Rialtas na hÉireann
Government of Ireland

Sláintecare.

Right Care. Right Place. Right Time.

Sláintecare Integration Fund
End of Programme Report
2019 – 2021

Acknowledgements

The Department of Health Sláintecare Programme Management Office would like to acknowledge and thank all the organisations funded under the Sláintecare Integration Fund for their dedication to the provision of quality healthcare, and to acknowledge the commitment and resilience shown by organisations in the face of the unprecedented challenges presented by the COVID-19 pandemic. We would also like to thank the projects for providing information through their monitoring and financial reports.

Contents

Foreword

Minister for Health
Stephen Donnelly TD

Through the Sláintecare Integration Fund we have seen wonderful examples of innovation and change. These projects are leading examples of how innovative thinking can bring about meaningful and long-lasting change to health and social care in Ireland.

The projects which were funded through the Sláintecare Integration Fund have tested new ways of working and delivered innovative models of care, which bring care closer to home, including putting the patient at the centre of service design and delivery.

These projects have demonstrated the innovative ways we can work in partnership to deliver the Sláintecare vision. The project partners ranged from hospitals, hospital groups, community health organisations, community and voluntary organisations and universities. Many of the projects were delivered in partnership between hospitals and CHOs, or hospitals and community organisations, highlighting the emphasis on integrated care and shifting care to the community.

The projects which are highlighted in this report show how joined-up thinking and working in partnership can help us reach Sláintecare's goals of shifting the majority of care to the community, reducing waiting lists and improving experiences for patients and staff across the health and social care system in Ireland.

I want to thank all our health and social care professionals for their dedication and commitment to delivering safe, timely and high-quality care to patients. The frontline staff delivering these projects have shown true resilience and flexibility. They have delivered these projects against the backdrop of COVID-19, which challenged our healthcare system in manner never previously seen. These projects have highlighted the energy and appetite for change that exists, particularly where we have seen the optimisation of care pathways through new technologies and cooperation across the health system. Many of the changes we have seen throughout the pandemic and through the Sláintecare funded projects have embodied the core Sláintecare principle of delivering the right care, in the right place, at the right time.

As many of these projects move to their next phase, as they are mainstreamed and/or scaled up, I am confident that the innovation and best practice that all these projects represent will be of great value to the work underway to transform our health and social care services by putting patients first and ensuring every person across the country can access the right care in the right place at the right time.

Reform depends on the continued cooperation of multiple health and social care stakeholders, and it is only through working together that we can make the Sláintecare vision a reality.

Glossary of terms

ANP	Advanced Nurse Practitioner
ALOS	Average Length of Stay
CHO	Community Health Organisation
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
DoH	Department of Health
ED	Emergency Department
HF	Heart Failure
HLO	High Level Outcome
HSCP	Health and Social Care Profession
HSE	Health Service Executive
NGO	Non-Government Organisation
OPD	Outpatient Department
QoL	Quality of Life
Section 38/39	The HSE funds a range of services providers under either Section 38 or section 39 of the Health Act 2004. Section 38 arrangements involve organisations that are funded to provide a defined level of service on behalf of the HSE, while under Section 39 the HSE provides grant aid to a wide range of organisations, to a greater or lesser extent.
SIF	Sláintecare Integration Fund
SISAP	Sláintecare Implementation Strategy & Action Plan 2021 - 2023
SPIO	Sláintecare Programme Implementation Office
Tusla	The Child and Family Agency
WTE	Whole Time Equivalent

Executive Summary

The Sláintecare Integration Fund (SIF) formed part of the Sláintecare Action Plan 2019 which established the building blocks for a significant shift in the way in which health services are delivered in Ireland.

Budget 2019 provided €20 million for the establishment of a ring-fenced Sláintecare Integration Fund to support service delivery which focuses on prevention, community care and integration of care across all health and social care settings. The SIF supported 123[1] HSE and NGO sector projects, to test and evaluate innovative models of care providing a 'proof of concept' with a view to mainstreaming/scaling of successful projects through the annual budget estimates process.

The selection criteria for funding were:

- Encourage innovations in the shift of care to the community or provide hospital avoidance measures.
- Scale and share examples of best practice and processes for chronic disease management and care of older people.
- To promote the engagement and empowerment of citizens in the care of their own health.

Why?

The Health Service Capacity Review 2018 identified three key areas of reform to alleviate future population pressures on the healthcare sector. These pressures are associated with a sharp increase in our over 65s population, who are high users of health services, and the high proportion of the population aged 50+ years who have three or more comorbidities. The three reform pillars are (1) Healthy Living, (2) Enhanced Community Care & (3) Hospital Productivity Measures. Many of the reforms described in these three pillars have been tested and evaluated through **the Sláintecare Integration Fund projects including:**

- New integrated care pathways across hospital and community settings for the care of older people and people with chronic diseases.
- The shift of procedures to lower acuity settings, social inclusion measures, hospital avoidance measures .
- HSE National priority Healthy Living programmes and promoting patient self-care and improving healthy behaviours.

The delivery of reforms as described in these three pillars is a Priority project in Reform Programme One in the **Sláintecare Implementation Strategy & Action Plan 2021—2023** which was approved by the Government in May 2021.

The current status of the 123 SIF projects is as follows:

106	Projects are mainstreamed, which means they will receive recurring funding annually
2	Projects have received once off funding to facilitate reviews by HSE in 2022
2	Projects were granted a funded extension to facilitate completion of review in 2022
13	Projects have been completed
123	**Total**

[1] Three additional NPHET projects also received funding in response to COVID-19 but are not included as part of this report

Executive Summary cont.

There were **732 outputs** and **560 outcomes** reported by all **123 projects**. **523 (72%)** of output targets were either achieved or exceeded while **387 (69%)** of outcome targets were achieved or exceeded.

The following is a high-level summary of the outcomes reported by projects:

1 

Reduced referrals, or more appropriate referrals to relevant health specialists within the community, e.g., home outreach/community referral rather than referral to acute location (Scheduled Care)

2 

Emergency Department attendances avoided/reduced (Unscheduled Care)

3 

Facilitating timely hospital discharge, reduction in Average length of stay (ALOS)

4 

Health literacy — empowering citizens with the knowledge to manage their health

5		Hospital admissions avoided; acute bed days reduced
6		Improved health status
7		Increased access to care, reduction in waiting times for patients
8		Increased Integration of Care, e.g., home outreach/community referral rather than referral to acute location
9		Long term care avoidance
10		Patient and Professional Satisfaction, through the use of surveys
11		Cost reduction

Executive Summary cont.

Sláintecare Integration Fund — Key Achievements

Outlined below are some of the highlights reported by the projects. Figures need to be interpreted cautiously as projects were undertaken during COVID-19 and some figures are approximated. All data has been self-reported by projects. The figures in the following infographic (Infographic 1) are also included in Figures 6 and 7 in section 3 of this report.

123
Projects funded

€28m
Total funding

315
Whole Time Equivalents

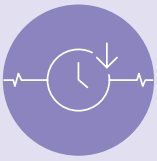
63,793
Patients seen

61,521
Tests undertaken

19,397
Bed days avoided

8,112
Patients seen
from Waiting Lists

3,370
Emergency Department
Attendances avoided



2 days to 6.5 years
the range of
Waiting times reduced

15,145
Reduced referrals to
Scheduled Care

52,408,821
Views of Online Digital Health Guides

Health literacy — Empowering citizens with the knowledge to manage their health through a combination of services delivered in-person/virtually and online engagement with digital health information

Infographic 1

36 SIF funded projects; across a range of services including chronic disease management, mental health, physical activity, older persons, and smoking cessation; had a primary high-level outcome to improve health status. The following graphic (Infographic 2) sets out some of the key achievements relating to specific project types. **Project data outlined here is specific to individual projects, for example not all projects focusing on Chronic Disease management would have recorded improvements in anxiety reduction:**

Number of Chronic Disease Management Projects	Number of Patients seen	Reduction in Anxiety	Reduction in Depression	Improvement in Chronic Disease Outcomes
9	1,031	Up to 90%	Up to 80%	Up to 90%

Number of Living Well Projects	Number of Patients seen	Improvement in Quality of Life	Increase in Physical Activity Levels	Improvement in Self-Efficacy
6	1,891	10%	31%	15%

Number of Mental Health Projects	Number of Patients seen	Improvement in Well-Being	Improvement in Employment Rates	Increase in Social Interactions
7	1,475	Up to 53%	Up to 120%	Up to 180%

Number of Older Persons Projects	Number of Patients seen	Improvement in Stress Levels	Decrease in Social Isolation	Reduction in Loneliness
6	5,102	Up to 60%	Up to 15%	Up to 49%

Number of Physical Activity Projects	Number of Patients seen	Improvement in Strength	Improvement in Endurance	Improvement in Flexibility
6	1,719	Up to 62%	Up to 33%	Up to 29%

Number of Smoking Cessation Projects	Number of Patients seen	Rates of Smoking Cessation
2	1,868	Up to 79%

Improved Health Status through lifestyle, self-management & physical activity projects with a specific focus on Chronic Disease Management, Mental Health, Physical Activity, Older Persons and Smoking Cessation	Number of Beneficiaries
	13,086

Infographic 2

Executive Summary cont.

