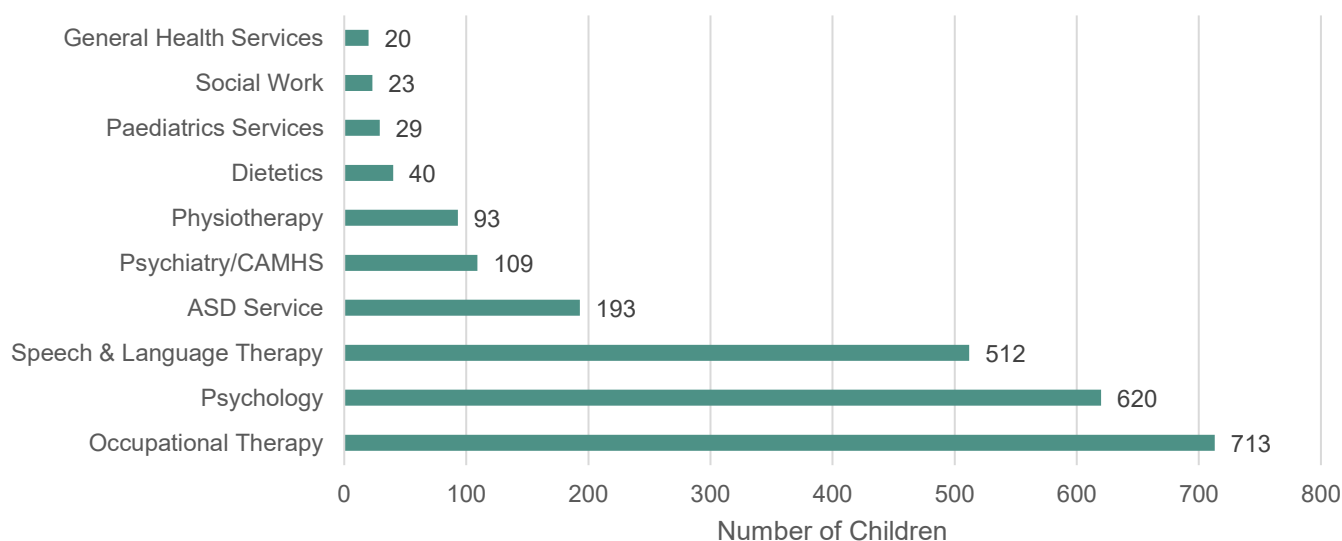


fig. 3.50

The disability category breakdown reveals a prevalence of autism, accounting for 47% (720 of 1,528) of all completed assessment reports in Q1 2026. This is more than double the next largest category "multiple disabilities" at 21% (321 cases). Together, mutism and multiple disabilities account for 68% of all confirmed disability diagnoses.

20% of completed reports resulted in "No disability identified". This autism prevalence aligns with national and international trends of increased autism diagnoses and has significant implications for service planning, particularly in ensuring sufficient multidisciplinary capacity, workforce skills and service availability to meet the diverse and often complex needs identified through assessment. Access to supports is based on the nature and complexity of an individual's needs rather than diagnostic category.

Service Requirements in Completed AON Reports (N=1,528)



Source: Assessment of Need Process 1st Quarter 2026 Management Report

fig. 3.51

The service requirements data reveals a clear hierarchy of needs among children assessed. Occupational Therapy is the most frequently identified requirement (69%), followed closely by Psychology (60%) and Speech & Language Therapy (49%). These three core therapies account for the majority of service demand. ASD-specific services (19%) and Psychiatry/Child and Adolescent Mental Health Services (CAMHS) (11%) represent significant secondary requirements, while allied services such as Physiotherapy (9%), Dietetics (4%), and Social Work (2%) are less commonly required. While these findings may help inform understanding of the needs identified through the AON process, they should not be considered representative of all children with disabilities or used in isolation to determine workforce requirements. Service planning should take account of population need, service utilisation patterns, and demand across the wider disability, primary care and mental health systems.

Data Review Findings

Assessment of Needs (AON)

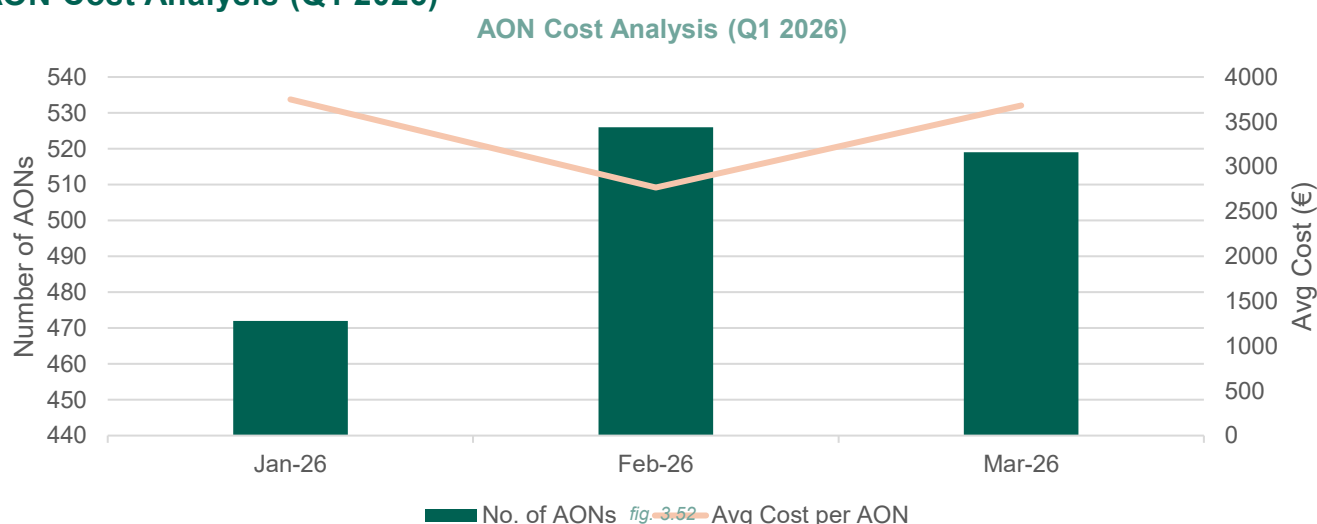
Regional AON

In Q1 2026, a total of 2,242 AON applications commenced Stage 2 of the assessment process. 695 (31%) of these commenced within the statutory timeline.

Regional performance varies significantly:

HSE South West leads with 60% commencing within timeline (321 of 538), HSE Mid West shows comparatively lower performance, with no assessments commencing within timeline (0 of 11) commencing within timeline. The Dublin regions, despite handling the highest volumes, show mixed compliance rates ranging from just 3% (Dublin & North East) to 40% (Dublin & Midlands).

AON Cost Analysis (Q1 2026)



Source: Assessment of Need Process 1st Quarter 2026 Management Report

The AON cost analysis for assessments commissioned from private providers in Q1 2026 reveals notable variability in assessment costs across the quarter. A total of 1,517 assessments were commissioned from private providers at an average cost of €3,386 per assessment. February shows the highest volume and lowest average cost (526 assessments) (€2,767), suggesting potential economies of scale or process efficiencies that month. Conversely, January and March show higher per-assessment costs (€3,750 and €3,683 respectively) despite lower volumes.



Data Review: Workforce

Data Review Findings

Workforce

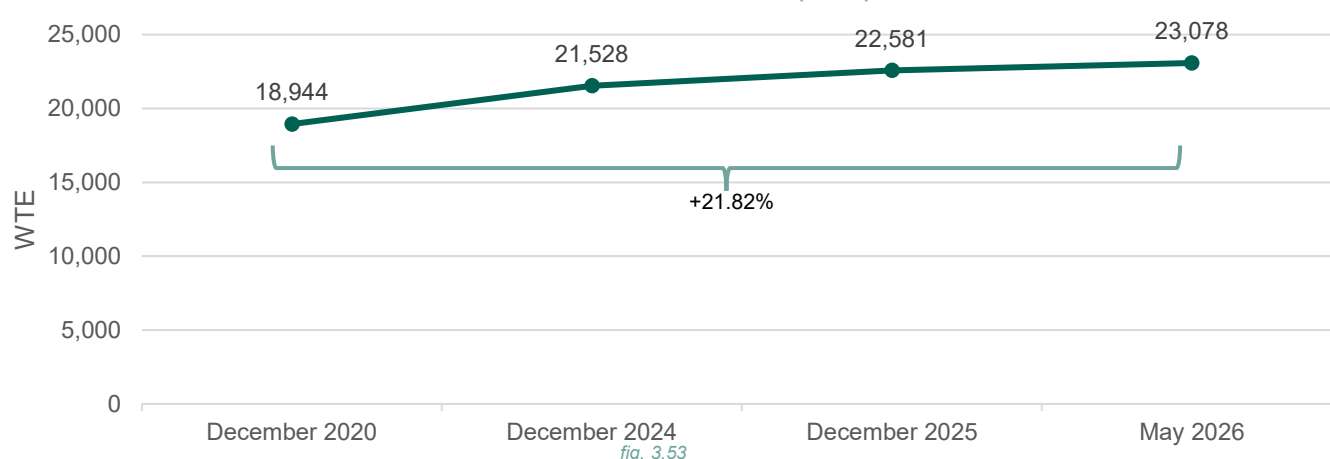
Total Disability Workforce as of May 2026

	WTE Dec 2020	WTE Dec 2024	WTE Dec 2025	WTE May 2026	WTE Change 2025	WTE Change 2026	WTE Change Dec '24 to May '26	% Change Dec '24 to Mar '26
Overall (HSE + 38)	18,944	21,528	22,581	23,078	+1,053	+497	+1,550	7.20%
HSE	4,085	4,506	4,672	4,780	+166	+120	+259	6.35%
Section 38 Voluntary Organisations	14,860	17,022	17,908	18,121	+887	+378	+1,264	7.43%
Section 39 (total estimate only)	~	~	~	*27,000	~	~	~	~

Source: Disabilities Employment Report May 2026; Internal HSE Workforce Update Feb 2026

Table 3.54

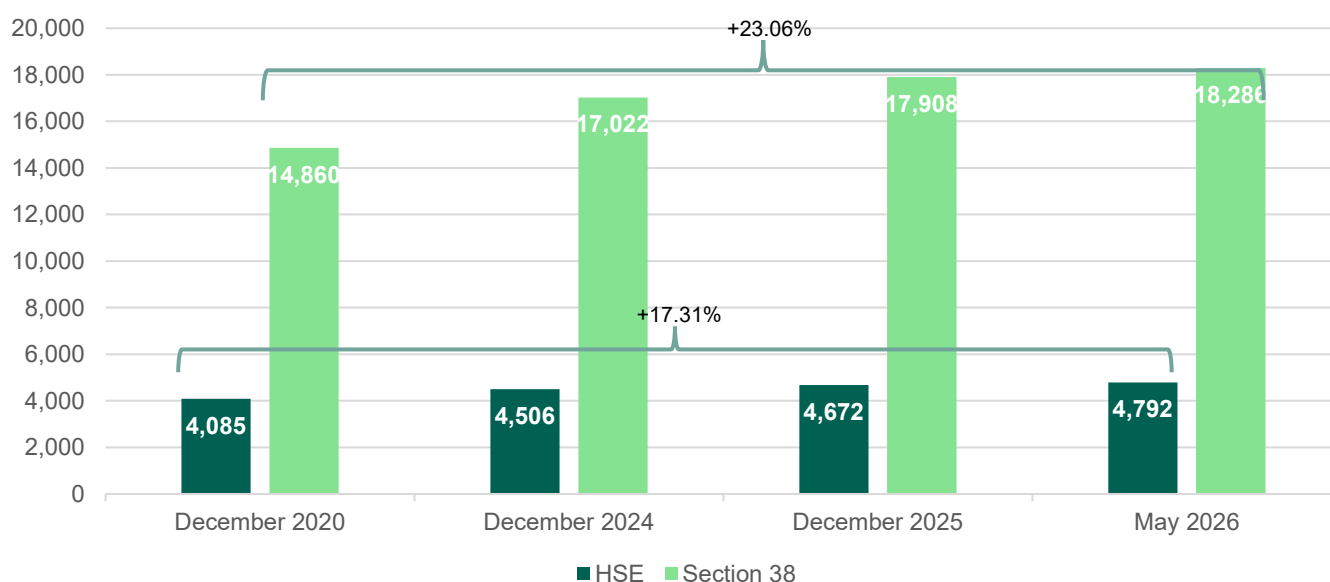
Workforce Growth Trend (WTE)



The majority of disabilities services workforce is made up of Section 38 and 39 organisations, comprising approximately 90%. *Specific workforce metrics for Section 39 organisations were not available at the time of writing, apart from an overall estimate of 27,000 as of February 2026. Unless otherwise stated, workforce analyses relating to adult disability services are based on available HSE and Section 38 workforce data and should therefore be interpreted as a partial view of the overall disability workforce.

Provider Type Analysis

HSE vs Section 38 WTE Growth



Source: Disabilities Employment Report May 2026

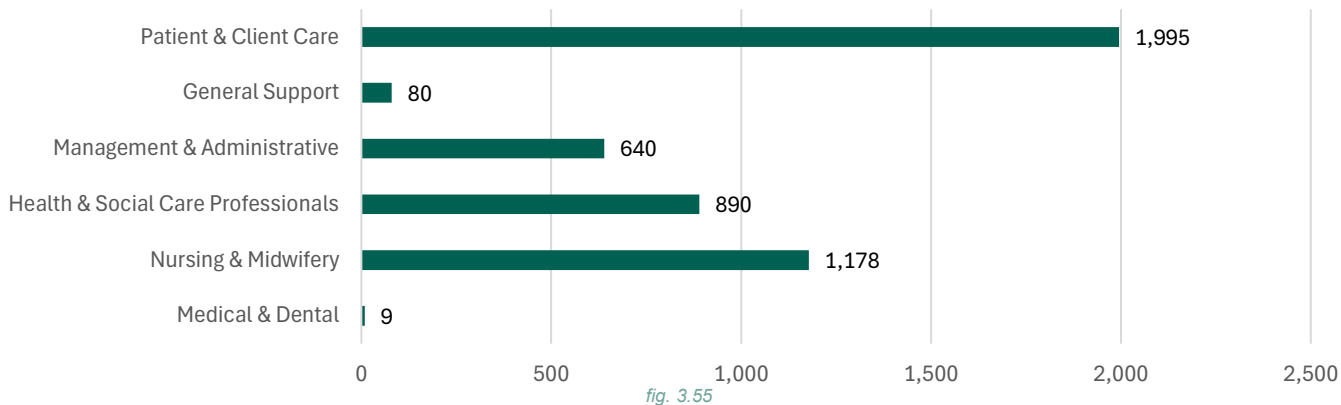
Based on limited available data, it also appears the voluntary sector experienced a higher rate of workforce growth than the HSE over the period.

Data Review Findings

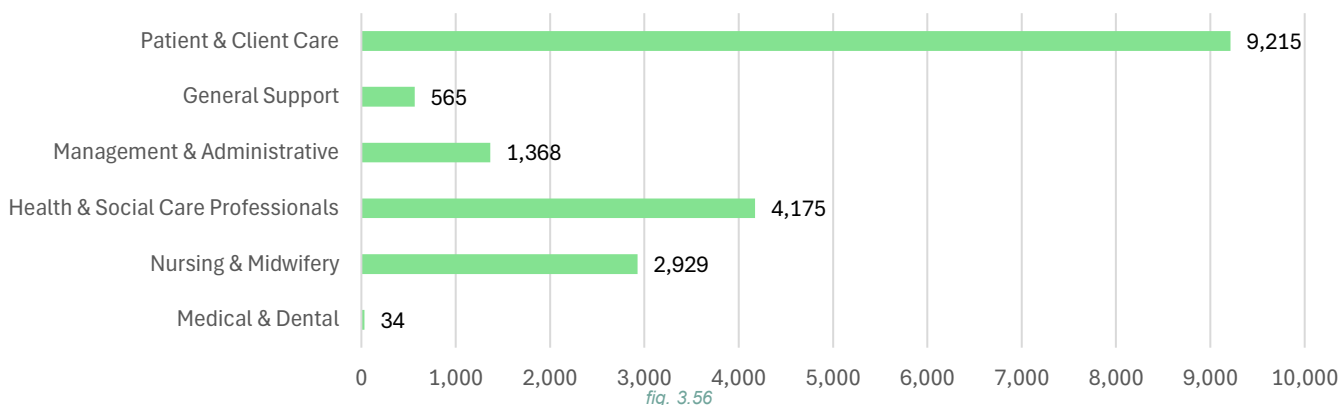
Workforce

Workforce By Discipline

HSE Workforce by Discipline



Section 38 Workforce by Discipline

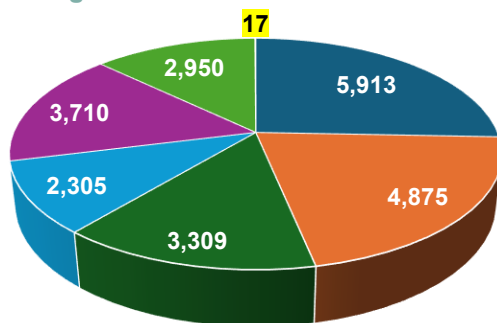


Source: *Disabilities Employment Report May 2026*

Patient & Client Care represents the largest share of both workforces, reflecting 41.6% of HSE and 50.4% of Section 38. Section 38 organisations have a substantially larger absolute number of Health & Social Care Professionals than the HSE, reflecting the voluntary sector's role in multidisciplinary care delivery. Nursing & Midwifery remains the second-largest group for the HSE at 24.6%, while Section 38 shows a more concentrated profile in Patient & Client Care, alongside a sizeable Health & Social Care Professional workforce.