38 of the SIF projects were mainstreamed by HSE through Enhanced Community Care funding as part of the roll out of community specialist teams for Older Persons and Chronic Disease Management teams, which commenced in 2021.

The testing of **four SIF projects** has fed directly into the new patient care pathway design process which is currently taking forward the development and finalisation of 73 individual care pathways across 16 specialities in the HSE.

Impact of COVID-19

The delivery of the Sláintecare Integration Fund projects was impacted by the onset and duration of the COVID-19 pandemic. In March 2020, 70 (HSE/S38) projects were paused as project staff were redeployed to meet the needs in the healthcare system. Of these, 23 projects resumed in April/May 2020 as part of the HSE response to COVID-19. Following an Assessment of Readiness to Resume process by the Sláintecare Programme Implementation Office, HSE & Pobal[2], the remaining 47 projects resumed between July & December 2020. The projects revised and adapted their service delivery model to include online and virtual options. The projects had the opportunity to change their outputs, outcomes, and respective targets. The projects continued to engage and care for patients throughout the pandemic, highlighting their flexibility and ensuring the patient is paramount, a key principle of Sláintecare.

In December 2020, forty-nine (49) projects, all which had an end date between December 2020 – June 2021, were provided with an extension of no greater than six months to the end of June 2021 to allow for a full evaluation of projects which was delayed in 2020 as a result of COVID-19. The evaluation process informed joint HSE and SPIO decision making regarding the mainstreaming of projects and the provision of funding on a permanent basis.

In May 2021, a decision was made to fund a further extension of no greater than six months from 1 July 2021 to the end of December 2021 for 71 projects to enable these projects continue while the Estimates process was ongoing and future funding decisions were made regarding the allocation of Budget 2022.

[2] Pobal administer the Sláintecare Integration Fund on behalf of the Department of Health. See **www.pobal.ie**

Delivering the Sláintecare Integration Fund Programme

A Performance Delivery Agreement was put in place between the DoH Sláintecare Programme Implementation Office (SPIO) and Pobal for the delivery of The Sláintecare Integration Fund. The agreement set out the roles and responsibilities of both the Department and Pobal across a number of key areas ranging from ICT requirements, financial operations, liaison, governance and oversight. A SIF co-ordination Team established to provide planning and monitoring oversight for the Fund included representation from SPIO, Pobal and the HSE. Projects reported progress against their outputs and outcomes targets monthly. Interim Reports and Final Reports have been completed for all projects.

Budget

The final budget commitment for 123 SIF projects was €28m including the cost of extensions.

Conclusions

The programme achieved what it set out to do

The SIF supported 123 HSE and NGO sector projects, to test and evaluate innovative models of care providing a 'proof of concept' with a view to mainstreaming and scaling successful projects through the annual budget estimates process. This has been achieved across the three project selection criteria and there are multiple examples, highlighted in this report, of projects moving care out of acute settings, empowering citizens.106 projects have been mainstreamed into the healthcare system, to date.

Impact of the programme is evident through the outcomes and outputs data

Projects reported on the achievements of their projects and in total there were 732 outputs and 560 outcomes resulting from the programme. The impact of SIF on the healthcare system is evident, for example, in the hospital admissions avoided and ED attendances avoided or the reduction in waiting lists, but the impact is also felt by patients and their families where waiting times have improved or journey times to receive treatment have been reduced.

Programme was resilient and flexible in the context of COVID-19 and other challenges

The SIF programme has proven to be both resilient and flexible. The challenges faced by healthcare staff over the course of the programme have been immense and they have responded by developing new ways of working and adapting their model of care to include online and virtual options of service delivery. In many cases this allowed for greater reach for a project.

Learnings derived for the future delivery of similar programmes

Some of the key learnings that projects highlighted from implementation of the projects were that stakeholders needed to be engaged early in the process, there is a need to have a flexible approach to service delivery and additional time is required for the recruitment process. These learnings are expanded upon in the report. Projects recognised the benefit of developing project management skills and competencies including managing deliverables and milestones, budget management and monthly outcome-based reporting which significantly contributed to the successful delivery of the SIF projects.

01

Introduction

The Sláintecare Integration Fund formed part of the Sláintecare Action Plan 2019 that established the building blocks for a significant shift in the way in which health services are delivered in Ireland.

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- To promote the engagement and empowerment of citizens in the care of their own health.

1.1 Background

The SIF was announced by then Minister for Health in March 2019. The open call for applications, which invited health and social care providers from the not-for-profit sector to apply, closed in April 2019. A total of 477 applications for funding were received. Applicants included hospitals, hospital groups, Community Healthcare Organisations, community and voluntary organisations, Universities and Primary Care Centres, highlighting the emphasis on integrated care and shifting care to the community, with 123 successful applicants receiving a funding award. The then Minister for Health stated that the successful applicants (projects) are *"leading examples of how innovative thinking can bring about meaningful and long-lasting change to health and social care in Ireland"* (Department of Health, 2019).

The SIF was administered by Pobal, on behalf of the Department of Health (DoH). The initial delivery timeframe was from 9th September 2019 to 31st December 2020, however due to the impact of COVID-19 the timeframe was extended. The delivery of the Sláintecare Integration Fund projects was impacted by the onset and duration of the COVID-19 pandemic. In March 2020, 70 (HSE/S38) projects were paused as project staff were redeployed to meet the needs in the healthcare system. Of these, 23 projects resumed in April /May 2020 as part of the HSE response to COVID 19. Following an Assessment of Readiness to Resume process by the Sláintecare Programme Implementation Office, HSE & Pobal, the remaining 47 projects resumed between July & December 2020. The projects revised and adapted their service delivery model to include online and virtual options. The projects continued to engage and care for patients throughout the pandemic, highlighting their flexibility and ensuring the patient is paramount, a key principle of Sláintecare.

In December 2020, forty-nine (49) projects, all which had an end date between December 2020 and June 2021, were provided with an extension of no greater than six months to the end of June 2021 to allow for a full evaluation of projects which was delayed in 2020 as a result of COVID-19. The

Introduction cont.

1.1 Background cont.

evaluation process informed joint HSE and SPIO decision making regarding the mainstreaming of projects and the provision of funding on a permanent basis. In May 2021, a decision was made to fund a further extension of no greater than six months from July 1st to December 31st 2021, for 71 projects to enable these projects continue while the Estimates process was ongoing and future funding decisions were made regarding the allocation of Budget 2022.

There was a Performance Delivery Agreement in place between the DoH Sláintecare Programme Implementation Office (SPIO) and Pobal for the delivery of The Sláintecare Integration Fund. The agreement sets out clearly the roles and responsibilities of both the Department and Pobal across a number of key areas ranging from ICT requirements, financial operations, liaison and governance, and oversight. A SIF Co-ordination Team was established to provide planning and monitoring oversight for the Fund including representation from SPIO, Pobal and HSE. The SIF Co-ordination team met on a regular basis. Projects reported progress against their outputs and outcomes targets monthly. Interim Reports and Final Reports have been completed for all projects. Pobal provided semi-annual updates to DoH on progress against its work programme.

1.2 Project Monitoring

Projects were implemented by a broad range of organisations. For each project there was a lead organisation, and for many there were also one or more partner organisations that collaborated on implementation, more detail on this is provided in Section 2. Each project was provided with a grant agreement which set out the details of their grant such as the number of WTEs to be funded, project output and outcome targets and budget details.

Output and outcome targets for each project were individualised due to the diverse nature of the work being carried out. As the programme progressed these outputs and outcomes were revised in some cases, taking into account COVID-19; information provided in monthly, interim, and final progress reports; and data provided to DoH. Changes to grant agreements over the course of the programme were facilitated through the addendums process.

From August to October 2020, Sláintecare projects engaged in a change to Grant Agreement process. **This change process was required as a result of a number of factors including:**

- The pause on projects activities from March - July 2020, placed on the majority of HSE/Section 38 projects, as a result of the COVID-19 pandemic.
- Required changes and extensions to the HSE/Section 38 and NGO/Section 39 projects that were not formally paused due to COVID-19.
- Pre-COVID-19 project delays as a result of recruitment challenges for a number of projects.
- Pre-COVID-19 delays and challenges in delivering on agreed project actions, outputs, and outcomes within the original Programme's timeframe for delivery (i.e., all projects to be completed by December 31, 2020).

1.3 Case management

Each project was assigned a Development Coordinator (DC) as a primary point of contact within Pobal for support and guidance as required to facilitate compliance with contractual requirements for the duration of the programme. DCs supported the pre-contracting process facilitating projects to enter into grant agreements; advised on and processed change requests; facilitated addendums to contracts and project payments as well as reviewed data submitted as part of the reporting process. A significant amount of support was provided for projects to complete their monthly and final progress reports which entailed establishing and reporting on verifiable output and outcome indicators as well as setting outcome baseline figures.

Pobal organised induction meetings in January 2020 to help familiarise all projects with the requirements of the programme. All remaining support events were then conducted online as the programme progressed, due to the COVID-19 pandemic, and were conducted to assist with reporting and allow projects to share experiences from their projects. Access to an online portal was provided for projects to submit documentation and progress reports. Supporting documentation was also provided such as the Sláintecare Integration Fund Operational Manual[3] which provided information to projects to ensure the effective administration of the Fund and to ensure compliance with the Sláintecare Integration Fund grant agreement.

1.4 Methodology

This report details the progress achieved by the Sláintecare Integration Fund programme which ran from September 2019 to December 2021.[4] The principal sources of information for this report are Final Progress Reports, submitted once, and Monthly Progress Reports, submitted on an ongoing basis, by projects. This data has been aggregated to provide high level analysis of projects and is supplemented by additional data provided by projects and includes third party sources of information such as project evaluations.

It should be noted that in some cases the figures presented in this report are approximated. Projects have, in some cases, used historical data from a period prior to project start dates and compared this to data post-project as a way to estimate bed days avoided or emergency attendances reduced. As SIF projects are diverse in nature, high-level reporting and grouping of data used here should be considered approximate.

[3] https://www.pobal.ie/app/uploads/2021/03/SIF-Operational-Manual-Version-2-30032021.pdf

[4] This includes data up to 31st December 2021 for four projects extended into 2022.

02

Programme overview

The SIF programme funded a total of 123 projects with three additional projects also receiving funding during the course of the programme due to the COVID-19 pandemic. Projects were locally or regionally based in most cases with 11 being described as nationally focused. This section of the report provides a high-level overview of the organisations that were funded, as well as an analysis of the types of projects under a number of categories. Also included is a summary of the status of projects at the end of the programme, including future funding status and an analysis of recruitment to the projects.

Projects were delivered in multiple locations across the country. Some projects operated in specific hospitals while others were delivered across part or all of a CHO area. The following map (Figure 1) broadly displays where projects were delivered.

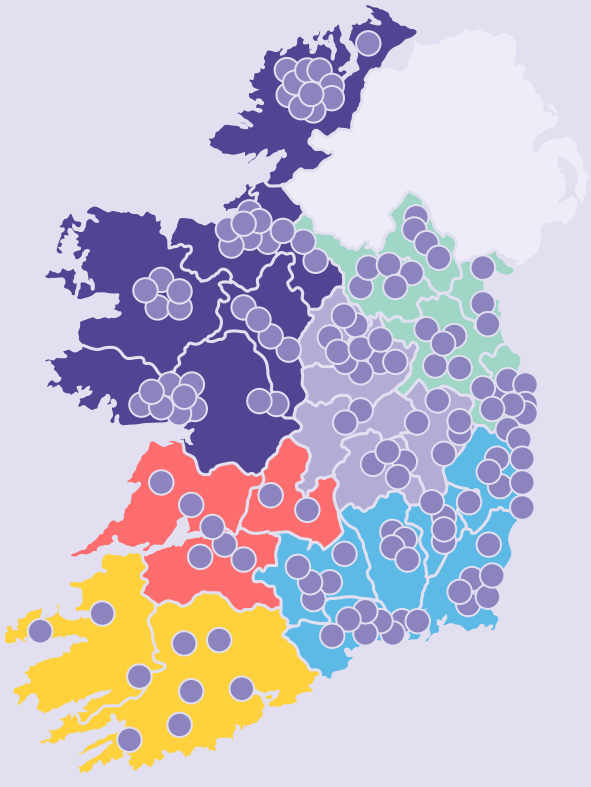


Figure 1 Projects overlaid on Regional Health Areas

2.1 Overview of Grantees

SIF projects were undertaken by three types of organisations: HSE organisations; Section 38 organisations, which comprised of 23 non-acute agencies and 16 voluntary acute hospitals currently within the HSE Employment Control; and Section 39 & others (Non-Acute/Community Agencies/NGO/Other). The following table (Figure 2) gives a breakdown of the number of projects by these three types and the percentage of funding allocated. A full list of projects is included in Appendix 1.

Organisation type	Number of Projects	% of Original Grant Amounts €
HSE	72	58%
Section 39/NGO/ Other	32	22%
Section 38	19	20%
Total	**123**	**100%**

Figure 2 Projects by Project type

The NGOs that received funding under SIF come from across Irish civil society and feature groups focusing on specific healthcare issues such as asthma and epilepsy to organisations involved in sports, housing issues, and supporting the elderly.

The majority of projects (83%) also featured collaborations with partner organisations that formed part of the implementation teams. These partners included CHOs, NGOs, third level institutions, Local Authorities, and various local networks, among others.

Programme overview cont.

2.2 Overview of Projects

The 123 projects funded as part of SIF are focused on three key criteria:

- Encourage innovations in the shift of care to the community or provide hospital avoidance measures
- Scale and share examples of best practice and processes for chronic disease management and care of older people as near to home as possible
- Promote the engagement and empowerment of citizens in the care of their own health

The most common focus of all projects tested new integrated care patient pathways across hospital and community settings for the management of people with Chronic Disease and Older persons as can be seen in Figure 3 with 53 out of 123 (43%) projects focusing on these criteria.

Criteria	Number of Projects	% of Original Grant Amounts €
Scale and share examples of best practice and processes for chronic disease management and care of older people	53	43%
Promote the engagement and empowerment of citizens in the care of their own health	47	38%
Encourage innovations in the shift of care to the community or provide hospital avoidance measures	23	19%
Total	**123**	**100%**

Figure 3 Projects by by selection criteria

As part of the project monitoring process the outputs and outcomes of each project were tracked against targets that were set as part of the project grant agreement. **Typical outcome targets included for example:**

- Reduced wait time for OPD appointment
- Reduction in ED attendances and hospital admissions
- Reduction in referrals to scheduled care

The majority of outcome targets were set based on baseline data using information from prior to project commencement where possible, for some projects starting completely new initiatives this was not possible. In total there were 732 outputs and 560 outcomes reported by all 123 projects. 523 (72%) of output targets were either achieved or exceeded while 387 (69%) of outcome targets were achieved or exceeded.

2.2.1 Status of projects at the end of programme

The status of the 123 SIF projects is as follows:

106	Projects are mainstreamed, which means they will receive recurring funding annually
2	Projects have received once off funding to facilitate reviews by HSE in 2022
2	Projects were granted a funded extension to facilitate completion of review in 2022
13	Projects have been completed
123	**Total**

2.2.2 Recruitment

In total 315 Whole Time Equivalent (WTE) positions were approved for funding over the course of the programme. The roles that were required for each project were diverse, with the following table (Figure 4) showing the categories of roles for which funding was provided for all projects.

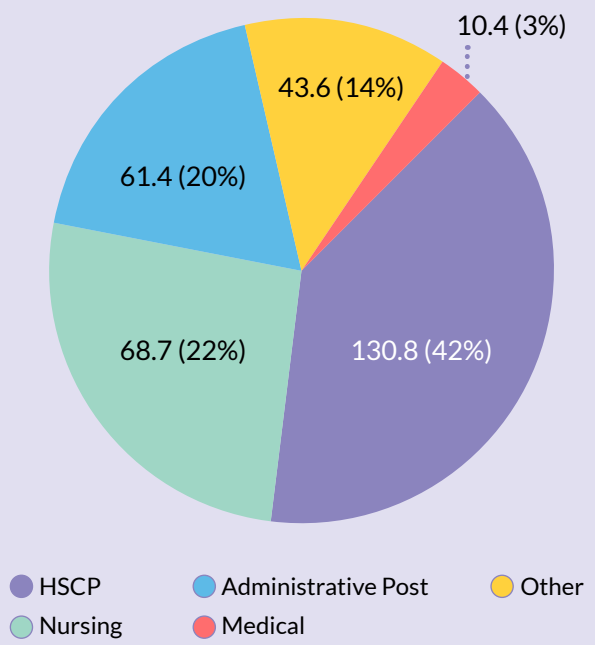


Figure 4 WTE categories

See below for a snapshot of the posts recruited to projects:

Category	Grade	Total
Administrative Post	Family Support Project Manager	0.2
	Grade VI – (Carers Development /Dementia Officer)	1
HSCP	Assistant Psychologists	8
	Cardiac Physiologist, Chief I	1.5
HSCP cont.	Chiropodist, Clinical Specialist	1.5
	Clinical specialist dietician	0.5
	Clinical specialist physio	0.1
	Dietitian Manager-in-charge III	0.99
	Emergency Medical Technician, Leading (Advanced Paramedic)	3.6
	Integrated Exercise Practitioner	1
	Link Workers	16
	Manager (Clinical Specialist Physiotherapist)	0.5
	Medical Scientist, Specialist	0.5
	Occupational Therapist, Clinical Specialist	1
	Optometrist, Clinical	2.5
	Pharmacist	1
	Physiotherapy Assistant	3
	Programme Dev Worker	0.8
	Respiratory Physiologist	1
Medical	Consultant	1
	Consultant – Orthopaedic Surgeon	0.25
	Consultant Cardiologist	0.25
	Consultant in Palliative Medicine	0.1
	Consultant Ophthalmic Surgeon	1.05
	Registrar Specialist	0.6
	Senior Cardiac Physiologist	1
Nursing	Advanced Nurse Practitioner	13
	Clinical Nurse Specialist	32
Other	CNM Promotion/project Manager	0.5
	Community Coordinator	0.3
	Project Coordinator	0.5
Grand Total		95.24

03

Key Achievements of Sláintecare Integration Fund Projects

Mainstreaming and Scaling of Innovation Integration Projects

The purpose of the SIF project was to test and evaluate innovative models of care providing a 'proof of concept' with a view to mainstreaming/scaling of successful projects through the annual budget estimates process, whereby units within the government departments bid for ongoing funding for various projects. As of December 2021, 85%, of the SIF projects are being mainstreamed, which means they will receive recurring funding on an annual basis.

38 of these projects were mainstreamed by HSE through Enhanced Community Care funding as part of the roll out of community specialist teams for Older Persons and Chronic Disease Management teams, which commenced in 2021. The testing of **four SIF projects** has fed directly into the new patient care pathway design process which is currently taking forward the development and finalisation of 73 individual care pathways across 16 specialities in the HSE. These projects will reduce waiting times through a shift of patient care from hospital to community services.

Outlined below are some of the highlights that have been delivered across the projects:

Resources (Jan 2020–Dec 2021)		**Outputs** (Jan 2020 – Dec 2021)		
€	WTE	Patients seen	Tests Undertaken*	Views of Online Digital Health Guides
€28,201,110	**315**	**63,793**	**61,521**	**53,753,408**

Figure 5

Outcomes – High Level (Jan 2020 – Dec 21)	
No. of inpatient Bed Days avoided through hospital avoidance and reduced length of stay (estimated)	**19,397**
Waiting lists reduced (no. of patients)	**8,112**
Waiting times were reduced by a range of	**2 days – 6.5 years**
Emergency Department Attendances avoided (Estimated)	**3,370**
Reduced referrals, or more appropriate referrals to relevant health specialists within the community, e.g., home outreach/community referral rather than referral to acute location (Scheduled Care)	**15,145**
Improved Health status through lifestyle, self-management & physical activity projects with a specific focus on chronic disease management, mental health, Physical Activity, Older Persons, and Smoking Cessation (number of patients who engaged with projects)	**13,086**
Health literacy- empowering citizens with the knowledge to manage their health through a combination of services delivered in-person/virtually and online engagement with digital health information (Child Health, Chronic Disease Management and Online Health Guides)	**52,408,821 Views of Online Digital Health Guides**

Figure 6

*Tests include respiratory tests, enteric tests and STI tests.

04

Profile of selected projects

This section of the report presents a number of projects as they relate to the original three selection criteria for SIF funding. Included here is a description of the service provided and the outputs and outcomes achieved, feedback from participants in the projects and also links to webinars in which the projects participated as part of the learning network established for the SIF projects.

4.1 Encourage innovations in the shift of care to the community or provide hospital avoidance measure

The projects funded under this selection criteria focused on shifting care out of acute hospitals into the community by testing new integrated care pathways aligned to HSE National Models of Care in a number of clinical specialties which have significant national out-patient waiting lists and waiting times (Urology, Ophthalmology, and Orthopaedics). The Voluntary sector and HSE statutory services worked collaboratively to deliver innovative responses to the needs of socially excluded groups, mental health and disability service users and vulnerable groups to ensure patients experienced the right care in the right place at the right time by enhancing access to care locally within communities.

A snapshot of the key outcomes of these projects below clearly identifies how these innovative ways of working contributed to reductions in waiting lists and waiting times for a range of scheduled care services. Other outcomes from the projects in this category include reduced Emergency Department Attendances, Hospital admissions avoided, and Reduced Length of Stay in unscheduled and scheduled in-patient acute hospital care services. Patients reported a positive, timely care experience which can be heard in the following webinar: **Sláintecare Webinar "Improving Access to Care."**

Profile of selected projects cont.

4.1 Encourage innovations in the shift of care to the community or provide hospital avoidance measure cont.

The testing of four of these projects, detailed in the following sections, has fed directly into the new patient care pathway design process, which is currently taking forward, the development and finalisation of 73 individual care pathways across 16 specialties in the HSE. The following SIF projects which tested new care pathways in four of these specialities led to reductions in waiting lists and waiting times for specific categories of patients on Urology, Neurology and Ophthalmology waiting lists.

4.1.1 Clinical Specialty: Urology. Project ID 376: ANP for development of male LUTs and benign urology and Project ID 203: Urology Pathway-Proof of Concept Project

Two SIF projects were supported to test a new Lower Urinary Tract Symptoms (LUTS) care pathway designed by HSE National Lead in Urology and National Clinical Programme. Both projects were led and delivered by an Advanced Nurse Practitioner (ANP) in community and outpatient (OPD) facilities. Project 376 diverted treatment away from traditional consultant led clinics, creating a more streamlined efficient service. Similarly, Project 203 achieved a reduction in waiting lists and streamlined the pathway between primary and secondary care.

The projects highlighted that urology care is currently mainly hospital centred with the total Outpatient Urology waiting list as of July 2021 being 31,983 and that 17% of patients on this waiting list have LUTS and benign Urology service needs. Learn more about this project by clicking on the following link to view the SIF webinar which featured this project:
Sláintecare Webinar "Improving Access to Care."

Outcomes to date include:

- **ID 376: Over 90%** of patients appropriate for direct referral to the Advanced Nurse Practitioner led service with remaining referrals to be seen by Consultant at OPD clinic.
- **ID 376: 6% (41)** reduction of ED attendances by people with chronic urological conditions, who were treated by GPs instead. This reduction exceeded the target reduction of 1 – 1.5%.
- **33% (1)** Reduction in the number of visits per patient, as a result of being directly referred to the ANP led Nurse clinic.
- **Up to 48%** reduction in patients on the LUTS OPD waiting list due to the delivery of ANP led clinic.
- **100%** patient satisfaction is reported based on initial feedback.

> "It was great to attend the clinic as I was nervous about going to the hospital. I was given lots of time to master SIC technique."
>
> **— Participant**

4.1.2 Clinical Specialty: Neurology. Project ID 61 Towards Self-care in Headache

The Headache clinic SIF project was successfully tested in three sites.

Learn more about this project by clicking on the following link to view the SIF webinar which featured this project:
Patient impact of the Sláintecare Integration Fund

Migraine is the most common neurological condition in the world affecting 12-15% of the population and is classified by the World Health Organisation as the 7th most disabling disease worldwide, and 4th for women (Vos et al., 2015). In Ireland it affects 750-800K people, at estimated cost to the economy of €250 million each year as a result of lost productivity (Migraine Ireland). 25-30% of referrals to Neurology waiting lists (total waiting list 21,000) are related to Headache. The roll out of this project, which is a partnership between the voluntary and statutory services,

involves a move to nurse led clinics, dedicated Psychology service, **self-care programmes and support groups is projected to result in:**

- Reduced referrals to OPD.
- Significant increase in capacity for new patients to be seen at OPD by Medical Clinicians.

This project achieved:

- 23% (182 patients) reduction in waiting lists.
- There was a significant improvement in new: return ratio in the headache clinic in St James Hospital, it is currently 3:1 compared to prior setting for people with headaches (PwH) in General Neurology Clinic of 1:2.