Workforce Regional Comparison

Regional Distribution of Workforce



Region	% Full Time
Dublin & Midlands	60.05%
Dublin & North East	61.46%
Dublin & South East	59.47%
Midwest	41.52%
West & North West	62.69%
South West	70.91%
HSE Centre	94.12%

Table 3.55

- Dublin & Midlands ■ Dublin & North East ■ Dublin & South East
- Midwest ■ West & North West ■ South West
- HSE Centre

fig. 3.57

Source: *Disabilities Employment Report May 2026*

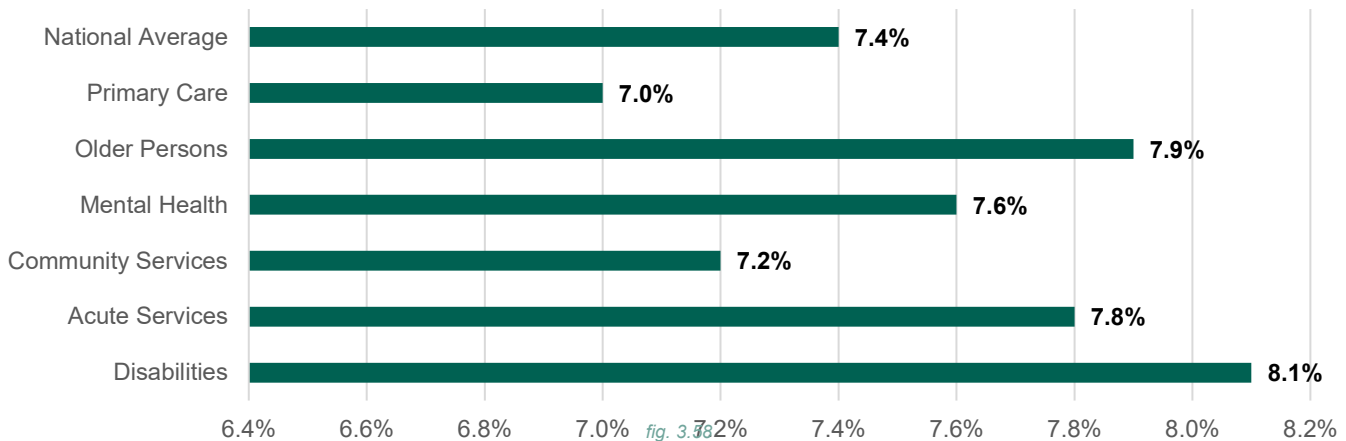
The above graphic pertains to HSE and Section 38 total WTEs only. Dublin & Midlands is the largest region, accounting for 25.6% of the workforce, while the three Dublin regions combined account for over 61% of total disability workforce. The Midwest has the lowest proportion of full-time staff (41.5%), while the South West has the highest (70.9%), indicating notable regional variation in working patterns.

Data Review Findings

Workforce

Staff Turnover

Turnover Rate by Care Group 2025



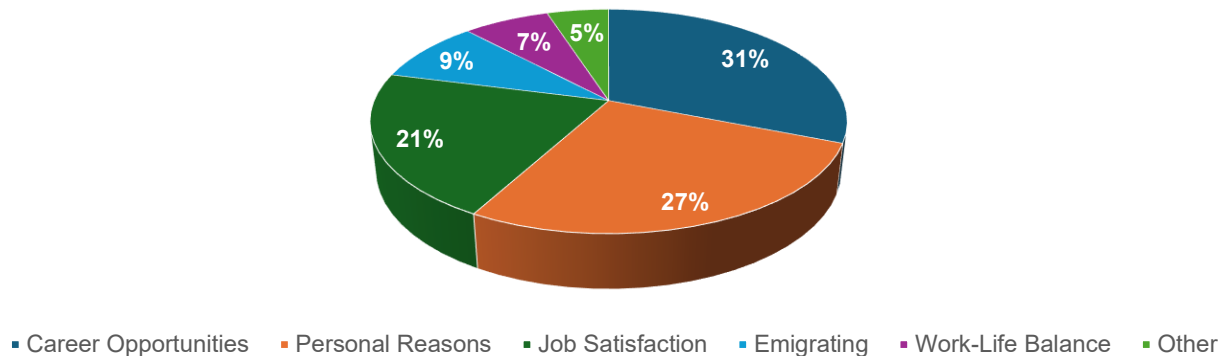
Source: Health Sector Workforce 2025 Turnover Report

The above graph presents the total turnover rate recorded for each of the listed categories across Medical & Dental, Nursing & Midwifery, Health & Social Care Professionals, Management & Admin, General Support and Patient & Client Care disciplines.

Disability services show the highest turnover rates across all care groups with a rate of 8.1%. Within Disabilities, Patient & Client Care shows the highest turnover at 9.4% with Health & Social Care Professionals also elevated at 8.5%.

The below graph presents reasons for staff leaving based on available workforce data. While this is not specific to disability services, it provides indicative insight into broader workforce turnover patterns.

Reasons for Leaving

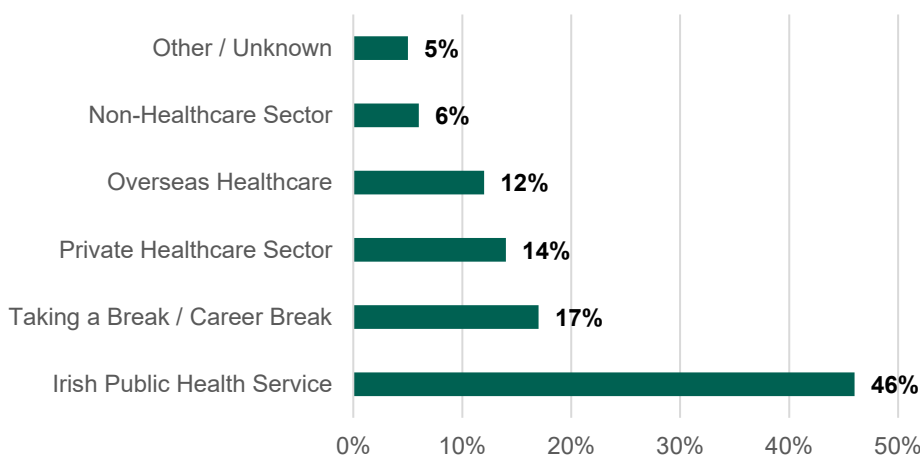


Source: Health Sector Workforce 2025 Turnover Report

fig. 3.59

Career opportunities are identified as the most frequently cited reason for leaving, followed by personal reasons and job satisfaction.

Destination of Leavers



46% of leavers remain within the Irish Public Health Service, indicating internal mobility rather than complete workforce loss. However, 26% leave for private sector (14%) or overseas (12%), representing a true talent drain. The 17% taking career breaks may return, presenting a re-engagement opportunity.

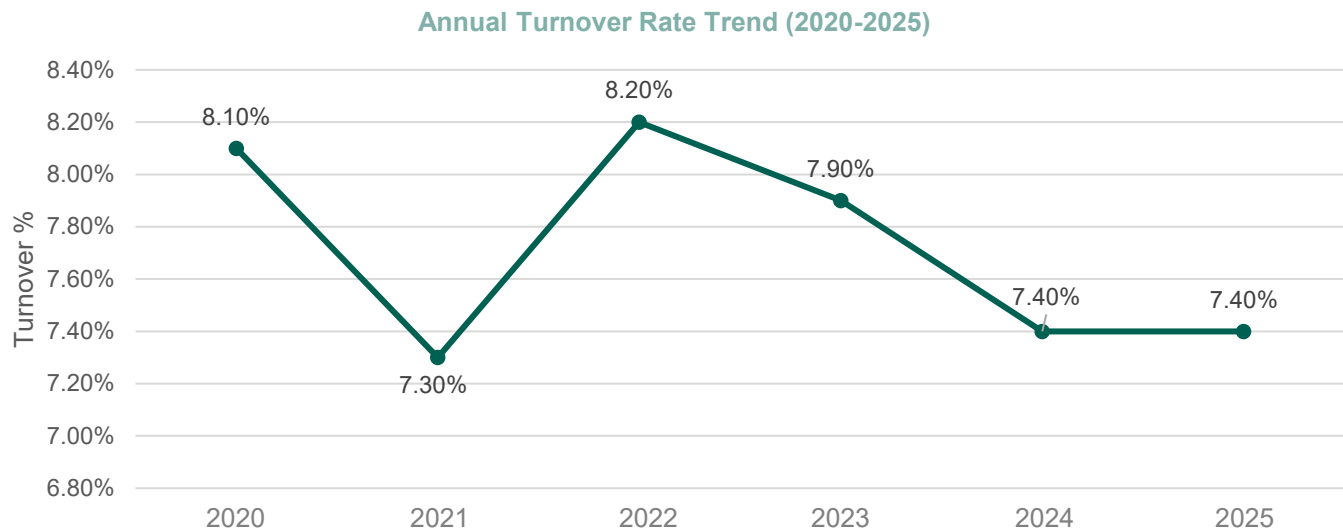
fig. 3.60

Source: Health Sector Workforce 2025 Turnover Report

Data Review Findings

Workforce

Staff Turnover



Source: Health Sector Workforce 2025 Turnover Report

fig. 3.61

Workforce turnover has improved from 8.1% in 2020 to 7.4% in 2025, representing a reduction of 0.7 percentage points. The peak was in 2022 (8.2%). Since 2022, turnover has declined and stabilised at 7.4% in 2024–2025. Disability services continue to have the highest turnover among care groups

Overall Workforce Summary

- **Workforce Growth:** Overall workforce grew 22% from 18,944 in 2020 to 23,078 in 2026.
- **Provider Mix:** Disability workforce is made up predominantly of Section 38 and Section 39 providers, which account for approximately 90%.
- **Staffing:** Patient & Client Care makes up approximately half of the workforce based on available HSE and Section 38 workforce data.
- **Regional:** Dublin regions account for more than 60% of total workforce.
- **Turnover:** Disabilities has highest turnover at 8.1% vs 7.4% national average. Career Opportunities are driving 31% of exits.
- **Retention:** 46% of leavers stay in Irish public health with 26% leaving for private sector or overseas. This presents a retention opportunity.

Data Review Findings

Workforce

CDNT Workforce

Year	Funded WTE	Filled WTE	Gap between Funded and Filled WTE
2025	2499.7	2042.3	18%
2024	2396.1	1866.3	22%
2023	2255.1	1594.5	29%
2022	2102.6	1548.8	26%
2021	1892.4	1527	19%

Source: CDNT National Workforce October 2025 Report

Table 3.56

Workforce Growth Trends (2021-2025)

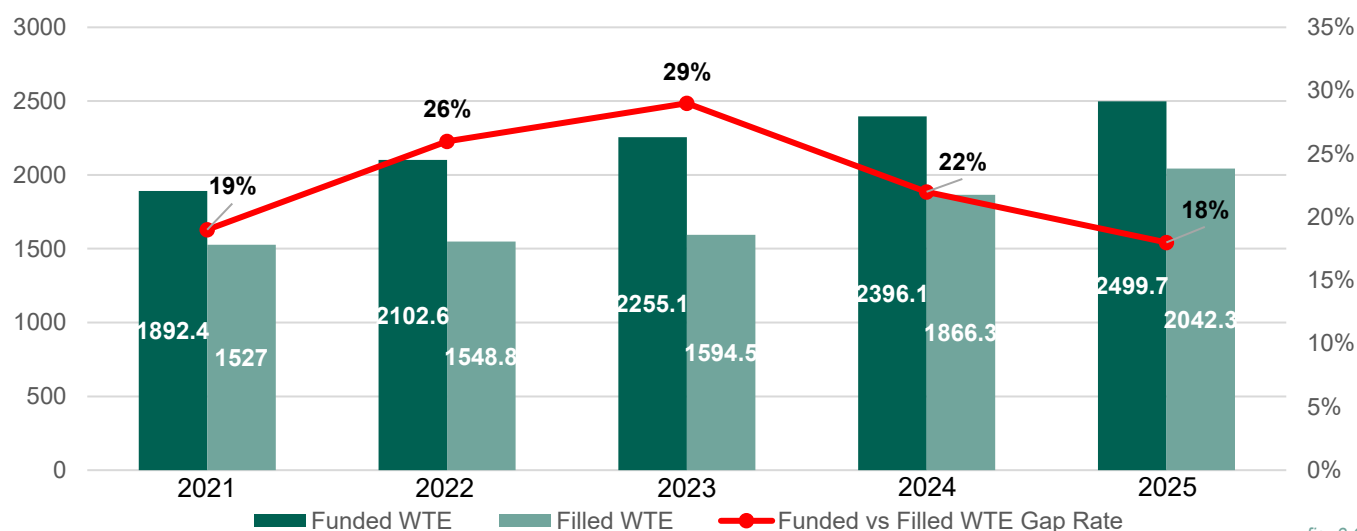


fig. 3.62

Source: CDNT National Workforce October 2025 Report

Since 2021, the CDNT workforce has grown by 32% in funded posts over 4 years (from 1,892.4 to 2,499.7 WTE). Filled positions have increased by 34% (from 1,527 to 2,042.3 WTE) at a similar rate to funded posts and contributing to a reduction in the gap between funded and filled WTE. The gap between funded and filled WTE reduced from 29% in October 2023 to 18% in October 2025.

CDNT Provider Type Performance

Provider Type Performance

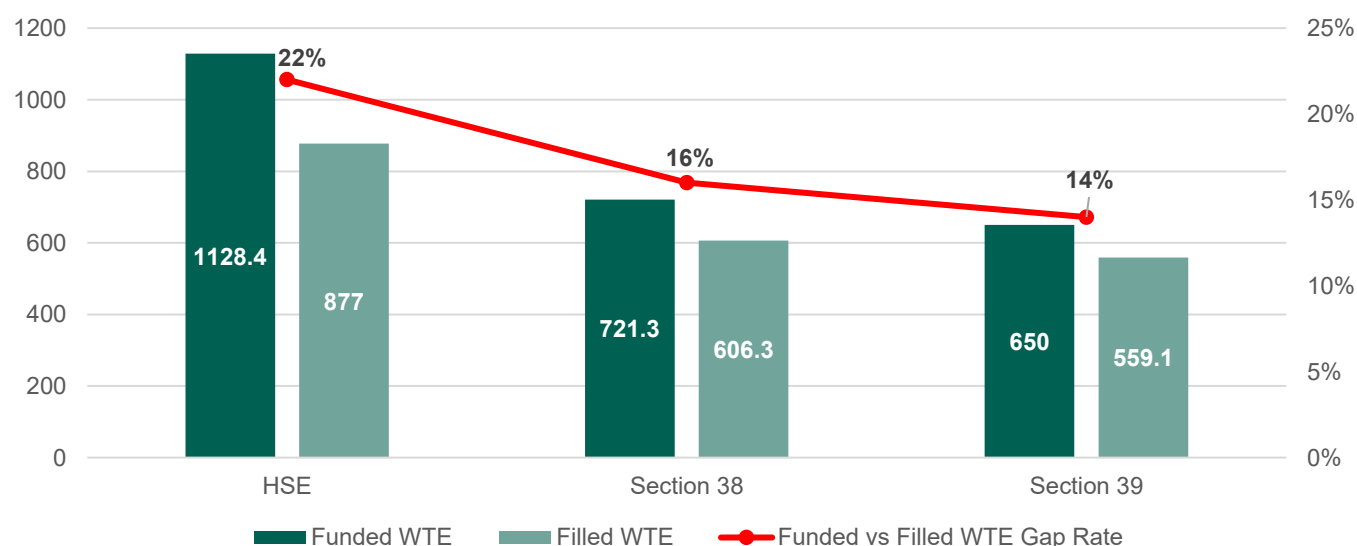


fig. 3.63

Source: CDNT National Workforce October 2025 Report

Data Review Findings

Workforce

CDNT Providers Type Performance

Year	Oct 2023 Gap between Funded and Filled WTE	Oct 2025 Gap between Funded and Filled WTE	Provider Type	CDNTs Managed
HSE	36%	22%	HSE	43
Section 38	22%	16%	Section 38	25
Section 39	26%	14%	Section 39	25

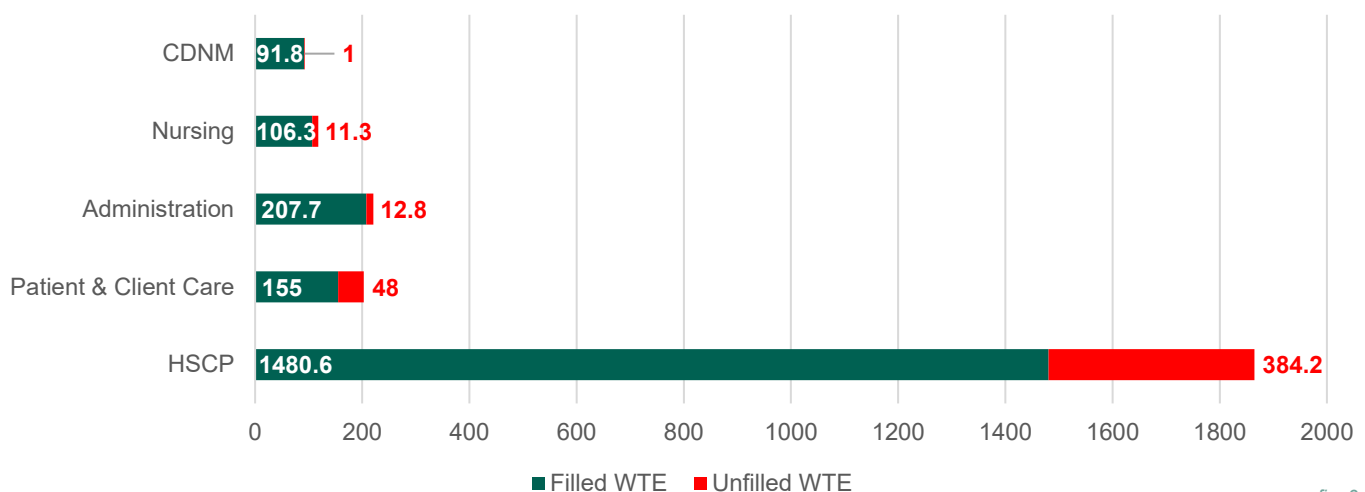
Table 3.58

Source: CDNT National Workforce October 2025 Report Table 3.57

HSE directly manages 46% of CDNTs (43 of 93). However, HSE-managed CDNTs demonstrate the largest gap between funded and filled WTE (22%), compared with Section 38 (16%) and Section 39 (14%). 2023 saw the largest gaps between Funded and Filled WTE across all providers in the 2021-2025 period, with the HSE experiencing the largest reduction (36% to 22%).