> "CNS has been so kind and helpful. She has made me more aware of my headache and helped me and advised me so much. I am so grateful to ye all. Thanks so much for a great service. Keep up the great work."
>
> **— Participant**

4.1.3 Clinical Specialty: Ophthalmology. Project ID 79 Implementation of Integrated Eye Care

Demand for eye services currently outstrips the supply of available services. Nationally there are 41,706 people (July 2021) waiting for an Ophthalmology outpatient appointment. Four Sláintecare Integration Fund projects provided a range of community-based Ophthalmology services for the population in CHO7 in Dublin South, Kildare, West Wicklow, and CHO1 in Donegal. The Implementation of Project 79: Adult Integrated Eye Care Team in CHO 7 is a collaboration with Royal Victoria Eye and Ear Hospital and College of Ophthalmology. This integrated pathway of care was designed by the National Clinical Programme for Ophthalmology to address an over reliance on hospital delivered care by providing community pre- and post-operative assessment targeting adult patients with chronic disease and adult patients requiring pre & post-operative cataract care.

Outcomes to date include:

- 1,789 patients have been offered treatment, 1,547 were for face-to-face clinics and 242 were virtual clinic appointments.
- Reduction in waiting time from 4.5 years to three years in four community health network areas; Firehouse Area, Walkinstown Area, Clondalkin and Kilnamanagh Tymon area, achieving the target of reducing the waiting time by 1.5 years.
- Hospital OPD waiting list was reduced by 1,789 (89%) clients in year one, who were transferred from the acute hospital settling to primary care.

4.1.4 Clinical Specialty: Orthopaedics. Project ID 94 The Trauma Assessment Clinic

This SIF project tested virtual trauma assessment clinics in five sites. This project is delivered by the National Clinical Programme for Trauma and Orthopaedic Surgery (NCP TOS), Royal College of Surgeons in Ireland in Letterkenny University Hospital, Cork University Hospital, University Hospital Waterford, Connolly Hospital Blanchardstown, and Midland Regional Hospital at Tullamore.

This project promotes the Trauma Assessment Clinic (TAC) pathway of care by implementing virtual clinic programmes. The target group for this project are patients who sustain a fracture because of trauma. 55,000 new fracture patients attend annually in outpatient fracture clinics, averaging 2.6 return visits per patient. The TAC offers a novel care pathway for patients with simple, stable injuries. TAC embodies the provision of safe, patient centred, efficient and cost-effective treatment via a multidisciplinary team (MDT) approach.

Outcomes to date include:

- 70% (482) reduction in unnecessary fracture clinic referrals which is in excess of the target of 38% (261), With the introduction of virtual TAC clinics, there was a significant amount of education completed on each site including education leaflets for patients and staff creation and completion of referral forms to TAC.

Profile of selected projects cont.

4.1.4 cont.

- There is a 58% (6,380) reduction in actual fracture clinic attendances in adult hospitals compared to a target of 38% (4,180) and baseline of 11,000.
- 27% (2,915) of patients were seen directly by physiotherapist with direct discharge to community physiotherapist.

4.2 Promote the engagement and empowerment of citizens in the care of their own health

Projects selected under this criterion centred around prevention and on empowering people and communities to be more engaged in their own health and wellbeing, with an emphasis on benefitting more socially excluded groups and communities. 26 of these projects (see Appendix 4) are being mainstreamed or scaled in 2021/2022 through additional investment for dedicated health and wellbeing staff to deliver the following programmes and support the implementation of a number of national policy frameworks.

4.2.1 Social Prescribing

The HSE launched its **Social Prescribing Framework**[5] in September 2021. Six Social Prescribing projects (IDs 15, 31, 162, 253, 284 & 370) have now been mainstreamed by the HSE. This complements the existing resources and is addition to the Social Prescribing Link Workers who have been appointed under the **Sláintecare Healthy Communities Programme**. The programme operates whereby GPs and other health professionals refer patients to a Social Prescribing Link Worker who will work with the person to develop a wellbeing plan which most often involves supporting them to access a community-based option of their choice. Social prescribing is an initiative that can improve the wellbeing of a wide range of individuals including people who are socially isolated, lonely, have long term conditions, unexplained symptoms, or mental health difficulties. Partnership with community and voluntary organisations is key to social prescribing and the Social Prescribing Link Worker is always employed by one such organisation e.g., Family Resource Centre or Local Partnership Company. The policy context for social prescribing is strong. It is named as a priority in the Programme for Government, in mental health policy, Sharing the Vision, in the HSE Healthy Ireland implementation plans and the HSE Service plan.

Learn more about this project by clicking on the following link to view the SIF webinar which featured this project:
New Ways of Working

4.2.2 Prevention of STIs through an innovative nurse led service Project ID 40

The SIF project ***Prevention of STIs through an innovative nurse led service (ID 40)*** - Athlone Institute of Technology provided supports for sexual health, contraception, and related matters to students at Athlone Institute of Technology. This project is being mainstreamed into the HSE and aligns with the **Healthy Ireland Healthy Campus Framework**, which was launched in June 2021.

4.2.3 Living Well Projects

The **'National Framework for the Integrated Prevention and Management of Chronic Disease** in Ireland[6]' describes a continuum of health promotion, disease prevention, diagnosis, treatment, disease management and rehabilitation services that are coordinated across different healthcare providers and healthcare settings.

Sláintecare funded the testing of the "**Living Well Programme**" across six CHO areas which is being mainstreamed in 2022. (CHO1, 2, 5, 6, 8 & 9). All six projects (IDs 38, 78, 185, 219,

[5] https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/mental-health-and-wellbeing/hse-social-prescribing-framework.pdf
[6] https://www.hse.ie/eng/about/who/cspd/icp/chronic-disease/documents/national-framework-integrated-care.pdf

413, and 418) collaborated to develop standard operating procedures, devise a communications strategy, and design a research project to evaluate participant outcomes.

"Living Well" is a generic Chronic Disease Self-Management Programme, which provides a structured format for people with chronic conditions to develop the core self-management skills required to live a healthy life with their condition(s). Participant efficacy is enhanced via the peer-led model.

Learn more about this project by clicking on the following link to view the SIF webinar which featured this project: **Sláintecare Right Care Right Place Right Time Webinar.**

> "It really helped me to get the help that I needed, I lost all hope, didn't know where to turn, I didn't know how, it made me think so I have made a new start which was the best thing I did all year, and I am very grateful to The living well programme."
>
> **— Participant**

Evaluation is embedded into the delivery of the Living Well programme at CHO level, supported by an independent research approach to assess the effectiveness of the online delivery model of the programme.

The summary of key findings from the final evaluation are:

1. The present high rate of completion of the online programme (92%) compares favourably with the average reported internationally for in-person programmes (75%).
2. 94% of participants were satisfied with the *Living Well Programme*.
3. In contrast to public health messaging to continue to attend healthcare appointments, one in three reported avoiding seeking GP or medical care when they should have due to fear of contracting COVID-19 at pre-Living Well. Notably however, there was a statistically significant decrease in avoidance of seeking GP or medical care due to fear of COVID-19 from pre-Living Well to 6 months post-Living Well completion.
4. There was a statistically significant decrease in GP attendance from pre-Living Well to 6 months post-Living Well completion. This finding likely indicates a positive effect of the programme to develop the practical skills and confidence of participants so they can manage their health condition better and have fewer requirements for medical appointments, which is consistent with evidence from in-person CDSMP delivered during routine care in Ireland (Hevey et al. 2020). However, it is difficult to ascertain the degree of the effect of programme on healthcare use as many participants noted they avoided healthcare appointments, particularly in the earlier stages of programme implementation, due to fear of COVID-19. This was in contrast to public health messaging at the time which encouraged people to attend their GP or A&E if they needed to do so. However, as noted above, there was a statistically significant decrease in avoidance of seeking GP or medical care due to fear of COVID-19 from pre-Living Well to 6 months post-Living Well completion.
5. There was a statistically significant increase in overall Quality of Life (QoL) from pre-Living Well to post- Living Well, and from pre-Living Well to 6 months post-Living Well completion.
6. Overall health related quality of life (HRQOL) statistically significantly increased from pre-Living Well to post-Living Well.
7. There was a statistically significant decrease in both levels of depression symptoms and depression case-ness from pre-Living Well to post- Living Well, and from pre-Living Well to 6 months post-Living Well completion.
8. There was a statistically significant increase in self-efficacy for managing health from pre- Living Well to post-Living Well, and from pre-Living Well to 6 months post-Living Well completion.
9. There was a statistically significant increase in self-efficacy to do an online programme to support health from pre-Living Well to post- Living Well, and from pre-Living Well to 6 months post-Living Well completion.
10. There was a statistically significant decrease in the extent to which illness interfered in overall activities, in social activities, hobbies and work (where relevant) from pre-Living Well to post-Living Well, and from pre-Living Well to 6 months post Living Well completion.

Profile of selected projects cont.

4.2.3 cont.

11. There was a statistically significant increase in time spent walking from pre-Living Well to post-Living Well.
12. There was a statistically significant increase in overall time spent doing aerobic exercise from pre-Living Well to post-Living Well. There was no statistically significant increase in other exercise activities; however, engagement in such activities was impacted by restricted access to facilities during COVID-19 restrictions and fear of contracting COVID-19 during lockdown.
13. There was a statistically significant increase in participants' perception of support available to manage their health pre-Living Well to post-Living Well, and from pre-Living Well to 6 months post-Living Well completion.

4.2.4 Integrating online STI testing with public STI services Project ID 57

The online/home STI testing project which was piloted in three counties has been expanded and is currently available in 22 counties (listed here **https://www.sexualwellbeing.ie/sexual-health/sexually-transmitted-infections/sti-testing/home-sti-testing-pilot/**). Plans for a wider National Service are in progress.

4.2.5 Physical Activity Pathways in Healthcare Framework

In 2022, a co-ordinated and cross-disciplinary plan is to commence, as per the 2021 HSE NSP, to work towards building a Physical Activity Pathways in Healthcare Framework, supported by the Department of Health, the National Physical Activity Plan Implementation Group, the HSE and Sport Ireland. Six SIF physical activity projects (IDs 21, 56, 135, 140, 220 and 233) have been identified as good examples of the types of intervention that the Local Sports Partnerships or the HSE will be looking to implement for people living with a variety of chronic conditions. These projects will continue to be supported and assessed for scaling potential within the *Physical Activity Pathways in Healthcare Framework*, once operational.

Learn more about this project by clicking on the following links to view the SIF webinar which featured these projects: **Right Care Right Place Right Time** and **Collaborative Working for Innovation & Change**

> "I am finding the chair yoga very beneficial, especially the leg exercises. I am finding the variety of exercises during the program very good, and I noticed my walking with rollator has improved with just the few sessions I have participated in."
>
> **— Participant**

4.3 Scale and share examples of best practice and processes for chronic disease management and care of older people.

Projects selected under this criterion sought to enhance community care to ensure people get the right care, in the right place at the right time through the delivery of integrated care for people with chronic disease (heart failure, diabetes, asthma & COPD) and older persons. Nurses and Health & Social Care Professionals are leading many of these community-based specialist services. The aim of the integrated care programme for chronic disease is to provide

end-to-end care for people with chronic diseases in the community and do this by:

- Supporting patients themselves with education & skills training for self-management.
- Supporting GPs with easy access to specialist services brought from the hospital to the community.
- Linking with local hospital Consultants and providing diagnostic services in the community.

The aim of the integrated care programme for older persons is to provide care to older people by offering integrated care to older people in the community as an alternative to ED attendance or hospital admission, as much as possible. Nurses and Health & Social Care Professionals are leading many of these community-based specialist services.

A snapshot of the key outcomes of a selection of projects below clearly identifies how these innovative ways of working contributed to increased number of GPs accessing these community-based specialist services, reduction in hospital readmissions, reduced waiting times for community-based pulmonary rehabilitation, spirometry assessments, cardiac diagnostic services, and group education and exercise sessions. 38 of the SIF projects, which were testing integrated care pathways for people with chronic diseases and older people, were mainstreamed and will receive recurring annual funding from the HSE through Enhanced Community Care funding allocated to the HSE in Budget 2021.

Learn more about these projects by clicking on the following links to view the SIF webinars which featured these projects:

- Enhanced Community Care **https://youtu.be/jEUTLNzoNMg**
- Improving Access to Care **https://youtu.be/qFP5Pd17LFg**

4.3.1 Donegal Heart Failure Integrated Care Service Project ID 129A

The aim of this project was to enable the establishment of a Heart Failure Integrated Care Service in County Donegal to provide structured care and management for individuals living with Heart Failure.

Approximately 3,200 people in Donegal (2% of the population) have a diagnosis of Heart Failure (HF) with a further 3,200 people having asymptomatic left ventricular dysfunction whereby the left side of the heart must work harder to pump the same amount of blood. HF is one of the most common reasons for hospital admission of the elderly, often requiring a prolonged stay. Each year 200-250 primary HF admissions account for between 2000 and 2500 bed days in Letterkenny Hospital. The availability of Heart Failure Integrated care clinics in the community setting enabled early diagnosis and treatment and improved health outcomes for people with HF. This was achieved through Specialist Nurse led clinics, early access to Cardiac Diagnostic Services in Primary Care, and Consultant and GP led management between Primary and Secondary Care. Increased access to HF services aims to ensure a reduction in length of hospital stay for patients and reduced need for multiple hospital visits.

A number of output targets had been set at the start of the project. **These include:**

- **HF clinics to be delivered in GP practices**, which was achieved with a change of delivery system due to COVID-19.

Profile of selected projects cont.

4.3.1 cont.

- 400 diagnostic tests to be carried out, of this, **259 echocardiographs were completed** due to a delay in recruitment, however the numbers of patients accessing the service is projected to increase.
- A target of 35 patients was also set for the number of patients to receive specialist nurse input and over the course of the project 198 patients received input, including **64 hospital discharges followed up, 39 new outpatients and 95 patients taken off the Hospital Heart Failure recall waiting list.**
- A key outcome of this project was to reduce readmission rates for the year by 1% leading to a reduction of 182 bed days, over the course of the project, a reduction of **272 bed days** was reported**.**

Additional benefits have also been reported by the projects that had not been specifically set out as targets at the beginning of the project: **Waiting times for new patient referral for the heart failure service have reduced from 18 months to two-six weeks**, depending on clinical urgency and patient location. The number waiting for new assessment at the end of the project period was five, with all but one having an appointment date within weeks. This figure had been 22 patients in December 2020 with patients waiting up to 18 months.

Patients overwhelmingly report satisfaction with the new service in particular those attending the new 'spoke' locations which are much closer to their homes, citing reduced travel costs, increased parking availability and reduced need for self/family to take time off work as main areas of benefit. For many, it was their first specialist nurse and echo review in three or four years, and all reported it was greatly welcome.

4.3.2 Integrated care for Type 2 Diabetes in the Community Project ID 153

This project proposed an end-to-end implementation of the model of integrated care for Type 2 Diabetes in two community health networks in Community Healthcare West (CHO 2) and in Cork Kerry Community Healthcare (CHO 4). The project is led by the HSE, Chronic Disease Commissioning Team, Primary Care Strategy and Planning.

The total number of people living with diabetes in Ireland is growing year on year and the majority have Type 2 Diabetes. Most can have their care in general practice, with access to community-based diabetes specialist supports. The two targeted networks were resourced with a Diabetes Clinical Nurse Specialist (CNS), Senior Diabetes Dietitian and Senior Diabetes Podiatrist who maintain close links with the hospital-based specialist team. All GP Practices within these networks can access these specialised integrated diabetes care services **which traditionally would only have been available in a hospital setting.** As with other projects that had planned for face-to-face delivery, this project was impacted by the restrictions in place due to the COVID-19 pandemic and the team had to adapt and respond. The decision was made to deliver some CNS clinics from Primary Care Centres instead of in GP practices, and structured diabetes education sessions were changed to virtual delivery. Even in this difficult operating environment, as projects had to adapt to changing ways of working, this project exceeded 14 of its 18 output targets and achieved all three of its outcome targets.