Staff Category Analysis

Staff Category Analysis (Filled vs Unfilled WTE)



Source: CDNT National Workforce October 2025 Report

fig. 3.64

Health and social care professionals account for 73% of total workforce and has 84% of all unfilled posts (384 of 457 WTE).

HSCP Discipline Breakdown - Critical Workforce Segment

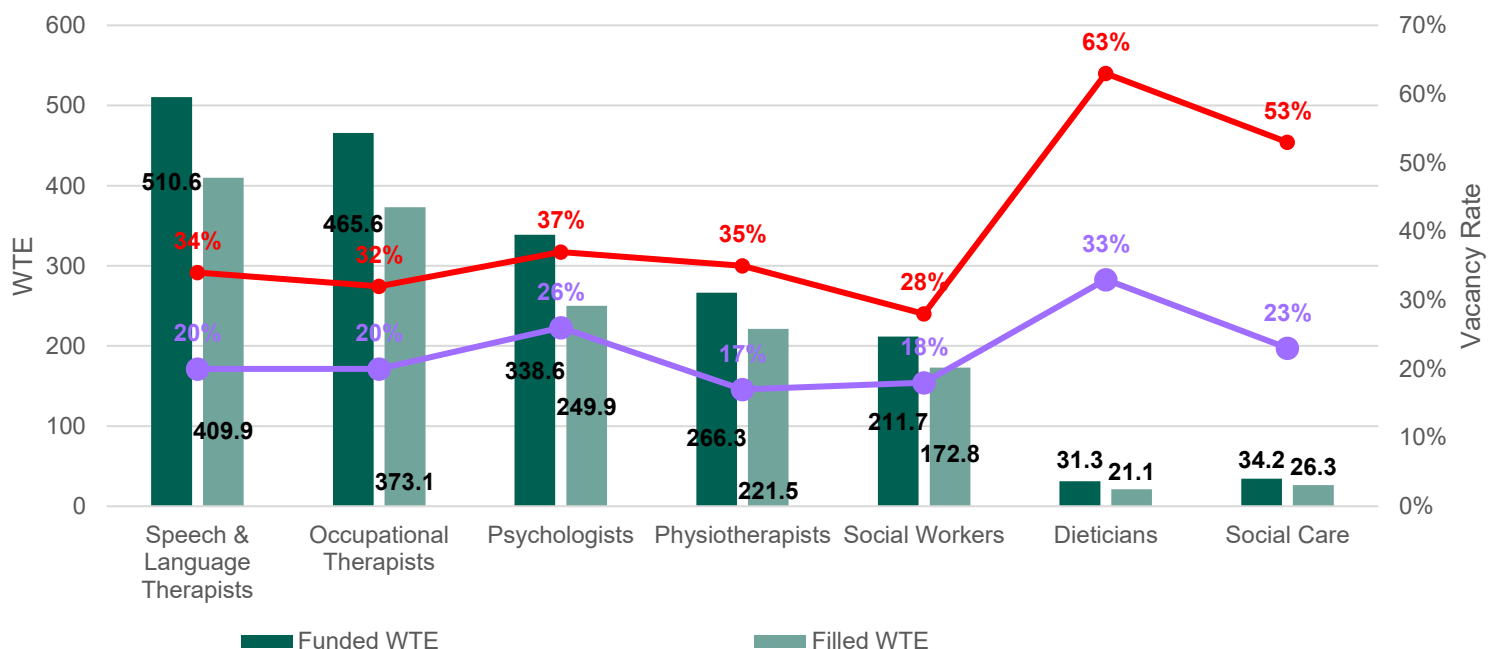


fig. 3.65

Source: CDNT National Workforce October 2025 Report

Data Review Findings

Workforce

CDNT Provider Type Adherence to WTE

All disciplines have shown improvement since Oct 2023. Dietitians showing the most improvement with the gap in funded versus filled WTE reducing from 63% to 33%. Speech and Language Therapists and Occupational Therapists are the largest disciplines, together accounting for 47% of total workforce. This aligns with service needs identified in AON reports.

CDNT Workforce Regional Comparison

Regional Funded vs Filled Gap Rates vs National Average

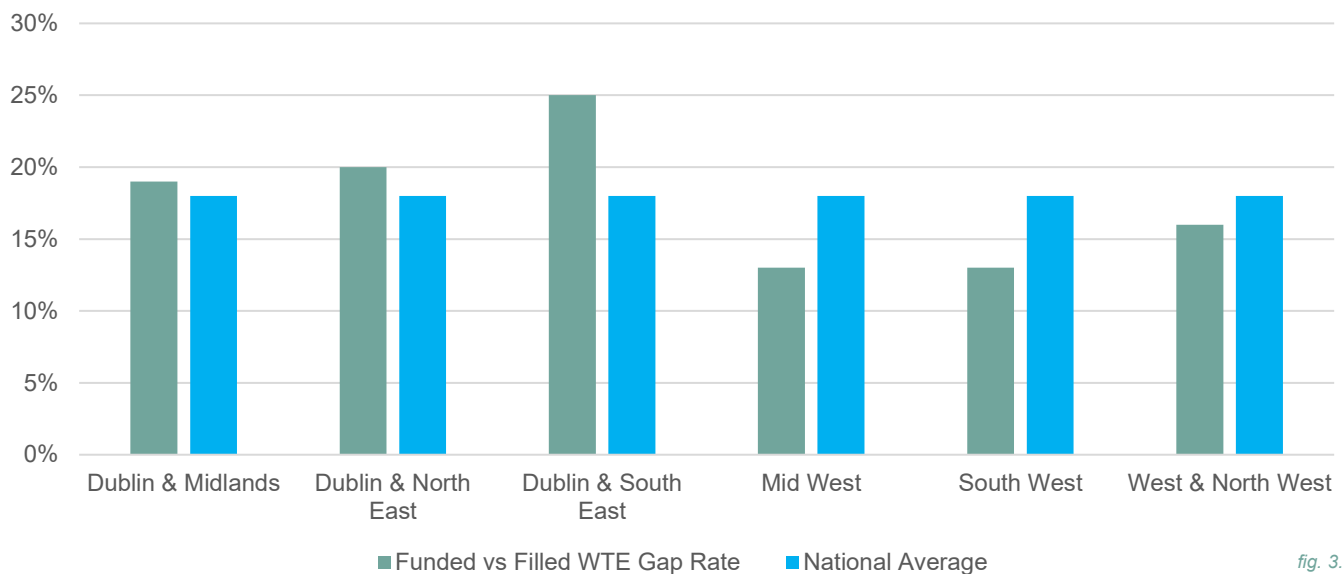


fig. 3.66

Source: CDNT National Workforce October 2025 Report

The national average gap between funded and filled WTE for disability staff sits at 18%. Dublin and South East has highest rate at 25%. Mid West and South West have the lowest rate at 13%. Regional variation in WTE adherence indicates differences in workforce availability across areas.

Recruitment Pipeline

Recruitment Pipeline Status (October 2025)

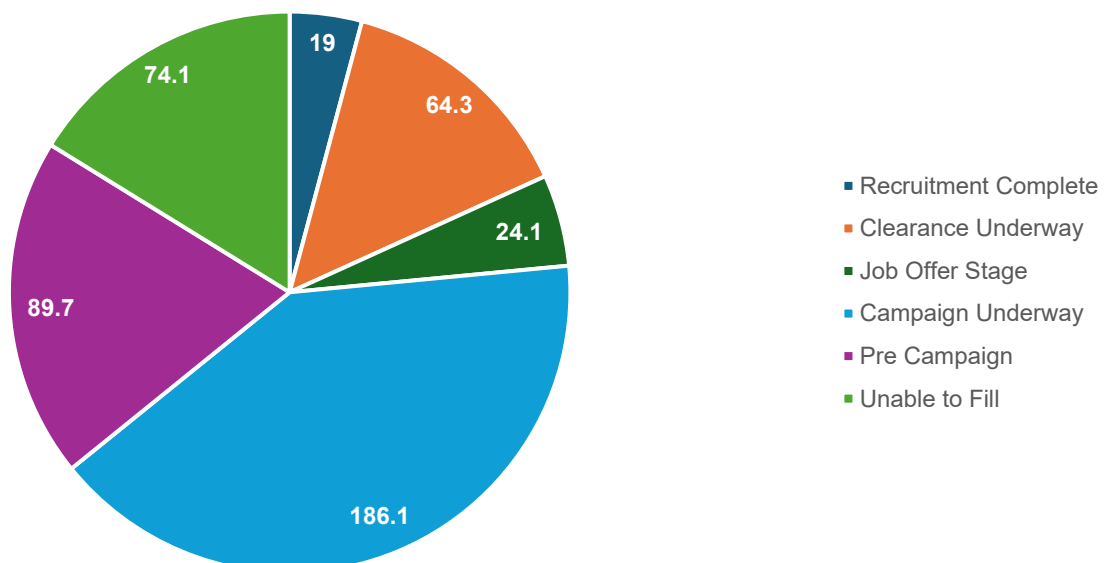


fig. 3.67

Source: CDNT National Workforce October 2025 Report

As of October 2025, 74.1 WTE posts were classified as 'Unable to Fill', indicating that 16% of vacancies are currently classified as 'Unable to Fill'. The recruitment pipeline data reflects posts that have entered formal recruitment processes. It does not provide visibility of the time taken to progress vacancies through local approval, funding or recruitment authorisation processes prior to recruitment commencing, which may also contribute to workforce delays.

Data Review Findings

Workforce

Unable To Fill / Recruitment Unsuccessful

Table 24: Unable To Fill / Recruitment Unsuccessful Grades (WTE)

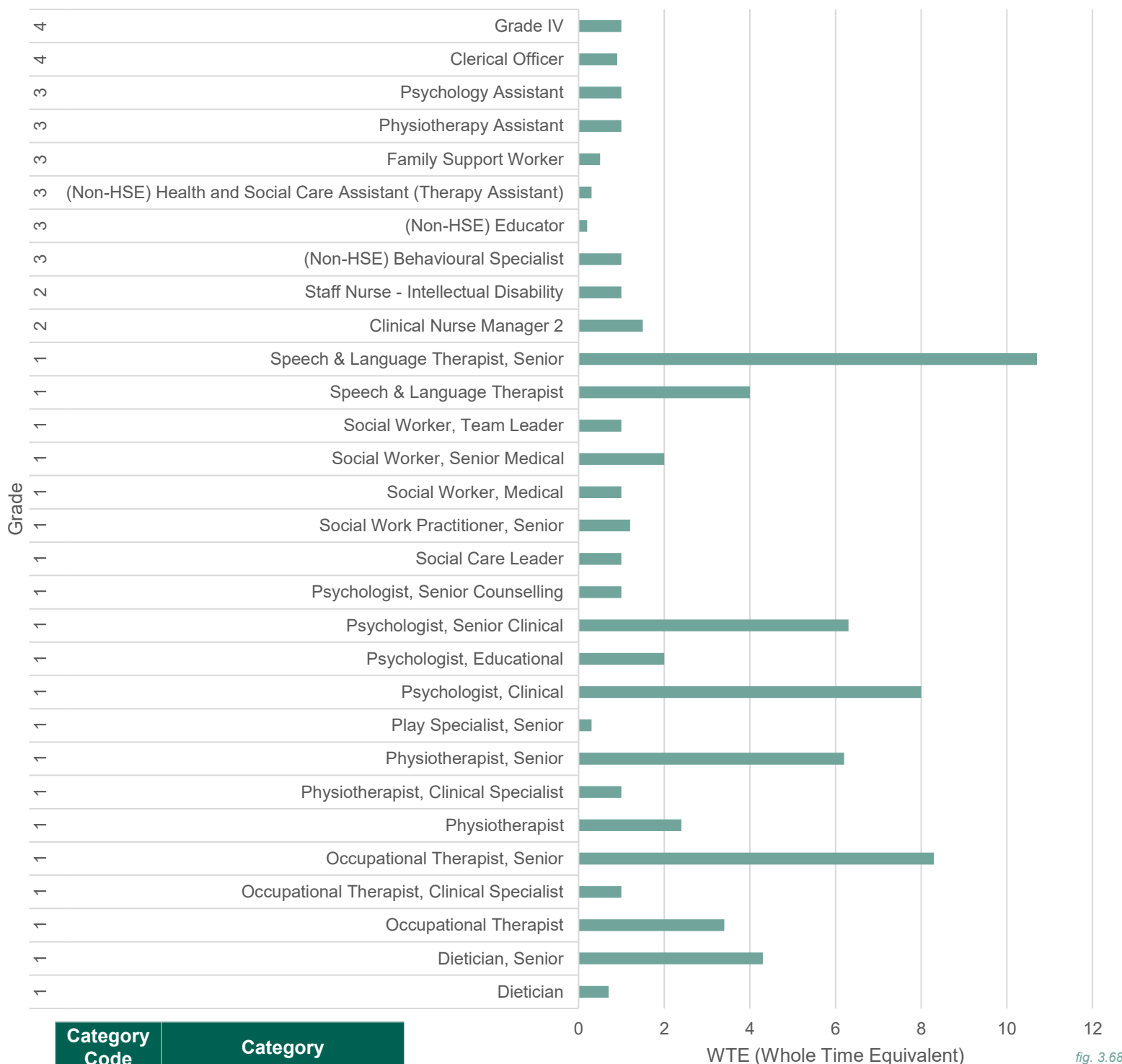


fig. 3.68

Category Code	Category
1	Health & Social Care Professionals
2	Nursing
3	Patient & Client Care
4	Administration (Grade III to VI)

Table 3.59

Source: CDNT National Workforce October 2025 Report

■ Unsuccesul Recruitment(s)

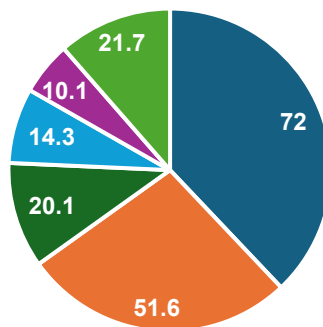
Senior Health and Social Care Professional (HSCP) grades dominate hard-to-fill posts, indicating particular challenges in recruiting to senior and specialist roles

Data Review Findings

Workforce

Leave and Absence Impact

WTE On Leave



- Maternity Leave (paid & unpaid)
- Parental Leave / Parents Leave
- Sick Leave >3 months
- Flexible Working
- Career Break
- Other (Secondments, Carers Leave, etc.)

fig. 3.69

Leave Type	Typical Duration
Maternity Leave	6-12 months
Parental Leave / Parents Leave	Variable
Sick Leave > 3 months	3+ months
Flexible Working	Ongoing
Career Break	1-5 years
Other (Secondments, Carers Leave, etc.)	Variable

Source: CDNT National Workforce October 2025 Report

Table 3.60

189.7 WTE (9.3% of filled workforce) are on leave at any given time. Maternity/parental leave accounts for 65% of all leave. The majority of absence relates to maternity and parental leave, which is typically planned and therefore more predictable from a workforce planning perspective.

Effective Working Capacity

Measure	WTE	% of Funded
Total Funded	2499.7	100%
Total Filled WTE	2042.3	82%
Less: Staff on Leave	189.7	8%
Effective Working Capacity	1852.6	74%
Capacity Gap (vs funded)	647.1	26%

Source: CDNT National Workforce October 2025 Report

Table 3.61

Effective working capacity (Total filled less staff on leave) is approximately 74% of funded establishment. Leave patterns should inform service planning and temporary staffing strategies.

Contract Type and Workforce Stability

Contract Type Distribution

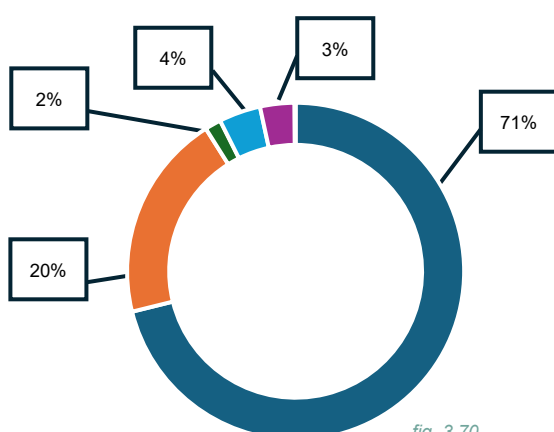


fig. 3.70

Source: CDNT National Workforce October 2025 Report

- Permanent Whole-time
 - Permanent Part-time
 - SPC (WTE & PT)
 - Fixed Term Contract
 - Agency
 - Secondment
- 91% of the workforce has a permanent contract, indicating a predominantly stable contract base. Agency staff represent 3.3% of workforce.