The outputs of this project include, amongst others: a total of

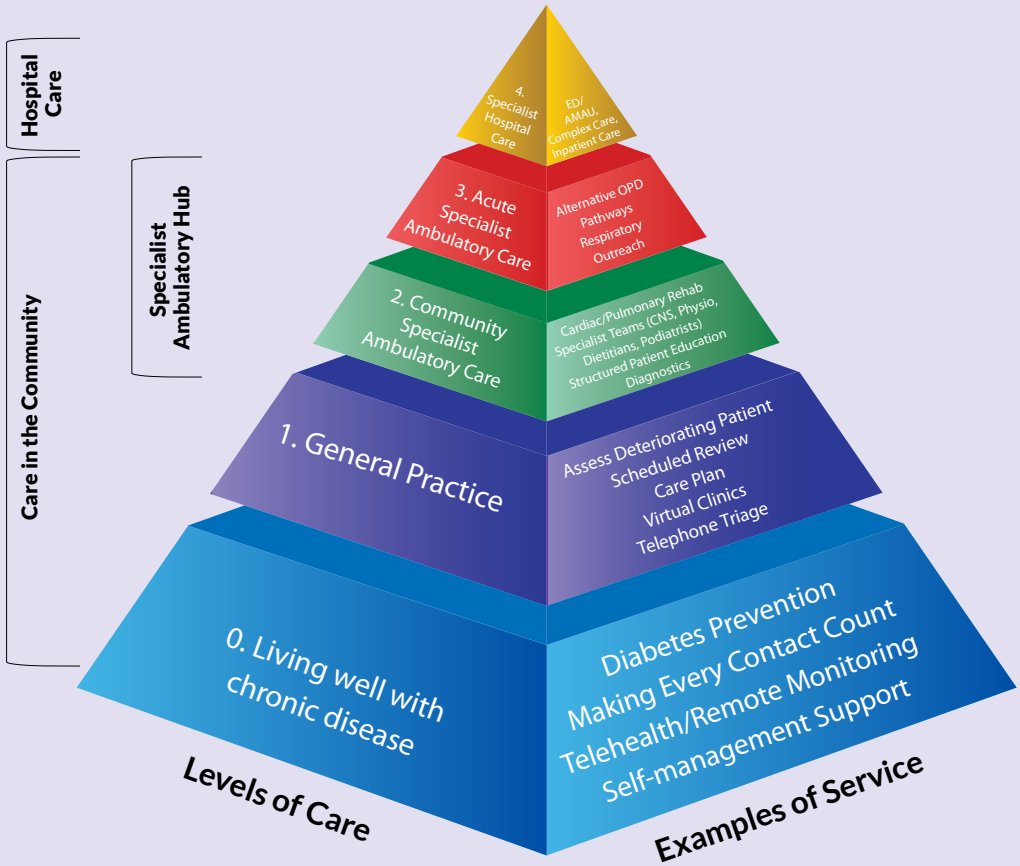
- **195 new patients seen** either in-clinic or as a virtual consultation in both networks combined, which is 52% over the target,
- **48 Group education sessions conducted** in both networks, exceeding the target by 40 sessions due to virtual delivery; and
- **503 new or return patients seen on a 1:1 basis** either in-clinic or as a virtual/telephone consultation, almost doubling the target of 256.

Outcomes for the project include:

- Increased number of GPs accessing the CNS Diabetes Integrated Care Service, this was achieved for CHO 2, doubling the figure from five to ten, while the figures remained unchanged for CHO4 due to recruitment issues.

The project also reports how the needs of patients have been met in a number of ways. For instance, there is now **less travel time required to attend podiatry services**. Previously patients had to attend Hospital in Galway City, travelling up to one hour for their appointments, and this was hampered by poor rural public transport services. They quote research evidencing an association between risk of amputation and distance from the diabetes centre and they hope that locally delivered services will reduce the risk of lower limb complications. Also highlighted is the fact that people identified at high risk of diabetes (pre-diabetes) **now have access to behavioural change and lifestyle support** provided by the dietitian. An additional benefit of a dedicated diabetes service is that patients are seeing the same podiatrist and the same dietitian at each review facilitating care continuity and individualised care planning.

Chronic Disease Integrated Service Model



Profile of selected projects cont.

4.3.3 End to End Implementation of the Model of Integrated Care for COPD & Asthma Project ID 159

This project delivered flexible, coordinated services for COPD patients in the community, reducing demand on hospital services and is delivered in CHO 8 CHN Longford & Central Westmeath and CHO 6 CHN North-East Wicklow. The project lead organisation is St Michael's Hospital Dun Laoghaire.

Improved access to diagnostic facilities in the community allows for the timely, accurate diagnosis of respiratory conditions and earlier instigation of appropriate management plans. The service will improve health outcomes and reduce acute service demand by enhancing patients' knowledge of their disease, the treatment and management options available to reduce/prevent exacerbations, and by increasing confidence in their own self-management capabilities. It provides access to a specialist service nearer patients' homes (in GP practices or primary care centres), thus reducing time and travel demands for patients and their carers. Local pulmonary rehabilitation programmes will empower patients, improve their physiological and psychological health, and promote adherence to health-enhancing behaviours.

- This project sought to have eight GP practices referring to the service each month and this target was exceeded with an average of ten per month. There was, up to the end of June 2021 **15 different GP practices referring to the new services.**
- A number of exercise and education group sessions were run per month, with **23 Pulmonary Rehabilitation classes being conducted, almost three times the target of eight classes.**
- Yearly targets for the number of new patients to be seen by the CNS were projected to be almost met (120 projected, 122 targeted) based on figures from April to June 2021.

Two outcome targets were also set by the project with both being exceeded.

- A target of 168 patients to access Pulmonary Rehabilitation had been set with **337 patients availing of the PR service across both CHO areas.**
- A second target was set for 112 Spirometry assessments per quarter with **120 patients being seen in Q2, a 7% increase on the target figure.**

> "I really enjoyed the education sessions, everything was explained so clearly. The programme has helped with my breathing… The whole programme was great, never done anything like it."
>
> **— Participant**

The project involved the recruitment of two senior physiotherapists specifically for PR in Longford/Westmeath. They inherited a waiting list of 173 patients, **within six months they had significantly reduced the waiting list by 46%** to 102 patients. Already the project is improving access and availability of PR from 21% availability to 64% availability to the respiratory patients in Longford/Westmeath. In Northeast Wicklow, respiratory patients previously had to travel to St. Michael's Dun Laoghaire to avail of PR, provision of PR in Northeast Wicklow **again improves access to the service for the respiratory population from 26% availability prior to the project to 37% availability** since project implementation.

4.4 Recognition of SIF funded projects

SIF funded projects and organisations achieved significant recognition through feedback from patient surveys, external evaluations, publications, and awards.

Further details are available in Appendix 3.

05

Challenges and learnings

This section of the report looks at challenges that arose over the course of the programme, in particular challenges faced by projects as they implemented their projects, and the learnings they reported.

5.1 Challenges

As part of their progress reporting, projects were asked to detail the challenges they faced over the course of the programme, **the most common challenges reported are as follows:**

5.1.1 External Factors

As SIF is a programme largely operating in the front-line healthcare environment, two external issues, the COVID-19 pandemic and the cyberattack on the HSE, impacted how and when projects were rolled out and their successes and shortcomings. As SIF funded projects are diverse in the type of work being carried out, their settings, and resources required, these two issues manifested in a variety of ways depending on the project, similarly the responses to these issues also required tailored solutions.

5.1.2 Recruitment

Almost half (49%) of projects identified recruitment of key project personnel as a challenge to their project delivery. The recruitment and retention of staff was affected by the pause on projects during the on-set of COVID-19; personnel that had been offered a position within the project may not have been available once the pause was removed. A number of projects stated that due to the short duration and the type of contract on offer this reduced the candidate

Challenges and learnings cont.

5.1.2 cont.

pool for positions greatly. Projects addressed some of these recruitment issues by modifying roles or combining two positions into one which delayed the delivery and commencement of certain project actions.

5.1.3 Resources

The second challenge identified by almost half of projects (45%), was resourcing. The move to on-line forums required additional IT infrastructure resources such as laptops, phones, and broadband connectivity for beneficiaries. There were varying issues with procuring PPE in the early stages of the pandemic such as supply chain issues, specialised equipment not being immediately available, and funding issues. The lack of face-to-face engagement required some projects to collate packs for issue to the beneficiaries prior to engagement, this also put more demand on projects' administration resources. In some cases, accommodation sourced pre COVID-19 was no longer fit for purpose as a result of health guidelines and social distancing requirements.

5.1.4 Online service delivery

20% of Projects noted a significant challenge in not being able to engage face-to-face with both stakeholders and beneficiaries. This impacted the timelines of the projects in particular training of stakeholders and identification and engagement of beneficiaries. Projects quickly sought other means of engagement, in particular on-line forums, to deliver key aspects of the projects such as training or rehabilitation classes and in some cases, this may have actually increased the number of patients attending classes.

While the shift to on-line delivery was the solution for many projects, it also introduced further challenges for others. For instance, in traditional face to face appointments patients can be observed more effectively, moving to an on-line forum made some clinical assessments more difficult. Training programmes were re-designed to adapt to an on-line forum which was time consuming. Often patients, in particular the elderly, may not have access to computers or have a high level of IT literacy.

5.2 Learnings

Prior to the COVID-19 pandemic, Sláintecare developed a Learning Network for the 123 projects. The Learning Network enabled projects to share experiences and learnings from their projects, and support each other to address challenges. Two in person Learning Network events took place in 2019 and early 2020, which over 300 project staff attended. The learning network moved online in June 2020 and monthly webinars were held so that projects could continue to share their experiences and learnings during the pandemic. The webinars have proven a huge success, with 15 Webinars held between June 2020 – December 2021 and 7,500 people registered to join the webinars.

The webinars have showcased stories from a variety of projects and services, grouped in themes such as Chronic Disease Management, eHealth, Improving Access to Care, Health and Wellbeing, Enhanced Community Care, among others. These themes align with the fundamental principles of Sláintecare, ensuring that all care is planned and provided so that the patient/service user is paramount.