Data Review Findings

Workforce

Projected Workforce Recruitment Pipeline for Q1 2026 (As of October 2025)

Metric	WTE	Notes
Current Filled WTE (October 2025)	2042.3	Active staff in post
Expected fills (next 3 months as of October 2025)	107.4	Recruitment Complete + Clearance + Offers
Projected Filled WTE (Q1 2026)	2149.7	Estimated workforce position
Projected Gap between Funded and Filled WTE (Q1 2026)	14%	Based on current funded posts
Remaining 'At Risk Vacancies'	163.8	Pre-campaign + Unable to fill

Source: CDNT National Workforce October 2025 Report

Table 3.62

CDNT Workforce Summary

- **Progress:** The gap between funded and filled WTE was reduced from 29% in October 2023 to 18% in October of 2025, reflecting increased alignment between funded staffing levels and filled posts.
- **Workforce Growth:** There was a 28% increase in filled positions over the same 24 month period, from 1,594 to 2,024.
- **Regional Disparity:** Dublin & South east region sees larger gaps between funded and filled WTE than all others at 25%. This is significantly higher than the Mid West and South West regions which both had a gap of 13%.
- **Health & Social Care Professionals:** 84% of all vacancies are in the Health & Social Care Professionals category.
- **Workforce Stability:** 74 WTE in Psychology and Senior Speech and Language Therapist and Occupational Therapist roles remain unfilled.
- **Recruitment Pipeline Activity:** 107 WTE's were classified as in late-stage recruitment. Leading to a projected 14% gap between funded and filled WTE across the CDNT workforce as of Q1 2026.
- **Effective Capacity:** Only 74% of funded posts are actively working.
- **Workforce Stability:** 91% permanent contracts indicates strong retention foundation.
- The CDNT workforce is a key enabler of service access and delivery. Variations between funded and filled WTE across CDNTs and therapy disciplines, alongside persistent waiting lists, highlight the importance of workforce planning in supporting assessment, intervention and ongoing service provision.
- **Note:** The most recent nationally available CDNT workforce report at the time of analysis was October 2025. More recent workforce data may subsequently become available and should be incorporated into future monitoring and workforce planning activity.



Stakeholder & Lived Experience Insights

Stakeholder Engagement – Executive Summary



National Disability Services Needs Analysis 2026

ENGAGEMENT AT A GLANCE



47

stakeholders
consulted
(1:1 and small groups,
virtual)



89

survey responses
(service users,
families, providers)



6

weeks

Qualitative and directional – not statistically representative

WHO WE HEARD FROM



HSE – national,
regional and
operational roles



Voluntary sector
service providers



System-function
professionals



Families and people
with lived experiences

14 THEMES ACROSS 6 CATEGORIES



System
Capacity &
Sustainability



Planning,
Infrastructure
& Delivery
Alignment



Data, Digital &
Insight



Governance &
Integration



Lived
Experience



Future Focus

KEY MESSAGES



- Demand and waiting lists are increasing
- Workforce capacity remains constrained
- Families play a central role in coordinating care
- Services and data are fragmented
- People want person-centred, community-based support

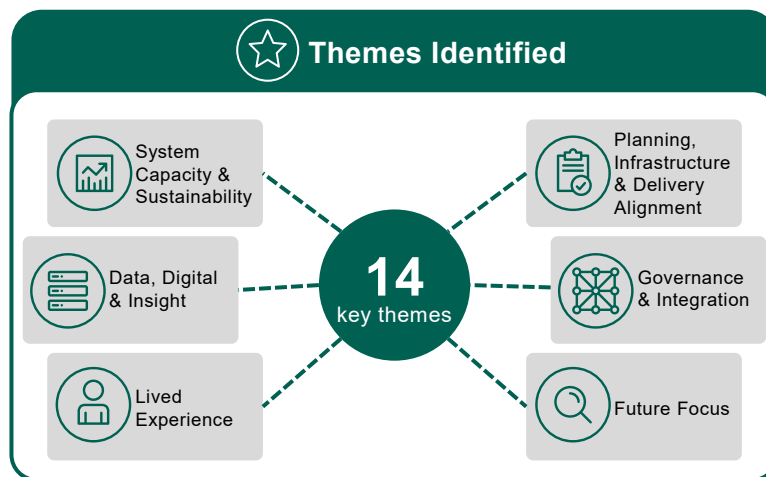


Based on stakeholder workshops, interviews, written submissions and a family representative survey, National Disability Services Needs Analysis 2026.

Stakeholder Engagement

Introduction

A stakeholder engagement process was undertaken as part of the National Disability Services Needs Analysis to gather perspectives from individuals involved in the planning, commissioning, delivery, oversight and use of disability services in Ireland. Over a six-week period, **47 stakeholders** participated in individual or small-group virtual consultations, and a further **89 stakeholders** participated in surveys. Participants represented a range of perspectives across national, regional and operational levels, including the HSE, voluntary service providers, system functions, and individuals and families with lived experience of disability services. Stakeholder feedback was analysed using a thematic approach, resulting in 14 themes grouped within six overarching categories: **System Capacity and Sustainability**; **Planning, Infrastructure and Delivery Alignment**; **Data, Digital and Insight**; **Governance and Integration**; **Lived Experience**; and **Future Focus**. The consultation findings provide qualitative, directional insights into stakeholder experiences and perspectives. While not statistically representative, the engagement identified a range of considerations relating to service demand, waiting lists, workforce capacity, funding and capital requirements, data and information systems, and organisational arrangements within an evolving service environment.



Stakeholder Engagement

Stakeholder engagement was undertaken using a purposive sampling methodology. Representation was sought across organisational levels and service settings, including the HSE, voluntary service providers, individuals involved in system functions, family members and Disabled Persons Organisations. The consultation findings reflect the perspectives captured through this engagement process. As the sample was not designed to be statistically representative of the wider disability services sector, the findings should be interpreted as qualitative and directional in nature. Nevertheless, they provide useful contextual insight into stakeholder experiences and perceptions and support the interpretation of findings arising from the literature review and data analysis components of the needs assessment. The consultation methods and stakeholder groups are outlined in the table below:

Format	Group
1:1	HSE
1:1	Voluntary Organisations
1:1	Service User Family Member
Focus Group	Family Member Organisations
Survey	Voluntary Sector Providers
Survey	Service users/ families of people with a disability

Table 3.63

Stakeholder Engagement

Overview of Key Themes

The table below presents an overview of the key themes identified from the thematic analysis of stakeholder consultations, which have been grouped into six overarching categories. Stakeholders described a system operating in an environment of sustained pressure from rising demand, increasing complexity of need, and persistent workforce constraints, affecting both children's and adult's services.

Stakeholders noted that services are operating within a context influenced by factors such as demand levels, funding cycles, capital timelines and the configuration of service pathways. This context was associated with reported access pressures, varying opportunities for early intervention, and the use of more reactive responses in some instances, alongside ongoing development of lower-intensity and community-based options.

They also described a system where data exists, but remains fragmented, and digital infrastructure varies across service types. While stronger operational systems are in place in some areas (notably CDNTs and day services), adult services remain more dependent on manual disjointed processes, limiting person-centred insight, outcomes measurement and coherent planning.

Stakeholders highlighted opportunities to strengthen integration across housing, transport, education, acute care and disability services, alongside evolving roles and accountabilities within the context of ongoing restructuring and external oversight. At the same time, interviews identified a number of enablers of improvement, including enhanced service planning, clearer pathways, more flexible community-based support models, improved use of data, and increased national consistency in operating approaches.



System Capacity & Sustainability

- Workforce and capacity constraints
- Unmet need and access pressure
- Increasing complexity of need
- Funding model constraints



Planning, Infrastructure & Delivery Alignment

- Capital investment, infrastructure and estates
- National planning and local delivery alignment



Data, Digital & Insight

- Data availability and use
- ICT infrastructure and digital enablement
- 'Single person view' and building coherent insight



Governance & Integration

- Integration across health and social services
- Governance, accountability and organisational restructure
- External pressure and scrutiny



Lived Experience

- Service access and navigation; service adequacy and quality; communication; planning; continuity of care; family burden and emotional impact



Future Focus

- Practical improvements, required actions and investments

Stakeholders' accounts suggest that these themes are interdependent: e.g. workforce and funding affect capacity; planning and capital affect access; data and digital maturity affect visibility and decision-making; and governance and integration shape whether services can be experienced as coherent and person-centred.

Stakeholder Engagement

System Capacity and Sustainability

Workforce and Capacity Constraints

Stakeholders identified workforce availability as an important factor influencing service capacity across disability services. Challenges were noted in relation to recruitment and retention in key disciplines, particularly among health and social care professionals, alongside some reliance on agency staffing and varying pay arrangements across provider types and sectors. Stakeholders also highlighted a number of structural workforce considerations that may influence the overall impact of recruitment activity on capacity, including recruitment timelines, staff movement across services, and the sustainability of roles such as case management, where career pathways and continuity were noted as areas of ongoing development. Alignment between training pipelines and service needs was also referenced as a contributing factor.

Workforce challenges were described as affecting both children's and adult services. Particular pressure in adult services was expressed where stakeholders reported more limited visibility of need due to less consistent data, fragmented systems, and limited person-level insight. Stakeholders reported that this constrains the ability to plan capacity, understand demand, and coordinate services proactively.

Some stakeholders reported evidence of stabilisation in parts of the workforce. Stakeholders noted that the alignment of pay rates within home support services had contributed to improved provider stability following periods of workforce movement between disability and older persons' services. However, workforce supply continued to be described as constrained, with ongoing considerations relating to recruitment, skill mix and long-term sustainability across providers.

Workforce availability is described as a key determinant of whether funded service developments and approved capacity can be operationalised. Stakeholders also highlighted how it impacts delivery of community-based pathways rather than relying on short-notice crisis responses, because those models require consistent staffing, supervision, and coordination across services. Furthermore, stakeholders noted that higher levels of turnover and agency staffing can make it more challenging to maintain continuity of care and service relationships.

Provider survey findings aligned with consultation feedback that workforce capacity is a central constraint on service delivery. Respondents highlighted

recruitment and retention challenges, Section 39 pay differentials, difficulty filling specialist and frontline roles, and concerns regarding the age profile and future supply of staff in PA, home support and day service roles

Unmet Need and Access Pressure

Across consultations, stakeholders described demand for disability supports as exceeding available provision across the life course, with particular pressures at key transition points (including childhood to adulthood), within residential and respite services, and in the context of sustained demand growth associated with demographic change and evolving levels of need.

Stakeholders described a pattern whereby needs often become more apparent at points of escalation, rather than being identified early and addressed through planned supports. This was noted particularly in adult services, where the systematic capture of unmet need was described as less developed.

Within day services, stakeholders described strong and increasing demand, including an estimated annual rise in referrals of approximately 10%, alongside capacity constraints in provider expansion and limited progression pathways for individuals once in receipt of services.

Stakeholders noted a relationship between access pressures, pathway clarity and expectations, highlighting differences between what families expect and how services are currently structured and resourced. In practice, stakeholders described unclear or inconsistent pathways for accessing services, moving between services (e.g. children to adult services, or hospital to community), and understanding what level of support can be expected at each stage. This lack of clarity was linked to fragmented access routes, variable eligibility thresholds, and limited communication about realistic timelines or service offers, which can contribute to frustration and a perception that services are not meeting needs.

From an adult services perspective, stakeholders described variation in the availability of therapeutic and multidisciplinary supports compared to children's pathways. They reported that this contributes to challenges at the point of transition to adult services, where individuals, particularly those with more complex or evolving needs, may experience a reduction in coordinated supports, less clearly defined pathways, or difficulty accessing

Stakeholder Engagement

Unmet Need and Access Pressure (cont'd)

appropriate MDT input.

When demand exceeds available capacity, stakeholders noted that waiting times increase and that some individuals may experience escalation in needs. Pathways into services were described as, in some instances, occurring through urgent or unplanned routes, or involving placements that may not fully align with individual needs where planned options are not available. Stakeholders also referenced variability in the review of such placements, which may affect opportunities for step-down and result in extended use of more intensive support arrangements. Stakeholders highlighted the importance of continued development of community-based options within adult services, including respite, home support, supported living and personal assistance. A broader and more flexible service mix was identified as supporting more consistent delivery.

Stakeholders identified under-65 nursing home placements as an ongoing area of pressure within the system, often associated with limited availability of alternative options and constrained community capacity. Such placements were described as having implications for quality of life, with some individuals remaining in nursing home settings beyond the resolution of medical need, reflecting limited availability of step-down options such as home support, personal assistance and supported living.

Stakeholders also described a dynamic whereby disability services are working to support transitions from nursing home settings, while acute services may continue to discharge some individuals into these settings, in the context of broader system pressures. It was noted, however, that the number of individuals aged under 65 in nursing homes nationally has shown a downward trend since July 2025, at approximately 1,200 at the time of reporting.

Provider survey responses reinforced stakeholder consultation findings that unmet need extends beyond formal waiting lists and may not be fully visible in national datasets. Respondents described significant or very significant unmet need across residential services, respite, personal assistance, home support, day services, CDNTs, specialist supports and transition supports. Several responses also state that provider-held data captures cohorts not visible in HSE datasets, including people screened out, redirected, waiting, or never entering statutory pathways. Survey responses also validated stakeholder concerns regarding transition points, where families may struggle to navigate multiple systems.

The survey also identified specific cohorts that providers consider under-recognised or insufficiently visible in statutory planning data. These included deafblind children and adults, adults with DCD or undiagnosed DCD, children who fall between CDNT and Primary Care thresholds, people aged 18–61 with neurological or physical disability needs, unpaid family carers, and people with multiple or co-occurring diagnoses.

Increasing Complexity of Needs

Stakeholders consistently described increasing complexity in service user presentations, often as multilayered combinations of clinical, behavioural, social and ageing-related needs. Examples include rising autism prevalence, behavioural challenges, and increasing longevity/ageing-related needs, including dementia or physical decline.

Stakeholders highlighted groups with overlapping needs, including individuals with disabilities who also experience mental health issues, addiction or homelessness, and individuals within migrant and refugee populations with disabilities. While these intersections are not new, they were described as becoming more prominent over time. It was noted that existing service structures do not always fully reflect or align with these overlapping needs.

Several stakeholders described how increasing complexity amplifies demand pressures because supports are more resource-intensive, require multi-disciplinary coordination, and are harder to deliver through legacy models or under annual planning cycles. Complexity also raises requirements for suitable environments (housing design, safeguarding, accessibility) and increases the consequences of fragmentation across services and data systems.

Increasing complexity was described as giving rise to a number of challenges, including higher costs and longer timelines associated with the development of tailored accommodation solutions; greater reliance, in some instances, on more urgent responses for individuals with more complex needs; and a greater requirement for multidisciplinary team (MDT) supports, particularly within adult services where availability was described as limited.

Provider survey responses reinforced consultation findings that the profile of need is becoming more complex. Respondents pointed to increased prevalence of autism, behavioural support needs, mental health need, ageing-related support requirements, neurological conditions,

Stakeholder Engagement

multi-diagnosis, safeguarding complexity and family-related pressures.

Funding Model Constraints (annual vs multiannual)

Stakeholders frequently identified the absence of multiannual funding as a foundational constraint, describing annual funding cycles as misaligned with the timelines required for capital delivery, workforce development, and planned service reform.

Across a number of regions, stakeholders linked annual cycles to reactive commissioning, particularly in residential services where crises can drive short-notice purchasing and reduce opportunities for planned provision.

National perspectives also described funding increases being absorbed by demographic and cost pressures, limiting visible service expansion despite increased spend. Stakeholders expressed how a lack of multiannual funding makes it difficult to invest early in interventions that could stabilise demand, e.g., structured respite or home support packages, and restricts the system's ability to execute multi-year change programmes.

The provider survey further validated concerns raised through stakeholder consultations regarding the sustainability of current funding arrangements. Respondents highlighted short-term or annual funding cycles, unfunded core costs, delays in grant aid agreements, reliance on fundraising, and the absence of full economic cost funding as factors limiting service continuity, workforce stability and the ability to respond to emerging need.

Planning, Infrastructure and Delivery Alignment

Capital Investment, Infrastructure and Estates

Stakeholders repeatedly described housing and infrastructure as structural constraints on service capacity - particularly for residential and respite services. Stakeholders noted that capital delivery timelines, which can span several years, are not well suited to responding to short-notice needs. From an estates and capital perspective, the absence of fully developed and approved service plans, together with a lack of clear delivery pipelines, can limit forward planning. This can, in turn, lead to more reactive prioritisation and make it more challenging to target investment in a strategic, needs-based way.

Stakeholders also noted that a proportion of capital investment is allocated to regulatory compliance and legacy upgrades, which can affect the pace at which

new capacity becomes available. They further highlighted that some properties are not always used to their full potential or are used in ways that differ from their original purpose, which may contribute to ongoing capacity pressures.

Stakeholders reported that when capital delivery timelines do not align with emerging need, services may rely on unplanned or externally sourced placements (including private or spot-purchased provision) to meet immediate demand. Stakeholders noted that they are often higher-cost, less predictable, and more difficult to optimise over time compared to planned provision aligned with capital development, leading to longer-term cost and system sustainability implications.

Stakeholders also highlighted positive enablers within capital planning, including the development of standard exemplar designs (e.g. four-bed residential and respite models), which were described as supporting consistency and efficiency and aligning with practice in other sectors, while also noting that site and pipeline constraints can limit applicability in practice. Regional procurement frameworks were also described, which were said to have potential to reduce delays once locations and need are known, though not a replacement for service plans.

National Planning and Local Delivery Alignment

Stakeholders described a persistent gap between national policy intent/targets and local feasibility, driven by annual funding cycles, multi-year delivery timelines, workforce constraints, and variability in local infrastructure.

Stakeholders highlighted a recurring pattern whereby strong policy development has been achieved, but progress in implementation has been constrained by insufficient resourcing. This may, in some cases, contribute to challenges such as differing expectations, ongoing cycles of policy development without full implementation, and a reliance on local adaptations that may gradually diverge from the intended policy direction. This may lead to local variations that drift from policy direction under pressure.

Stakeholders also indicated that there is broad support for the overall direction of national policy, including key reforms such as decongregation and community-based care, which were described as central strands to system reform particularly in residential services. However, this support was described as conditional on clearer implementation pathways, including more defined roles, stronger links between national planning and local decision-making, and alignment with available funding, workforce and infrastructure.

Stakeholder Engagement

Stakeholders described tensions between national policy objectives - particularly decongregation and planned, community-based living - and local operational pressures such as early hospital discharge, crisis presentations, and urgent placement needs. They reported that, in practice, these pressures can result in short-term placement decisions that may not fully align with decongregation objectives, for example where individuals are placed in less appropriate settings due to limited immediate alternatives.

In children's services contexts, stakeholders described the closure of historical settings (including congregated child residential settings) without planned replacements, contributing to crisis presentation and emergency placement pressures.

Provider perspectives also expressed de-congregation among key priorities, alongside a call to shift from strategy writing to delivery. Provider survey responses supported stakeholder feedback that residential demand cannot be addressed solely through traditional group-home models. Respondents highlighted housing availability, cost and lease constraints as barriers, while also identifying demand for supported living, cluster models, own-front-door accommodation with shared staffing, individualised residential supports and broader alternatives to centre-based or shared residential models.

Data, Digital and Insight

Data Availability and Use

Stakeholders consistently described the system as having significant data but limited joined-up insight, with fragmentation across providers and systems, and uneven confidence in national datasets. Stakeholders reported that available information tends to focus on access, activity, and cost metrics, while data on outcomes and impact is more limited once individuals enter services. This was noted as particularly evident in services delivered by Section 38 and 39 providers, where some stakeholders described a potential gap in the monitoring of outcomes.

Day services were described as having relatively strong national data infrastructure and activity tracking, including a dedicated database and standardised processes, but stakeholders also highlighted gaps in outcomes data, including progression, inclusion and the effectiveness of services in meeting identified needs.

Stakeholders also highlighted the administrative burden and interpretability challenge of data, including concerns about inconsistent definitions, non-reporting

in some service areas, and reports that are difficult for non-specialists to interpret.

Stakeholders indicated that, in the absence of coherent and trusted data, including robust outcomes information, the system faces challenges in reliably quantifying unmet need, planning workforce and infrastructure requirements, demonstrating impact, and maintaining stakeholder confidence. Several interviews linked limited data integration and outcomes visibility to shorter planning horizons and more reactive service responses, while others noted that data limitations can make it more difficult to communicate performance in a clear and credible manner.

The provider survey highlighted the potential value of provider-held data for future planning. Respondents indicated that providers may hold information on cohorts not fully visible in statutory datasets, including people screened out of services, people waiting or redirected, undiagnosed adults, condition-specific cohorts, pathway gaps, geographic cold spots and outcome data. This suggests that future planning would benefit from more systematic integration of provider-held intelligence alongside national datasets. Survey responses also support the need to strengthen outcome measurement across the service.

ICT Infrastructure and Digital Enablement

Stakeholders described highly uneven digital enablement across service lines. An Information and Communications Technology (ICT)-focused interview set out a core system issue: disability services do not have a single case management system across all service types, and where data is strong it is often because systems are embedded as day-to-day operational tools, rather than creating an additional burden. CDNTs were described as a relative strength because clinicians use an ICT case management system as their primary working tool and metrics are generated automatically, producing consistent data.

In contrast, adult services (including residential, respite, PA and home support) were described as relying heavily on Excel trackers and fragmented local tools, with inconsistent completion across regions, and with major gaps in person-level visibility. Manual processes were reported to place additional demands on frontline staff time, reducing capacity within an already stretched workforce.

Stakeholder Engagement

Service user/lived experience feedback echoed the perception of outdated processes, limited technology enablement, and administrative burden (e.g., manual paperwork).

Stakeholders explicitly linked embedded ICT systems to higher quality data, more reliable operational monitoring, and improved capacity to understand and manage demand - whereas fragmented ICT increases manual burden and reduces the system's ability to coordinate care packages.

“Single person view” and the System’s Ability to Build Coherent Insight

A recurring insight across interviews is that the system lacks a ‘single view’ of the person across service types.

This was described as limiting visibility of an individual’s full package of supports (e.g. day, respite, PA and residential) and contributing to fragmented journeys, particularly during transitions. Lived experience feedback reinforced this perspective, describing service plans as functioning more as static records than as active, shared platforms, and noting that they are not consistently used to support coordinated or responsive care. Multiple professionals may be involved in a person’s care without a shared overview.

Governance and Integration

Integration Across Health and Social Services

Stakeholders consistently described disability services as operating across multiple domains, including housing, transport, education, acute and community health, and social supports. However, integration across these services was described as variable, with coordination often dependent on individual relationships rather than established, shared pathways.

Stakeholders highlighted that responsibility can become fragmented at organisational and funding boundaries, with individuals experiencing disrupted transitions or gaps in provision. This was particularly evident at interfaces between disability and mental health services, and between disability and primary care.

Integration challenges were also linked to practical access barriers, including limitations in transport funding affecting attendance, housing delays contributing to prolonged waiting or misaligned placements, and challenges within acute settings (e.g. communication needs not consistently met or discharge processes occurring earlier than appropriate).

Some stakeholders described examples of more structured integration, particularly in housing, where progress was reported to improve once demand was clearly mapped geographically and by need type. However, this progress was described as potentially fragile where cross-departmental coordination and accountability are not sustained.

Stakeholders emphasised that integration should extend beyond disability services to include equitable access to mainstream healthcare. Difficulties accessing services such as dental care were identified as a key rights and inclusion issue for people with disabilities, particularly those with complex needs.

Governance, Accountability and Organisational Restructure

Stakeholders identified considerations relating to governance arrangements in the context of externally delivered services and ongoing organisational change. Feedback referenced roles, responsibilities, escalation pathways and decision-making arrangements associated with service planning and delivery.

Stakeholder observations also highlighted the relationship between governance arrangements, service planning and capital prioritisation processes. Considerations were identified relating to infrastructure development and operation across different delivery models, including procurement and compliance requirements.

Several stakeholders also identified system dynamics whereby supports, once in place, are not always adjusted over time. Funding structures and service models were described as, in some cases, favouring continuity of existing supports over flexibility, contributing to ongoing system pressure and limiting responsiveness to changing needs.

Provider survey responses further highlighted the cumulative impact of administrative, regulatory and reporting requirements. Respondents described multiple reporting obligations across Service Level Agreement (SLA) monitoring, Key Performance Indicator (KPI) returns, financial reporting, charity governance, safeguarding and regulatory compliance, with some providers noting that reporting remains weighted towards activity rather than outcomes or unmet need.

Several stakeholders also noted the implications of the Health Regions Reform Programme, highlighting both opportunities for greater local responsiveness and the need for consistent approaches to planning, workforce development and service provision across regions.

Stakeholder Engagement

External pressure and scrutiny

Stakeholders noted that planning and decision-making take place within a broader context that includes public, media and policy-related scrutiny. In some instances, this was reported to increase focus on immediate or high-visibility issues, with potential implications for the balance between short-term responsiveness and longer-term system planning.

Across governance and integration themes, stakeholders described how these pressures, combined with capacity constraints and structural limitations, can contribute to the use of workarounds and reactive responses, with implications for equity, consistency, and public confidence in services.

Lived Experience

Through consultations with family members of people with disabilities, a consistent set of lived experience themes emerged across workshops, interviews, and survey responses. These sources collectively describe a system where families play a central role in sustaining care, navigating fragmented pathways, and compensating for gaps in provision.

Fragmentation, navigation burden and inconsistent pathways

Across all sources, families consistently described disability services as difficult to navigate, with coordination often dependent on individual relationships rather than clear, structured pathways.

Families reported that they are frequently required to identify, coordinate and pursue supports themselves, often without a consistent point of contact. This “self-navigation” is reflected in the survey responses, where a majority of respondents described access to supports as difficult or very difficult, reinforcing the experience of barriers at the earliest stages of engagement with services.



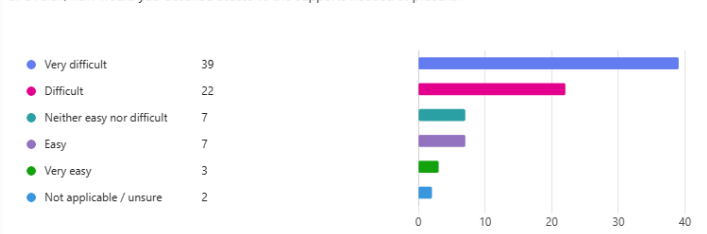
This lack of coordination was described as particularly pronounced at key transition points (e.g. diagnosis, school entry, and transition to adulthood), where services change or reduce and where navigation becomes more complex. Families reported that continuity is frequently lost at these points, with supports becoming fragmented and more reactive in nature.

Burden on families as default coordinators and providers of care

Across workshops, interviews and survey responses, families consistently described the system as placing significant responsibility on them to coordinate care and sustain supports. This includes coordinating appointments, navigating referrals, managing communication across multiple services, and sourcing or funding private supports, in particular for private therapies. Families described themselves as effectively acting as the central point of continuity in a system that does not consistently provide coordinated oversight.

This experience is reinforced by survey responses, which show that current supports are largely reported as meeting needs only to a limited or moderate extent, indicating that families must frequently bridge gaps in provision. This aligns with workshop findings that families often compensate for insufficient or inconsistent service inputs to maintain stability and progress.

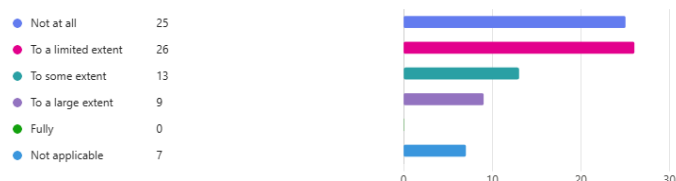
5. Overall, how would you describe access to the supports needed at present?



Stakeholder feedback highlighted the role of families in navigating service pathways, including follow-up on referrals, sharing information across services, and supporting communication between service providers. This is further supported by survey findings on service coordination, where responses were weighted toward services being “not coordinated” or only coordinated to a limited extent.

Stakeholder Engagement

17. To what extent do you feel the current supports help you and your family to sustain caring responsibilities (where relevant)?



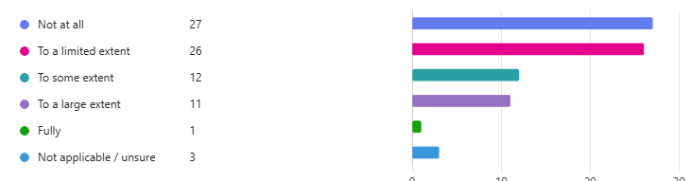
Access, adequacy and responsiveness of services

Across both workshop discussions and survey responses, families described significant challenges in accessing services, alongside concerns about the adequacy and responsiveness of supports once accessed. Common experiences included:

- Long waiting times for therapies, equipment, and assessments
- Supports that are time-limited or not aligned to need
- Significant regional variation in available services
- Limited or absent adult services (particularly therapeutic supports post-18 years of age)

Even where supports are accessed, families reported that they can feel minimal, unsuitable, or disconnected from actual needs, particularly for individuals with complex or evolving conditions. This is reinforced by survey findings that the majority of respondents reported that current supports only met their day-to-day needs to a limited extent or not at all.

9. To what extent do current supports meet the person's needs day-to-day?



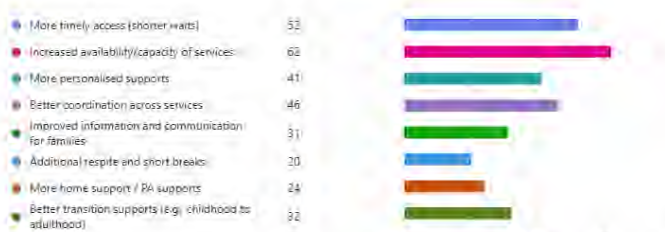
Survey findings also highlight delays in service access, where responses are weighted toward significant or ongoing waiting across multiple service types. Families reported that delays often extend over extended periods, and that by the time services are accessed, needs may have evolved, reducing the effectiveness of interventions. Respondents recorded waits of 11 months, 18 months, 2 years, 3 years, 4 years and, in some cases, up to 6.5 years for specific therapies, equipment, neurology input, Magnetic Resonance Imaging (MRI) results, autism assessments or specialist reviews.

7. Has the person you support experienced waiting or delays for disability services/supports within the past 24 months?



In addition, survey responses on “supports that would make the biggest difference” highlight consistent priorities such as respite, home support/PA, improved coordination, and timely access.

19. Looking ahead, what would you prioritise to improve disability supports over the next 3–5 years?



Across both data sources, services were described as reactive rather than anticipatory, with engagement often occurring at crisis point rather than through planned support aligned to predictable needs.

Planning, predictability and the experience of crisis

A recurring theme across all sources was the lack of forward planning and anticipatory support. Families described uncertainty regarding future supports, particularly in relation to ageing carers, housing arrangements and transition to adulthood.

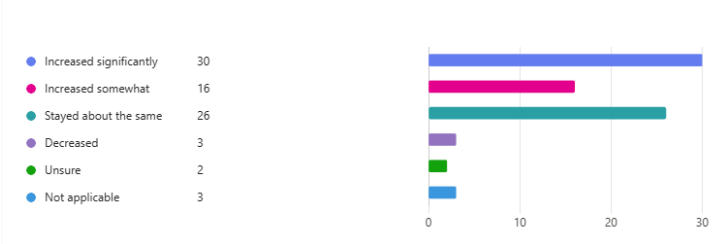
Survey responses reinforce this, indicating that needs frequently increase over time, while service provision does not consistently adjust in line with these changes. This dynamic contributes to a mismatch between need and support, particularly at key life stages.

Families reported that:

- predictable needs are often addressed only at crisis point
- structured pathways into adult services are limited
- planning processes do not consistently translate into delivery

Stakeholder Engagement

11. Over the past 3–5 years, have the person's needs changed (e.g., complexity, intensity of support required)?



Choice, autonomy and decision-making

Families described limited meaningful choice within the system, often characterising service offers as constrained and shaped by availability rather than preference.

Survey responses support this, showing that families often identify a narrow set of available supports, with significant emphasis on the need for more personalised, flexible options.

Examples described include:

- being offered supports that are not appropriate to need
- remaining on waiting lists without alternatives
- accepting suboptimal provision to maintain access

Across sources, choice was therefore described as both structurally constrained (by limited provision) and relationally constrained (by perceived system dynamics).

Inclusion in planning and recognition of the family context

Across stakeholder engagement activities, families described their ongoing role in supporting care arrangements and service navigation, particularly within adult services. Feedback highlighted considerations relating to family wellbeing, the sustainability of long-term caring arrangements, and approaches to family involvement in care planning and decision-making. While acknowledging the importance of individual rights, families reported that:

- The impact of care on parents and siblings is often not considered
- The sustainability of long-term care is not fully addressed
- Families can feel excluded from planning discussions or decisions.

This was linked to a broader perception that services are not sufficiently aligned with the realities of family life, particularly where care continues into older age.

This is echoed in the survey, where respondents referred not only to the needs of the person supported, but also to parental burnout, lost employment, reduced mental health, and the impact on siblings and wider family relationships. Survey responses repeatedly referenced the need for better communication, clearer planning processes, and more coordinated engagement across services.

Emotional impact

Across sources, families described the experience of engaging with disability services as emotionally demanding. Commonly reported impacts included:

- Ongoing stress and exhaustion
- Anxiety about the future
- Loss of trust in the system's ability to respond
- Feelings of frustration, confusion and isolation

Survey responses described the impact of navigating disability services on families and carers.

Respondents referred to the cumulative effects of extended waiting periods, repeated requests for information, and difficulties accessing supports in a timely manner. Some responses also highlighted the impact of these experiences on family wellbeing and confidence in services.

Communication, engagement and trust in services

Across workshops, interviews and survey responses, families described repeated participation in consultations, reviews, forums and complaints processes. Some stakeholders noted a perception that these activities had not always resulted in observable changes to service delivery.

While communication and engagement were recognised as important, families emphasised that these cannot substitute for service improvements.

Where communication was unclear or not linked to visible outcomes, this was associated with:

- reduced trust in the system
- disengagement from consultation processes
- reliance on persistence or escalation to access services

Stakeholder Engagement

Equity and reliance on private supports

Across workshops and survey responses, families highlighted increasing reliance on privately funded supports to maintain progress. This was seen as creating:

- Inequity between families who can and cannot afford additional supports
- A “hidden system” reliant on private provision
- Reduced effectiveness of statutory services as primary providers

Transport, accessibility and attendance

The survey also added greater visibility to practical accessibility barriers. A number of respondents described disability services as hard to attend because of lack of transport, distances to appointments, inaccessible buildings, sensory overload in clinical environments, or the practical burden of taking time away from school or work. These responses suggest that attendance barriers are not only about whether a service exists, but also whether it is physically, practically and sensorily-accessible to the person and family.

Conclusion – Lived Experience

Across the evidence sources reviewed, lived experience accounts indicate that families often play a significant role in supporting care continuity, navigating service pathways and accessing supports. These accounts describe experiences associated with service navigation, variability in access, and the practical requirements involved in coordinating support across different parts of the system.

The family representative group survey adds further depth to this evidence base. While the survey sample should not be interpreted as statistically representative of all families using disability services, the 80 responses provide a useful directional indication that the themes identified through workshops and interviews are also evident across a broader group of family respondents.

In particular, the survey findings reinforce recurring themes relating to access to services, waiting times, coordination between services, respite and home support, transition planning, use of private therapies, and perceptions regarding the extent to which engagement processes lead to visible service change.

Stakeholder Engagement

Future Focus

Across consultations, stakeholders proposed practical changes, actions and investments, spanning planning, service models, workforce data/digital and governance, to support more consistent service delivery.

Strengthen planning capability and make delivery more “pipeline-driven”

Stakeholders called for clearer residential service plans, supported by a defined pipeline of need and higher-quality service briefs to inform capital decision-making (including clarity on model of care and resident compatibility). They also highlighted the importance of stronger service ownership of capital planning, rather than an approach where infrastructure development progresses in advance of clearly defined service need. Stakeholders noted that standardised designs (including four-bed residential and respite models) and regional procurement frameworks are in development and are viewed as helpful enablers in reducing delays once need and location are established, while not replacing the need for robust underlying planning.

Expand and rebalance capacity toward planned, community-based pathways

Stakeholders highlighted investment in community residential capacity and residential infrastructure as central to improving access and consistency across regions. A commonly cited shift was away from crisis-driven, high-cost private placements toward more planned public/voluntary sector provision and whole-house models (three–four people per house) to improve value and predictability.

Stakeholders consistently emphasised the importance of investment in home support, PA, and respite services, noting their potential to support individuals to remain at home and, in some cases, reduce demand for more intensive residential care. Several stakeholders pointed to regional respite and community-based models, including more structured respite or shared-care approaches (for example, a four-bed respite house supporting multiple individuals through predictable weekly routines), as practical supports for families and as helping to ease pressure within the wider system.

Provider survey findings indicate mixed views on the scope for lower-intensity support models. Some providers identified significant potential for supported living, cluster models, personal assistance, home support, self-directed budgets and non-centre-based day supports. Others reported that the people they support require high-intensity or specialist supports and would not be appropriately supported through lower-intensity models.

Stakeholders noted that achieving this shift depends on the availability of both specialist disability accommodation and mainstream housing options. While disability services support individuals requiring higher levels of care and support, lower-intensity housing pathways are reliant on delivery through the wider housing system, including local authorities and Approved Housing Bodies.

Improve workforce supply, stability and role clarity

Stakeholders highlighted the importance of investment in workforce development, including strengthening recruitment and retention pipelines, to support the delivery of expanded capacity. They also highlighted the need for clearer staffing models, including guidance on roles and staffing levels, to support more consistent service delivery.

Stakeholders also described the need for practice development frameworks, referring to structured approaches to building skills, supervision and shared ways of working across disciplines (e.g. guidance on multidisciplinary practice, clinical supervision models, and competency development aligned with community-based and person-centred care). These were seen as important to support staff to work more flexibly across traditional discipline boundaries and deliver services outside of institutional settings.

In children’s services specifically, stakeholders highlighted pipeline and workforce development initiatives, including expansion of student placements within Children’s Disability Network Teams (CDNTs) and supports such as Basecamp, described as a peer learning and networking platform for staff. These were identified as practical enablers to strengthen recruitment pipelines, improve retention, and support ongoing professional development.

Standardise service models, reduce duplication, and strengthen provider governance

Stakeholders suggested more standardisation and less duplication across providers (e.g. Human Resources (HR) processes, governance arrangements, and SLA oversight), alongside structured service models with defined expectations. Several stakeholders emphasised the need for stronger accountability mechanisms for Section 38/39 providers, including clearer service specifications, more consistent monitoring of delivery against agreed outputs and outcomes, strengthened contract and SLA management, and more structured performance oversight at national and regional level. This was described as important to support consistency, transparency and value for money, while avoiding destabilisation of the provider sector.

Stakeholder Engagement

Future Focus (cont'd)

Ensure data and digital systems support service delivery

Stakeholders advocated for a shift from increased data collection towards better use of existing data, emphasising the importance of higher-quality, more focused data, alongside deeper analysis and shared interpretation, rather than volume-driven reporting. Practical digital enablers identified included the development of a single point of access, enhanced electronic health record functionality and information-sharing capabilities, and, in some instances, the implementation of tools to support service coordination, such as health passports and annual health checks.

Multiple stakeholders emphasised the importance of embedding outcome and quality-of-life measures alongside quantitative metrics in order to support a more comprehensive understanding of service impact and outcomes.

Enhance care pathways, transitions and family communication

Stakeholders highlighted the importance of earlier and more structured transition planning, particularly from childhood to adulthood, including clearer pathways and expectations to support continuity of care and reduce the risk of escalation to crisis. While progress was noted in pre-transition planning involving schools and CDNTs, this was described as being at an early stage.

Stakeholders also emphasised the importance of communication that is empathetic and engagement-focused, alongside clearer communication in relation to rights-based reforms.

Develop approaches to support more sustainable demand management

Some stakeholders suggested further exploration of personalised budgets, noting that, if progressed, these would require a structured and well-governed framework with clear policy, appropriate safeguards, and alignment with Assisted Decision-Making principles.

A number of stakeholders also advocated for embedding evaluation within policies, pilots and

programmes to support learning and enable effective approaches to be identified and expanded.

Conclusion

Stakeholders consistently described a system operating under sustained pressure, shaped by rising demand, increasing complexity of need, and workforce and infrastructure constraints, experienced across both adult's and children's services. While examples of strong practice and local innovation were noted, delivery was frequently described as reactive, influenced by annual funding cycles, multi-year capital timelines, and fragmented service pathways, limiting the system's ability to plan and respond proactively.

The findings also highlight structural challenges in how services are organised and supported. Stakeholders described fragmented data and uneven digital infrastructure, limiting visibility of need and outcomes, alongside gaps in integration across health and social services, where coordination often depends on local relationships rather than consistent pathways. Governance complexity, evolving roles under organisational restructuring, and external pressures were also identified as shaping how decisions are made in practice, at times reinforcing short-term responses over longer-term system planning.

Overall, stakeholders characterised the system as one where interdependent factors, including capacity, planning, workforce, funding, data, governance and integration, combine to influence the consistency and quality of service delivery. The findings highlight the importance of a whole-system approach, recognising the interconnected roles of specialist disability services, mainstream services and wider supports. Stakeholders also emphasised the need for planning and service delivery across the life course, recognising that needs evolve from childhood through adulthood and older age. The analysis highlights the extent to which these elements must operate in alignment to enable more coordinated, person-centred care and sustainable improvements over time.



05

Evaluation Findings

Evaluation Findings

Introduction

This analysis was undertaken to provide an assessment of current service delivery, system performance, and emerging demand across specialist disability services in Ireland. It draws on a combination of quantitative and qualitative evidence to examine both the scale and nature of need, the capacity of existing services to respond, and the extent to which current models of delivery align with evolving policy and demographic trends.

The evaluation is informed by a wide range of national datasets, including Census 2022, the NASS, HSE administrative data, the Disability Support Application Management Tool (DSMAT), and service-level data relating to Children's Disability Network Teams (CDNTs) and AON activity. These data sources provide insight into population characteristics, patterns of service utilisation, waiting list dynamics, and trends in demand across key service areas, including residential services, respite, day services, therapies, and supports for daily living.

Quantitative analysis is integrated with qualitative evidence drawn from stakeholder engagement, the literature review and wider system documentation. Stakeholder perspectives provide insight into how services are experienced in practice, highlighting both areas of progress and ongoing challenges in access, coordination, and service responsiveness. The literature review situates these findings within broader national and international evidence, identifying structural drivers of demand such as population ageing, increased longevity among people with disabilities, and the growing complexity of need.

This combined evidence base enables a more complete understanding of how the system operates in practice, beyond what can be observed through data alone. The analysis reflects a system undergoing significant transition. There is clear evidence of sustained effort to expand capacity and develop more integrated, person-centred models of care, particularly within children's services. At the same time, demographic change, increasing demand, and evolving expectations under a rights-based framework are reshaping the profile and scale of need. This is reflected in several emerging patterns, including growth in the number of individuals requiring support, increased complexity of presentation, and a greater need for coordinated, multidisciplinary and community-based responses.

Across all sources, a consistent set of cross-cutting themes has been identified. These include the relationship between demand and capacity, the impact of workforce availability on service delivery, variation in access and experience across geographic areas, and the influence of system structures and pathways on how services are planned and delivered. The analysis also highlights the importance of capital and infrastructure in enabling reform, the role of informal care in sustaining the system, and the need for forward planning in response to predictable future demand, including that associated with ageing carers and ageing service users.

Importantly, the findings reflect both areas of progress and areas where further development is required. Evidence indicates that capacity has expanded in several key areas, supported by workforce growth, service development, and improvements in system infrastructure. These developments have contributed to increased levels of service activity and improved system visibility. However, in line with broader demographic and policy trends, demand continues to evolve, and in some areas the pace and nature of service development has not fully aligned with the scale and complexity of need. This is associated with variation in access, waiting times, and service experience across different parts of the system.

The evaluation findings presented in this section synthesise this evidence into a structured assessment of system performance across key domains. They are intended to provide a balanced and evidence-based view of current delivery, highlighting areas of strength, identifying constraints and variation, and supporting the identification of priorities for future service planning, investment, and reform.

While this report provides a strategic assessment of need and capacity pressures, it is not intended to function as a service plan or capital investment programme. Future capital planning will require the development of approved service plans that translate identified need into defined service models, capacity requirements, locations, delivery approaches and infrastructure specifications, in line with public expenditure and procurement requirements.

Evaluation Findings

Tiered Evaluation Model

The evaluation findings are grouped into four tiers, reflecting the logical order in which they need to be addressed. The tiering prioritises enabling conditions first (those on which other improvements depend), followed by capacity, then delivery and experience, and finally long-term sustainability. This recognises that improvements in access and outcomes are contingent on foundational enablers such as governance clarity and data infrastructure being addressed.

Tier 1 - Foundational enablers

Overarching themes: Current State, Data, Digital and Insight

This tier establishes a clear and shared understanding of the current state of the system, which serves as the foundation for effective planning and subsequent action. It centres on developing an integrated and standardised data and information capability that provides a coherent view of demand, service use, capacity and outcomes, and on addressing the fragmentation that currently limits system-wide visibility. A reliable understanding of the current position is a prerequisite for the activity undertaken in the subsequent tiers, as decisions relating to capacity, delivery and sustainability depend on an accurate and consistent evidence base.

Tier 2 - System capacity

Overarching themes: System Capacity and Sustainability; Planning, Infrastructure and Delivery Alignment

This tier concerns the resources and enabling investment required for the system to respond to current and emerging demand. It encompasses workforce capacity including recruitment, retention, skill mix and configuration, considered alongside the funding, commissioning and capital arrangements that support it. It also includes the alignment of multi-annual funding, capital investment and infrastructure planning with identified need and demographic projections. Framing workforce, funding and capital together reflects their interdependence: workforce capacity is shaped by the funding and commissioning arrangements around it, and capital and infrastructure development depend on planning timelines and investment certainty. This tier follows Tier 1 because resourcing decisions are more effectively directed where governance and data foundations are in place.

Tier 3 - Access, delivery and experience

Overarching themes: Lived Experience; Access and timeliness

This tier concerns how services are accessed and experienced by individuals and families once enabling conditions and resourcing are in place. It includes the consistency and timeliness of assessment and access pathways across regions, the coordination of care across multiple services and sectors, and continuity of support at key transition points. It also reflects the role that individuals and families currently play in navigating and coordinating services. Activity in this tier is positioned after capacity and resourcing because improvements in access and experience are more likely to be sustained where workforce, funding and infrastructure have been aligned to demand.

Tier 4 - Sustainability and future readiness

Overarching theme: Future Focus

This tier considers the factors required to sustain progress and support the continued evolution of disability services over time. Unlike the preceding tiers, which focus on understanding the current state of the system, addressing capacity and resourcing requirements, and improving service access and delivery, Tier 4 is concerned with how progress is monitored, reviewed and maintained. It encompasses the arrangements needed to assess implementation, evaluate outcomes, identify emerging trends and risks, and support evidence-informed adaptation over time. As such, this tier operates on an ongoing basis and applies across all preceding tiers, helping to ensure that reform remains responsive, sustainable and aligned with evolving needs.



1

Tier 1

Table 5.1

Evaluation Finding – Demand for disability services is exceeding current system capacity

Lead: HSE
National
Disability
Services

Supporting partner(s):
Department of Children,
Disability and Equality
(DCDE); Section 38/39
providers; CDNTs, Private
Providers

Dependencies :
Population projections;
integrated demand and
utilisation data; workforce
data

Timeframe:
Short to
medium term

Summary of understanding

A consistent finding across all strands of the analysis is that current service capacity is not keeping pace with the scale and complexity of demand. This establishes a clear picture of the current state, from which structured, population-based capacity planning can follow.

Evidence base and how this conclusion was reached

Quantitative data analysis: Analysis of national datasets (including Census 2022, NASS, service utilisation data and administrative sources) indicates sustained growth in both the number of people engaging with disability services and the complexity of support required. Patterns of demand are evident across multiple service areas, including therapies, day services, respite and residential supports, with associated waiting lists and service pressures. The analysis draws on multiple national datasets to assess demand and service utilisation. While these datasets provide strong directional evidence of increasing demand, limitations in completeness and linkage between data sources mean that a fully integrated view of demand across the system cannot be established.

Literature review: The literature highlights demographic pressures, including increasing prevalence of disability, improved survival rates, and longer life expectancy, as key drivers of demand. It also identifies a structural misalignment between demand growth and service capacity, particularly where workforce expansion and infrastructure investment have not kept pace.

Stakeholder consultation: Stakeholders consistently reported increasing demand presenting across all service areas, alongside concerns regarding the system's ability to respond in a timely and consistent manner. Feedback highlighted growing waiting lists, delayed access to services, and increasing acuity of need at the point of service entry, reinforcing the findings from quantitative data.

Triangulation: Across all three evidence sources, there is a clear and consistent pattern: demand is increasing in volume and complexity, while capacity expansion remains constrained.

Action required

Establish, in partnership with DCDE, a validated, population-based understanding of current and projected demand relative to service capacity, and embed this within planning, commissioning and investment processes, translating it into an approved service planning framework. This includes strengthening demand-modelling capability and integrating data sources to support a single, reliable view of demand across the system.

Inputs / Resources Required

- Strengthened population-based demand modelling capability
- Integrated dataset linking prevalence, referral, and utilisation data
- Enhanced capital and service planning frameworks aligned to projections
- Alignment with national strategies (e.g. Disability Capacity Review, NSP)
- Alignment with Disability Capacity Review forecasting and population projection methodologies

Milestones to complete action

- Establish a validated national baseline of demand versus capacity
- Develop forward-looking demand projections across key service areas, and translate into service plans
- Integrate demand modelling into commissioning and funding decisions

Outcome indicator

- Demonstrable convergence between projected demand and planned service capacity
- Use of demand projections within service planning, commissioning and investment decisions, and approved service plans aligned to projected population need



2

Tier 1

Table 5.2

Evaluation Finding – Fragmentation and limitations in data systems reduce the reliability and usability of information for planning and oversight

Lead: HSE Data and Analytics Office	Supporting partner(s): DCDE; HRB; service providers; system owners (e.g. NASS and administrative datasets)	Dependencies: Data governance frameworks; system integration; reporting compliance; analytical capability	Timeframe: Short to medium term
Summary of understanding The analysis indicates that, while a substantial volume of data exists across the disability services system, it is fragmented across multiple systems and varies in quality, completeness, and consistency. This limits the ability to generate a single, reliable view of service demand, pathways and outcomes. Current datasets provide limited visibility of service activity measures such as appointment volumes, duration, frequency, utilisation patterns and space requirements. As a result, it is challenging to directly translate identified need into accommodation requirements based on service-user activity, and workforce-based proxies are often required for infrastructure planning. Addressing this requires the development of a more integrated, standardised and robust data infrastructure to support effective system planning, performance monitoring and decision-making.			
Evidence base and how this conclusion was reached Quantitative data analysis: The analysis draws on multiple data sources, including Census data, NASS, and HSE administrative and service-level datasets. While these sources provide valuable insights individually, limitations were identified in terms of data completeness, consistency of reporting, and the ability to link data across systems. These constraints limit the ability to develop a comprehensive, person-level or system-wide view of need, service utilisation and outcomes. Literature review: The literature identifies that Ireland's disability data infrastructure is developing but remains incomplete and uneven in coverage. While the introduction of systems such as NASS represents a significant advancement, challenges remain in achieving full participation, standardisation and comparability across data sources. The literature also highlights the importance of triangulating multiple data sources in contexts where no single dataset provides a complete view of need. Stakeholder consultation: Stakeholders consistently highlighted challenges in accessing, interpreting and applying data to inform planning and service delivery. Key issues identified, described as constraining visibility of demand, service pathways, and system performance include: • The absence of a “single view” of the individual across services • Variability in data collection and reporting practices across providers • Limited ability to link datasets across service areas, regions and pathways Triangulation: Across all three evidence sources, data limitations were identified as a key constraint on system oversight and planning.			
Action required Establish, in partnership with DCDE and HRB, a single, authoritative source of disability data for the system, building on existing national data governance initiatives and progressing greater integration across NASS, service utilisation datasets and other administrative systems. Establish agreed ownership and accountability for its maintenance. This means designating a lead function to hold national data standards, mandating consistent provider returns, and progressively connecting existing systems so that planning and oversight draw on one trusted evidence base rather than multiple partial ones.			
Inputs / Resources Required • Strengthened national data governance and standardisation frameworks • Improved completeness and consistency of data collection across providers • Integration of key datasets (e.g. NASS, administrative and service-level systems) • Development of linked, person-level data where appropriate and permissible, using national data infrastructure mechanisms to support dataset linkage and enhanced insight • Investment in analytical capability, reporting tools and infrastructure			



2

Tier 1

Table 5.3

Evaluation Finding – Fragmentation and limitations in data systems reduce the reliability and usability of information for planning and oversight (cont'd)

Milestones to complete action

- Define and implement minimum data standards and reporting requirements
- Develop and implement a phased roadmap for addressing priority data gaps identified through this analysis
- Improve coverage, completeness and data quality within existing systems (including NASS)
- Develop mechanisms to link datasets across service areas and regions, including integration of key disability datasets and progression towards a shared national evidence base
- Establish integrated reporting and analytical capability at national and regional levels
- Embed routine use of data within service planning, commissioning and performance management processes

Outcome indicator

- Improved completeness, consistency and reliability of core datasets
- Increased ability to produce integrated, system-wide analysis of demand, pathways and outcomes
- Enhanced use of data to inform service planning, commissioning and performance oversight



3

Tier 2

Table 5.4

Evaluation finding- Planning, funding and capital investment are not aligned to long-term, population-based demand

Lead:	Supporting partner(s):	Dependencies :	Timeframe:
HSE National Planning, HSE National Capital and Estates function	Finance; policy teams; regional planning functions; service providers, housing and capital delivery partners	Population-based modelling; multi-annual funding and capital planning; integrated demand, capacity and workforce data	Medium to long term
Summary of understanding Current planning, funding and capital arrangements are not consistently aligned to the scale, pace and nature of future demand. Demographic growth, increasing complexity of need and evolving policy direction are not yet reliably translated into long-term, system-wide planning. The absence of multi-annual funding certainty constrains structured commissioning and multi-year change programmes, while the sequencing, approval and delivery timelines associated with capital projects do not align to the immediacy of demand. This is distinct from the decongregation programme, an individualised programme providing like-for-like replacement enabling residents to move from large congregated settings into small houses, generally within the same community. As such it is not driven by population-based planning. Future demand, by contrast, requires a population-based approach. In addition to delivering new capacity, the evolving needs of existing service users may require ongoing adaptation, refurbishment and replacement of existing accommodation to ensure facilities remain fit for purpose and aligned with changing support requirements. Addressing this requires structured, population-based planning supported by aligned multi-annual funding and a capital delivery approach sequenced to service need, recognising that immediate service pressures, medium-term capacity expansion and longer-term demographic demand may require different planning and investment responses.			
Evidence base and how this conclusion was reached Quantitative data analysis: Demand for disability services is projected to grow over the medium to long term, driven by demographic change and increasing complexity of need. This growth is occurring where existing capacity is constrained, and data limitations hinder population-based planning. Sustained pressure is reflected in waiting lists across residential, respite and children's services, and in assessment backlogs, although the data does not directly measure capital delivery timelines. Literature review: The literature identifies demographic change as a structural driver of need and highlights that robust needs-based planning requires multiple data sources. It notes that the transition from congregated settings to community-based models depends on appropriate infrastructure and capital investment, and that the persistence of congregated provision reflects challenges in translating planned infrastructure into delivered capacity. Uncertainty regarding multi-annual funding presents further challenges for longer-term planning and reform at scale. Stakeholder consultation: Stakeholders described a system operating under sustained demand pressure, with a need for planned service expansion and the timely development of appropriate infrastructure. Planning was frequently described as more responsive than strategic, influenced by annual funding cycles and multi-year capital timelines. Triangulation: Across all three evidence sources, demand is changing over a longer horizon than current planning, funding and capital arrangements are equipped to address, indicating a systemic misalignment between planning and delivery timelines and long-term service need.			
Action required Consideration of a move to a multi-annual, population-based planning and funding for disability services, so that workforce, capital and service investment are committed against projected demand rather than annual cycles. This means securing multi-year funding certainty, aligning capital delivery timelines to the pace of need, and making population-based demand projections the agreed reference point for commissioning and investment decisions. This includes coordinated planning with housing partners.			



3

Tier 2

Table 5.5

Evaluation finding- Planning, funding and capital investment are not aligned to long-term, population-based demand (cont'd)

Inputs / Resources Required

- Stronger population and demand modelling capability
- Access to integrated demand, service-use, workforce and infrastructure data
- Multi-annual planning and funding mechanisms
- Planning frameworks that connect national policy direction with regional service configuration
- Analytical capacity to develop and update long-term scenarios
- Replacement, refurbishment, adaptation and regulatory compliance programmes for the existing disability estate

Milestones to complete action

- Establish an agreed baseline of current and projected demand across major disability service areas
- Develop medium- and long-term planning assumptions for key cohorts and service types
- Integrate projected demand into workforce, capital and commissioning planning
- Align regional and national planning cycles around common population-based assumptions
- Establish regular review mechanisms so projections can be updated as new evidence emerges

Outcome indicator

- Increased use of projected demand data in regional and national planning processes
- Clearer alignment between future demand projections and planned workforce / capacity investment
- Earlier identification of service pressure points
- Reduced reliance on short-term, reactive responses to emerging need

4

Tier 2

Table 5.6

Evaluation Finding – Workforce constraints are a primary limiting factor in service capacity and responsiveness

Lead: HSE
Workforce
Planning

Supporting partner(s)
DCDE; Section 38 and
Section 39 organisations;
HSE service providers;
multidisciplinary workforce
groups (including Health
and Social Care
Professionals)

Dependencies :
Recruitment pipelines;
workforce data; training
capacity; policy
frameworks, funding

Timeframe:
Medium term

Summary of understanding

The analysis indicates that workforce availability, distribution, and skill mix represent a critical constraint on service delivery. Addressing this requires a coordinated, system-wide workforce strategy that considers workforce configuration, competencies and long-term sustainability, supported through national workforce planning mechanisms including the HSE Pay and Numbers Strategy and broader disability workforce planning initiatives. The implementation of the Health Regions Reform Programme reinforces the importance of workforce planning arrangements that operate at both national and regional levels, ensuring workforce decisions reflect local service profiles, demographic trends and regional delivery responsibilities.

While workforce capacity issues are evident across disability services, the availability of workforce data varies considerably between service areas. Detailed workforce information is available for CDNTs, whereas visibility of adult multidisciplinary capacity, workforce distribution and service demand is more limited, making it difficult to assess adult MDT resources against current and emerging need.

Evidence base and how this conclusion was reached

Quantitative data analysis: Workforce datasets demonstrate growth in overall staffing levels; however, this growth has not kept pace with demand. Vacancy rates across key disciplines, particularly within Children's Disability Network Teams, remain significant, indicating a persistent shortfall in available capacity relative to need. Data limitations, including gaps in availability of workforce data from certain providers (notably some Section 39 organisations), constrain the ability to produce a fully complete and standardised workforce view.

Literature review: The literature identifies workforce capacity as a systemic issue, highlighting challenges in recruitment, retention, and workforce planning. It also points to the absence of clearly defined caseload standards and workforce models, limiting the ability of services to effectively plan and allocate resources.

Stakeholder consultation: Stakeholders consistently identified workforce shortages as a key constraint on service delivery, referencing difficulties in recruiting and retaining staff, reliance on temporary staffing, and the impact of staffing gaps on service access, continuity, and quality

Triangulation: There is strong alignment between quantitative evidence, literature, and stakeholder feedback in identifying workforce constraints as a primary factor underpinning service capacity limitations.

Action required

- Establish a complete, standardised workforce dataset and move to multi-annual funding so that workforce investment is committed against projected demand rather than annual cycles. This means mandating consistent workforce data returns from all providers to close current gaps (notably some Section 39 organisations), integrating these into a single reliable view of vacancies, turnover and skill mix, and replacing annual funding cycles with multi-year certainty that allows recruitment, retention and workforce planning to be sustained over time.

Inputs / Resources Required

- Comprehensive, integrated workforce dataset (including vacancies, turnover and skill mix)
- National workforce strategy aligned to projected need and service transformation priorities
- Expanded education and training pathways
- Development of competency frameworks aligned to community-based models
- Review of annual funding cycles



4

Tier 2

Table 5.7

Evaluation Finding – Workforce constraints are a primary limiting factor in service capacity and responsiveness

Milestones to complete action

- Develop a detailed workforce baseline by discipline, competency and region
- Establish national workforce planning and forecasting capability
- Define standardised workforce models and caseload benchmarks by service type
- Implement targeted recruitment and retention initiatives
- Establish regional workforce planning and forecasting capability aligned with national frameworks
- Undertake a national review of adult multidisciplinary team (MDT) resources, including workforce capacity, service coverage, regional variation and alignment with identified need.

Outcome indicator

- Reduction in vacancy rate across priority disciplines
- Improved alignment between workforce capacity and service demand
- Increased stability and sustainability of the workforce



5

Tier 3

Table 5.8

Evaluation Finding – Variation in access to service provision across regions

Lead:

HSE Regional Management

Supporting partner(s):

Section 38/39 providers; CDNTs, Private Provider

Dependencies: Resource allocation models; service configuration; national access policies

Timeframe:

Medium to long term

Summary of understanding

The analysis indicates that access to disability services is not consistent across regions. Addressing this requires the establishment of more standardised national access frameworks, supported by equitable resource allocation and oversight mechanisms.

Evidence base and how this conclusion was reached

Quantitative data analysis: Service utilisation and administrative data demonstrate variation in referral volumes, waiting lists, and service provision across geographic areas, indicating uneven alignment between need and service availability.

Literature review: The literature highlights regional variation as a recurring issue in disability systems internationally, noting that differences in local infrastructure, workforce availability and historical service development contribute to inequitable access.

Stakeholder consultation: Stakeholders reported significant variation in thresholds for access, availability of services, and waiting times between regions. These differences were described as impacting equity and consistency of care.

Triangulation: All evidence sources consistently highlight regional variation as a key system issue, confirming that access is influenced by local capacity rather than assessed need alone.

Action Required

Support the development of more standardised national approaches to service access, so that access is informed by assessed need rather than local capacity or historical service development. This includes national mapping of access and thresholds, more consistent eligibility and access criteria, and equitable resource allocation supported by ongoing monitoring across regions.

Inputs / Resources Required

- National service mapping and benchmarking
- Standardised eligibility and access criteria
- Enhanced performance monitoring

Milestones to complete action

- Conduct national mapping of service access and thresholds
- Define national standards for access
- Establish monitoring and reporting mechanisms

Outcome indicator

- Reduction in regional variation in access to key disability services



6

Tier 3

Table 5.9

Evaluation Finding – System Complexity and Navigation Challenges

Lead: HSE National Disability Services	Supporting partner(s): Section 38/39 providers; CDNTs; Private Providers; Advocacy Organisations	Dependencies: Service pathway design; governance structures; data integration ('single view'); case coordination mechanisms	Timeframe: Medium to long term
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Summary of understanding

A consistent finding across the consultation and analysis is that disability services are experienced as complex and difficult to navigate. Service users, families and stakeholders report challenges in understanding how to access supports, moving between services, and coordinating care across multiple providers. The evidence indicates that addressing this requires a shift from fragmented, service-led delivery towards more integrated, streamlined pathways that are organised around the individual and supported by improved coordination and system visibility.

Evidence base and how this conclusion was reached

Quantitative data analysis: While quantitative datasets provide insight into service utilisation and activity levels across different parts of the system, they do not currently offer a fully integrated view of how individuals move across services or pathways. Limitations in linkage between datasets mean that it is difficult to track service journeys or understand how complexity in navigation impacts access, timeliness, and continuity of care.

Literature review: The literature emphasises the importance of coordinated, person-centred service models, supported by integrated systems and clear pathways, in delivering effective disability services. It identifies that fragmented service structures and unclear access routes can create barriers to timely and equitable access, particularly for individuals with complex or evolving needs.

Stakeholder consultation: Stakeholders consistently highlighted the complexity of the current system, noting multiple entry points, overlapping service responsibilities, and a lack of clear, consistent pathways. Individuals and families were described as needing to navigate across services to access supports, with challenges in understanding eligibility, referral processes, and transitions between services. Feedback also highlighted duplication of assessments, gaps in coordination, and variability in access across regions. Operational challenges including constrained access to decision-makers, evolving governance structures, and variability in regional implementation were also identified as contributing to delays and uncertainty in accessing services.

Triangulation: Across all three evidence sources, there is a consistent pattern: while a wide range of services is in place, the system operates as a set of interconnected but not fully integrated components. This results in complexity for users, fragmented service experiences, and inefficiencies in service delivery.

Action Required

Support a shift towards more integrated, streamlined service pathways organised around the individual, so that people can access and move between supports with greater ease. This includes developing clearer, standardised pathways across service areas, strengthening coordination and navigation supports, and improving system visibility through better-connected data and information.



6

Tier 3

Table 5.10

Evaluation Finding – System Complexity and Navigation Challenges

Inputs / Resources Required

- Development of clearer, standardised service pathways across key service areas
- Strengthened case coordination and navigation supports (e.g. key worker functions)
- Integration of data systems to enable a 'single view' of the individual
- Alignment of governance structures and decision-making processes across regions

Milestones to complete action

- Map and standardise key service pathways (e.g. access, transition points, escalation routes)
- Define and implement coordination mechanisms across services and providers
- Establish consistent national guidance on access and eligibility pathways
- Embed integrated planning and coordination models within service delivery

Outcome indicator

- Improved service user experience in accessing and navigating services
- Reduced duplication of assessments and administrative processes
- More consistent access to services across regions
- Improved continuity of care across service pathways



7

Tier 3

Table 5.11

Evaluation Finding – The CDNT model has been established and is delivering progress

Lead: The development and oversight of CDNTs is led at national level through the HSE, with responsibility for implementation devolved across regional structures and service providers.	Supporting partner(s): CDNT delivery is supported through a mixed provider landscape, including HSE-managed services and Section 38 and Section 39 organisations, alongside multidisciplinary professionals delivering services within team settings.	Dependencies: Progress in CDNT implementation is dependent on the availability of multidisciplinary workforce, including therapy and clinical staff, the organisational capacity of providers to establish and sustain integrated team models, and supporting infrastructure and systems to enable coordinated service delivery. It is also influenced by demand levels and referral patterns across defined geographic network areas.	Timeframe: Short to medium term
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Summary of understanding

The analysis indicates that the establishment of CDNTs represents a significant structural reform in the delivery of children's disability services, with clear progress made in implementing a network-based, multidisciplinary model of care. However, this progress remains uneven when considered against the scale and growth of demand. While the model has been put in place in many areas, capacity constraints, particularly workforce-related, continue to affect the ability of teams to meet demand in a consistent and timely manner. This results in variation in access, waiting times and service experience across different network areas.

Evidence base and how this conclusion was reached

Quantitative data analysis: The data indicates sustained demand alongside evidence of continued improvement in CDNT service capacity. Overall demand remains high, with many children receiving intervention and supports, although some level of need continues to emerge over time. This is reflected in an ongoing waiting list, including children waiting longer for access in some cases. There is, however, clear evidence of positive progress, with reductions in waiting lists, growth in staffing levels, and increased volumes of assessment activity over recent years. Taken together, this suggests that capacity and access have improved significantly, although services continue to respond to evolving and growing demand.

Literature review: The literature highlights the transition towards interdisciplinary, community-based models as a core component of service reform, with CDNTs positioned as a key delivery mechanism. It also identifies workforce availability and system capacity as critical factors influencing the effectiveness and consistency of these models.

Stakeholder consultation: Stakeholder perspectives reflect variability in the operational functioning of CDNTs, including differences in access to services, team capacity, and the ability to deliver timely supports. Stakeholders also highlight increased demand and complexity of need as ongoing pressures affecting service delivery.

Triangulation: Across the data, literature and stakeholder input, a broadly consistent picture emerges. Structural progress has been made in establishing CDNTs as the core model of delivery, supported by evidence of capacity growth and increased service activity. Quantitative data on waiting lists, together with stakeholder perspectives on variability and capacity, suggests that while implementation has advanced, the experience of access to services continues to vary across areas. This indicates that progress, while evident, is continuing to evolve in response to the scale and complexity of demand.



7

Tier 3

Table 5.12

Evaluation Finding – The CDNT model has been established and is delivering progress

Action Required

Support the continued development of the CDNT model by building the workforce and organisational capacity needed to sustain consistent, timely access across all network areas. This includes strengthening multidisciplinary staffing, supporting the infrastructure and systems that enable coordinated team-based delivery, and monitoring access and waiting times to address variation between areas over time and support more equitable access based on assessed need.

Inputs / Resources Required

- Expansion of multidisciplinary workforce capacity across CDNTs
- Strengthening of organisational capacity to support fully operational team-based models
- Development of supporting infrastructure and systems to enable coordinated service delivery
- Continued alignment of service capacity with demand at a network level

Milestones to complete action

- Achievement of stable multidisciplinary staffing across teams
- Reduction in waiting times for access to CDNT services
- Improved consistency in service delivery across geographic areas

Outcome indicator

- Operational multidisciplinary CDNTs delivering coordinated, family-centred supports and working effectively across relevant care pathways
- Improved access to assessment and intervention at community level
- Reduced variability in service experience across network areas
- Greater alignment between service capacity and assessed population need for children's disability services



8

Tier 3

Table 5.13

Evaluation Finding – Timeliness of Assessment of Need processes has improved, but remains variable relative to demand and system pressures

Lead: HSE National Disability Services	Supporting partner(s): Section 38 and Section 39 organisations; Children's Disability Network Teams; multidisciplinary Health and Social Care Professionals	Dependencies: Performance in relation to AON timelines is influenced by the availability of multidisciplinary workforce, the balance between assessment and intervention activity, and the systems and processes used to manage referrals and assessments. It is also dependent on demand volumes, the complexity of cases presenting, and the broader configuration of children's disability services.	Timeframe: Assessment of Need processes are governed by statutory requirements under the Disability Act 2005. The analysis reflects ongoing performance within this legislative framework, with timelines assessed on a continuous basis.
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Summary of understanding

The analysis indicates that Assessment of Need processes continue to operate under sustained demand, with evidence of increased activity and throughput in recent years. Improvements in staffing and service capacity have supported higher volumes of assessments being completed. However, timelines remain variable, reflecting the complexity of demand, statutory assessment requirements, workforce availability and wider system constraints. This indicates that while performance has improved, maintaining consistent timeliness across all areas remains an ongoing focus.

Evidence base and how this conclusion was reached

Quantitative data analysis: The data indicates increased levels of assessment activity over recent years, suggesting improvements in system throughput and capacity. However, the persistence of overdue assessments and continued demand for AON processes indicate that timelines are not yet consistently achieved across all cases.

Literature review: The literature indicates that the Assessment of Need process is resource-intensive and can place significant demands on clinical capacity. Evidence shows that assessment activity requires substantial staff time, alongside additional procedural complexity arising from diagnostic requirements. This creates pressure within the system, as clinical resources must be balanced between assessment processes and the delivery of intervention and supports.

Stakeholder consultation: Stakeholder perspectives highlight the impact of AON processes on service delivery, including the time required to complete assessments and the resulting implications for available clinical capacity. Feedback also reflects ongoing demand for assessments and the challenge of balancing statutory requirements with the delivery of therapeutic supports.

Triangulation: Across the data, literature and stakeholder input, a consistent emerges of a system that has increased its assessment activity and capacity over time, while continuing to respond to high and evolving demand. Evidence of improved throughput is balanced by the persistence of overdue assessments and stakeholder feedback on process complexity. This suggests that while timeliness has improved in some areas, variation remains in the extent to which statutory timelines are consistently met.



8

Tier 3

Table 5.14

Evaluation Finding – Timeliness of Assessment of Need processes has improved, but remains variable relative to demand and system pressures

Actions Required

Support the continued improvement of Assessment of Need timeliness by maintaining assessment activity and working towards more consistent achievement of statutory timelines across all areas. This includes maintaining multidisciplinary workforce capacity and streamlining assessment processes so that statutory assessment activity can be delivered in a timely and sustainable manner.

Inputs / Resources Required

- Continued expansion of multidisciplinary workforce capacity to support assessment activity
- Streamlining of assessment processes to support timely completion
- Adequate multidisciplinary workforce capacity to support delivery of statutory assessment requirements
- Ongoing development of systems to support referral management, tracking and reporting



9

Tier 3

Table 5.15

Evaluation Finding – Day services are undergoing transition towards more person-centred models, but delivery remains uneven in meeting evolving needs

Lead: HSE National Disability Services	Supporting partner(s): Section 38 and Section 39 organisations; HSE service providers; community and voluntary sector providers	Dependencies: Progress in day service reform is dependent on the availability of appropriate infrastructure and community-based options, workforce capacity to deliver more flexible and personalised supports, and alignment between funding, policy and service design. Delivery is also influenced by the availability of transport, housing, and integration with other services that support participation and inclusion. The ability to sustain and scale more flexible models is linked to the availability and alignment of funding to support new approaches to service delivery.	Timeframe: Medium to long term
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Summary of understanding

The analysis indicates that day services are transitioning from traditional centre-based models towards more person-centred and community-oriented approaches. This reflects broader policy direction and evolving expectations regarding inclusion and participation. However, evidence suggests that existing service models have not yet fully adapted to the diversity and complexity of need, particularly for emerging cohorts and older service users. This is associated with a variation in the extent to which day services are able to deliver flexible, individualised supports in practice. This transition is influenced by the alignment of funding with policy intent and service design, which supports the pace and extent of change in practice. The transition also has implications for the disability estate, as more flexible and community-based approaches may require reconfiguration, repurposing or adaptation of existing facilities alongside investment in new service models

Evidence base and how this conclusion was reached

Quantitative data analysis: The available data highlights the scale of service provision but provides limited insight into outcomes or the quality of engagement within day services. While the HSE's Outcomes Focused Monitoring framework represents an important step towards strengthening outcome measurement, consistent data on service-user outcomes is still developing. This indicates that while activity levels are understood, there is less visibility on how effectively services are meeting individual needs or supporting participation

Literature review: The literature identifies a broader shift towards person-centred and community-based models of care, with day services expected to support inclusion, autonomy and participation. It also highlights increasing complexity of need, including ageing-related needs and changing demand profiles, which require more flexible and responsive service models.

Stakeholder consultation: Stakeholder perspectives indicate that traditional day service models do not fully meet the needs or aspirations of all service users, particularly in the context of increasing complexity and changing expectations. There is a recognised need for more flexible and individualised supports, alongside challenges relating to capacity, service configuration and alignment with emerging needs.

Triangulation: Across the data, literature and stakeholder input, a consistent view emerges of a system in transition. Policy and literature point towards more person-centred and community-based approaches, while stakeholder feedback highlights variability in how these are implemented in practice. Data limitations in relation to outcomes further suggest that while activity is being delivered, the extent to which day services consistently meet evolving needs is less clearly evidenced. This indicates that progress is underway, but not yet uniform across the system.



9

Tier 3

Table 5.16

Evaluation Finding – Day services are undergoing transition towards more person-centred models, but delivery remains uneven in meeting evolving needs (cont'd)
Action Required

Support the continued transition of day services towards more flexible, person-centred and community-based models that respond to changing and increasingly complex needs. This includes developing flexible service options, aligning funding with individualised service design, building workforce capacity for personalised delivery, and strengthening links with transport, housing and wider community supports.

Inputs / Resources Required

- Development of more flexible, community-based day service models
- Alignment of funding and service design to support individualised supports, including continued transition from legacy funding arrangements where appropriate
- Workforce capacity to deliver multidisciplinary and personalised approaches
- Increased investment to support the transition from traditional models to more flexible provision
- Improved data and outcome measurement to assess impact and effectiveness
- Integration with transport, housing and wider community supports

Milestones to complete action

- Expansion of community-based and non-centre-based day service options
- Increased availability of personalised support pathways
- Improved consistency in service models across regions
- Enhanced measurement of outcomes and service impact, through continued implementation of Outcomes Focused Monitoring approaches

Outcome indicator

- Greater availability of flexible and person-centred day service options
- Improved alignment between services and individual needs and preference
- Increased participation of service users in community-based activities
- Enhanced visibility of service outcomes and effectiveness



10

Tier 4

Table 5.17

Evaluation Finding – Sustained reform will require stronger monitoring, future planning and adaptive system management

Lead: HSE National Disability Services; DCDE; HSE Planning and Performance; HSE Data and Analytics	Supporting partner(s): Regional Health Areas; service providers; HRB; Department of Health; Department of Children, Disability and Equality; finance, workforce, capital and policy functions	Dependencies: Integrated data and reporting capability; agreed outcome indicators; population-based planning assumptions; regular review cycles; alignment between national and regional planning processes.	Timeframe: Ongoing / long term
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Summary of understanding

The analysis indicates that sustaining disability service reform will require consistent arrangements for monitoring, review and future planning. Across the evidence base, demand is expected to continue evolving due to demographic growth, increasing complexity of need, longer life expectancy and changing expectations regarding person-centred and community-based supports. While progress is evident across a number of service areas, maintaining and building on this progress will require ongoing visibility of demand, capacity, access, workforce and outcomes. This includes the ability to monitor implementation, assess whether service capacity is keeping pace with need, and adapt planning assumptions as new evidence emerges. The findings collectively indicate that long-term sustainability depends not only on addressing current challenges, but also on establishing mechanisms that support continuous learning, planning and adaptation over time.

Evidence base and how this conclusion was reached

Quantitative data analysis: The analysis identified limitations in the availability of consistent system-level indicators that can be used to monitor progress across disability services over time. While substantial information exists regarding activity, demand and service provision, the ability to track progress against long-term reform objectives and outcomes is less consistently available. This highlights the importance of establishing arrangements that support regular performance monitoring and longitudinal assessment of change.

Literature review: The literature consistently identifies monitoring, evaluation and continuous learning as important components of large-scale service reform. Evidence highlights the value of using agreed indicators, outcome measures and regular review processes to inform decision-making, assess progress and support adaptation as services evolve. International evidence also emphasises the importance of linking evaluation activity to planning and implementation processes to support sustainable improvement.

Stakeholder consultation: Stakeholders highlighted the importance of demonstrating progress over time and understanding whether reform initiatives are delivering the intended outcomes. There was strong support for more consistent performance reporting, outcome measurement and evaluation across disability services, including mechanisms that enable learning from implementation and support evidence-informed decision-making

Triangulation: Across quantitative analysis, literature and stakeholder engagement, a consistent theme emerges regarding the importance of strengthening the system's ability to monitor progress, evaluate outcomes and adapt over time. While the preceding findings identify specific challenges and opportunities across disability services, the evidence indicates that maintaining visibility of implementation progress and system performance will be important in supporting continuous improvement and informing future planning decisions.

Action Required

Support the establishment of consistent arrangements for monitoring, evaluation and future planning, so that progress can be tracked over time and planning adapted as needs evolve. This includes agreeing a core set of system-level indicators, embedding regular performance and outcome reporting across national, regional and provider levels, and linking evaluation findings to planning, funding and service-development decisions.



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Tier 4

Table 5.18

Evaluation Finding – Sustained reform will require stronger monitoring, future planning and adaptive system management (cont'd)

Inputs / Resources Required

- Integrated reporting and monitoring arrangements to support consistent visibility of implementation progress and system performance over time.
- Evaluation capability and analytical resources to assess progress, identify emerging issues and support evidence-informed decision-making.
- Structured review mechanisms to assess progress against strategic objectives and reform priorities.
- Alignment between national, regional and provider-level reporting and planning processes.

Milestones to complete action

- Establish routine monitoring and reporting arrangements.
- Implement consistent outcome measurement approaches.
- Integrate evaluation findings into planning and decision-making.
- Establish mechanisms to identify and respond to emerging trends and risks.

Outcome indicator

- Routine reporting on implementation progress and system performance.
- Increased use of evidence in planning and decision-making.
- Improved consistency of reporting across the disability system.
- Ongoing review and refinement of reform priorities based on emerging evidence

Evaluation Findings

Conclusion

The evaluation presents a consistent and evidence-based of a disability services system that is both progressing and under sustained pressure. Across quantitative data, literature and stakeholder consultation, the analysis highlights a system that has undergone significant structural reform in recent years, while continuing to respond to increasing and evolving demand.

There is clear evidence of measurable progress in key areas of service delivery. This includes increased levels of service activity, and the establishment of new models of care, most notably the implementation of Children's Disability Network Teams and the transition towards more community-based service provision. Improvements in data systems in some areas have also strengthened the visibility of service activity and supported more informed oversight. These developments reflect sustained system effort and investment and demonstrate a strong commitment to reform aligned with national policy direction.

However, this progress must be understood in the context of continued growth in demand and increasing complexity of need. The evidence consistently indicates that the scale, pace and diversity of demand are placing ongoing pressure on services across the system. This is reflected in patterns of waiting lists, variation in access, and differences in service experience across regions and service types. While capacity has expanded, it has not fully aligned with the evolving nature of demand, resulting in a system that continues to operate under pressure.

A number of cross-cutting factors are identified as influencing system performance. Workforce availability emerges as a central determinant of capacity, affecting both the volume and timeliness of service delivery. Similarly, the availability and sequencing of capital investment plays a critical role in enabling the development of appropriate infrastructure and new service models. These factors are further shaped by broader system dependencies, including, funding alignment, and the degree of integration across services.

The evaluation also highlights limitations within the current data landscape, with evidence indicating that data availability, coverage and integration remain uneven across the system. While some areas, such as CDNT services, demonstrate improved and more timely data, other areas continue to rely on incomplete or fragmented datasets. This creates challenges in developing a fully comprehensive view of demand, service utilisation and outcomes at a system-wide level and limits the ability to consistently link population need with service delivery and workforce capacity. As a result, planning and decision-making are, in some areas, supported by strong directional evidence but constrained by gaps in completeness, consistency and integration across data sources.

The evaluation highlights variation in the extent to which new models of care are being realised in practice. While policy direction towards person-centred, community-based supports is clear and widely reflected in the literature, implementation remains uneven. In areas such as day services and residential provision, traditional models continue to operate alongside newer approaches, and the extent to which services can deliver flexible, individualised supports varies across the system. Similarly, while progress in CDNT implementation and assessment activity is evident, variation persists in access, timeliness and service experience.

An important theme emerging from the evidence is the role of system structure and coordination in shaping service delivery. The organisation of services across multiple providers and service types creates complexity in how care is accessed and delivered. This can impact the consistency and coordination of services, particularly where roles, responsibilities and pathways are not clearly defined across the system.

Looking forward, the evaluation identifies a number of predictable and emerging pressures, including the impact of demographic change, increasing longevity among people with disabilities, and the growing cohort of individuals supported by ageing carers. These trends reinforce the importance of forward planning and the alignment of service development with projected need.

Overall, the findings indicate that disability services in Ireland are in transition, with a clear direction of travel and demonstrable progress, but with ongoing challenges in translating this progress into consistently accessible, timely and person-centred delivery across all areas. The evaluation therefore points to the need for continued focus on aligning capacity, workforce, infrastructure, service design and data capability with the scale and nature of demand, in order to support more consistent and sustainable service delivery into the future.

A scenic photograph of the Cliffs of Moher coastline, featuring steep cliffs meeting the ocean under a clear blue sky. A green field and a path are visible in the foreground. A large, semi-transparent teal triangle is overlaid on the left side of the image, containing the page number and title.

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Appendices

Appendix 1: Acronyms

Glossary of Acronyms

Alphabetical list of acronyms used throughout this report — part 1 of 4

Acronym	Definition
ACS	Alternatives to Coercive Sanctions
ADHD	Attention Deficit Hyperactivity Disorder
AGS	An Garda Síochána
AON	Assessment of Need
AOTI	Association of Occupational Therapists of Ireland
ASD	Autism Spectrum Disorder
BIC	British Irish Council
BWD	'Before We Die' (referenced in report; full term not specified)
CADU	Citizens Assembly on Drug Use
CAGR	Compound Annual Growth Rate
CAMHS	Child and Adolescent Mental Health Services
CDNM	Children's Disability Network Manager
CDNT	Children's Disability Network Team
CDNTIMS	Children's Disability Network Team data system (full term not specified in report)
CHO	Community Healthcare Organisation
CNRT	Community Neuro-Rehabilitation Team
COPOLAD	Cooperation Program between Latin America, the Caribbean and the European Union on drug policy
CRC	Central Remedial Clinic
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Central Statistics Office
DATF	Drug and Alcohol Task Force
DCDE	Department of Children, Disability and Equality

Table 7.4

Glossary of Acronyms

Alphabetical list of acronyms used throughout this report — part 2 of 4

Acronym	Definition
DCDEIY	Department of Children, Disability, Equality, Integration and Youth
DCR	Drug Consumption Rooms
DEY	Department of Education and Youth
DFI	Disability Federation of Ireland
DoH	Department of Health
DPO	Disabled Persons' Organisation
DRI	Drug Related Intimidation
DRIVE	Drug Related Intimidation and Violence Engagement
DSMAT	Disability Supports Application Management Tool
DUHEI	Drug Use in Higher Education in Ireland
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESRI	Economic and Social Research Institute
EU	European Union
EUDA	European Union Drug Agency
EWS	Early Warning System
EWSD	European Web Survey on Drugs
FPA	Focused Policy Assessment
GP	General Practitioner
HBSC	Health Behaviour in School aged Children
HCP	Health Care Professional
HIQA	Health Information and Quality Authority
HR	Human Resources

Table 7.5

Glossary of Acronyms

Alphabetical list of acronyms used throughout this report — part 3 of 4

Acronym	Definition
HRB	Health Research Board
HSCP	Health and Social Care Professional
HSE	Health Service Executive
ICT	Information and Communications Technology
IFSP	Individual Family Support Plan
IHA	Integrated Health Area
IHREC	Irish Human Rights and Equality Commission
KPI	Key Performance Indicator
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
MDT	Multidisciplinary Team
MeSH	Medical Subject Headings
MRI	Magnetic Resonance Imaging
NASS	National Ability Supports System
NDA	National Disability Authority
NDS	National Drugs Strategy
NIDD	National Intellectual Disability Database
NOCA	National Office of Clinical Audit
NPS	New Psychoactive Substances
NPSDD	National Physical and Sensory Disability Database
NSIO	National Social Inclusion Office
NSP	National Service Plan
OECD	Organisation for Economic Co-operation and Development

Table 7.6

Glossary of Acronyms

Alphabetical list of acronyms used throughout this report — part 4 of 4

Acronym	Definition
OT	Occupational Therapist / Occupational Therapy
PA	Personal Assistance
PDS	Progressing Disability Services (for Children and Young People)
PICO	Population, Intervention, Comparison, Outcome
PT	Physiotherapy / Physiotherapist
RHA	Regional Health Area
RT	Rehabilitative Training
RTE	Raidió Teilifís Éireann
SLA	Service Level Agreement
SLT	Speech and Language Therapy
SPC	Workforce grade (full term not specified in report)
TBC	To Be Confirmed
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation
WRC	Workplace Relations Commission
WTE	Whole Time Equivalent
YoY	Year on Year

Table 7.7