Access more information on the learnings from the SIF projects on the following links:

- Sláintecare webinars recordings and information: **https://www.gov.ie/en/publication/d19f8-slaintecare-right-care-right-place-right-time-webinars/**
- Sláintecare Learning Network events 2019 and 2020: **https://www.gov.ie/en/publication/ca8a1d-slaintecare-in-action/#january-march-2020**
- Sláintecare Integration Fund projects descriptors publication: **https://www.gov.ie/en/publication/0d2d60-slaintecare-publications/#slaintecare-integration-fund-projects**

In their final report, projects were also asked to detail any lessons learned during project implementation and what changes they would make if they were running the project again. Many of these lessons were project-specific or focused on technical aspects. **However, there are also some common themes across the majority of projects which relate to:**

Stakeholder Engagement

The type of engagement varies, for example seeking input from beneficiaries to co-design surveys, broadening the membership of steering groups, including operational staff or Local Authority representatives, and engaging early with GPs to have an adequate referrals process to projects.

Flexibility

This has resulted largely from social distancing requirements and the number of lockdowns brought on by COVID-19. With the benefit of hindsight, some projects said that they should have included online service delivery as an option from the start of the project without having to resort to it as a response. Flexibility around contracts and grant agreements was also noted and that going forward, outputs and outcomes should be active rather than fixed.

Recruitment:

The need for longer lead in time for recruitment of staff to the projects.

Project Management Competencies

Skills and competencies including requirements definition, managing to deliverables and milestones, budget management and monthly outcome-based reporting, contributed to the development of core project management skills and competencies of project staff, which significantly contributed to the successful delivery of the projects.

06

Financial summary — SIF Allocations and Expenditure

A total of €30,476,829 in grant aid was offered to 126 active SIF projects from September 2019 to January 2022.

This included €2,044,166 offered to 48 projects for extensions to June 2021, €2,885,913 offered to 56 projects for extensions to December 2021, and €160,642 for 3 projects for extensions to June 2022.

The full grant extensions were not taken up by all projects, resulting in a final budget commitment of **€29, 447,826** to the 126 projects from September 2019 to January 2022. The final budget commitment for 123 projects was €28m including the cost of extensions.

Grant allocations for the programme ranged from €51,388 up to €965,120. As of 31st January 2022, €23,874,429 (81%) of the committed grant had been paid out to projects. The total amount of funding paid to projects was lower than the expected 85% as a result of payments not made to projects that underspent against their budget.[7] The final 15% payment to projects is paid retrospectively on receipt of the final financial return and progress report from the projects.

Disbursement — Pobal

Payments will be made by Pobal to grantees, subject to agreements and contracting, as follows:

- 35% on receipt of signed grant agreement.
- 50% on receipt of interim expenditure and milestone report.
- 15% will be paid retrospectively on receipt of the final financial return and non-financial return (progress report).

Alternative payment schedules may be agreed as part of the contracting process.

Each project will have a budget agreed in advance of contracting.

6.1 SIF Expenditure Areas

SIF expenditure was eligible under the following three categories:

- **Direct Salary Costs:** this relates to core posts that are central to the work of the organisation. Eligible costs include salary, employers PRSI, pensions, travel, subsistence, and recruitment.
- **Direct Project Delivery Costs:** this relates to core expenditure directly attributable to delivering the project. Eligible costs include direct patient/client costs, venue/ room hire/meeting costs relating to the activities of the project.
- **Equipment Costs:** additional equipment that must be demonstrated as essential for the delivery of the project. Eligible costs include mobile phone for funded posts, printers, laptops, or medical equipment for activities related directly to the project.

73% of reported expenditure to January 2022 across SIF supported projects was accounted for by direct salaries, 20% by direct costs for project delivery, and 7% by equipment costs.

[7] Projects must have spent at least 50% of the grant paid to them in order to qualify for the next tranche of payment.

07

Conclusion

The programme achieved what it set out to do:

The SIF supported 123 HSE and NGO sector projects, to test and evaluate innovative models of care providing a 'proof of concept' **with a view to mainstreaming/scaling of successful projects through the annual budget estimates process, under the following criteria:**

- Scale and share examples of best practice and processes for chronic disease management and care of older people.
- Promote the engagement and empowerment of citizens in the care of their own health.
- Encourage innovations in the shift of care to the community or provide hospital avoidance measures.

This has been achieved across the three project selection criteria and there are multiple examples, highlighted in this report, of projects moving care out of acute settings, empowering citizens, with 106 projects mainstreamed into the healthcare system to date.

Impact of the programme is evident through the outcomes and outputs data

Projects reported on the achievements of their projects and in total there were 732 outputs and 560 outcomes resulting from the programme. The impact of SIF on the healthcare system is evident, for example, in the number of hospital admissions avoided and ED attendances avoided or the reduction in waiting lists but the impact is also felt by patients and their families where waiting times have improved or journey times to receive treatment have been reduced.

Programme was resilient and flexible in the context of COVID-19 and other challenges

The SIF programme has proven to be both resilient and flexible. The challenges faced by healthcare staff over the course of the programme have been immense and they have responded by developing new ways of working and adapting their model of care to include online and virtual options of service delivery. In many cases this allowed for greater reach for a project.

Learnings derived for the future delivery of similar programmes

Some of the key learnings that projects highlighted were that stakeholders need to be engaged early in the process, there was a need to have a flexible approach to service delivery and additional time is required for the recruitment process.

Projects recognised the benefit of developing project management skills and competencies including managing to deliverables and milestones, budget management and monthly outcome-based reporting which significantly contributed to the successful delivery of the SIF projects.

Appendix 1
All projects current status

Project ID	Project Name	Lead Organisation	Current Status	Summary on page
2	Sustain and expand TRY	Donore (Community Drugs Team) Company Limited by Guarantee	Mainstreamed	109
8	HSE - Child Digital Health	HSE	Mainstreamed	177
9	HSE - Digital information, signposting, and support for people with chronic conditions	HSE Communications	Mainstreamed	178
15	Dublin 8 Social Prescribing Project	Fatima Groups United Company Limited by Guarantee	Mainstreamed	146
18	Sheds for Life	Irish Men's Sheds Association Company Limited by Guarantee	Extended to Facilitate Completion of review (Delay due to COVID-19)	165
21	Primetime for Older Adults	Laois Sports Partnership Company Limited by Guarantee	Mainstreamed	155, 156
23	Community Living Mental Health Recovery Co-Ordinator	HAIL Housing Association for Integrated Living	Mainstreamed	149
24	Linkworkers to support the coordination of health and social care for patients living in disadvantaged communities	RCSI Department of General Practice	Closed	148
29	Introduction of Molecular Laboratory in Microbiology	Mercy University Hospital Cork Company Limited by Guarantee	Mainstreamed	57
31	Expansion of Social Prescribing service in Waterford and mainstreaming of pilot service in Waterford Metropolitan area	Sacred Heart Community and Childcare Project Company Limited by Guarantee	Mainstreamed	179
38	Consolidating the Implementation of the Stanford Chronic Disease Self-Management Programme in CHO Dublin North City & County	HSE CHO Dublin North City & County (CHO 9)	Mainstreamed	142-144
40	Student Sexual Health Service (Athlone Institute of Technology)	Athlone Institute of Technology	Mainstreamed	110
41	Develop a Respiratory Integrated Care Programme for COPD in CHO/ DNCC Beaumont Hospital (Level 4)	CHO 9	Mainstreamed	97

Project ID	Project Name	Lead Organisation	Current Status	Summary on page
48	LGBT Champions Programme	LGBT Support and Advocacy Network Ireland Company Limited by Guarantee	Mainstreamed	180
56	Arthritis Rehabilitation through the Management of Exercise and Diet (ARMED)	Our Lady's Hospital Navan	Mainstreamed	157
57	Integrating online STI testing with public STI services: A pilot to assess feasibility and impact	HSE Sexual Health & Crisis Pregnancy Programme	Mainstreamed	59
61	Towards Selfcare in Headache	Clinical Design & Innovation – Health Service Executive Clinical	Mainstreamed	111
73	Individual Placement and Support Adult Community mental health teams	CHO DNCC (CHO 9) Office of the Head of Service Mental Health	Mainstreamed	150
78	Delivery of the Stanford Chronic Disease Self-Management across SECH	HSE Southeast Community Healthcare (SECH)(CHO5)	Mainstreamed	142-144
79	Implementation of Integrated Eye Care	Community Healthcare Dublin South, Kildare & West Wicklow (CHO7)	Mainstreamed	61
84	North Dublin Integrated Community STI Service	Mater Misericordiae University Hospital	Mainstreamed	60
94	Trauma Assessment Clinic	Royal College of Surgeons in Ireland	Mainstreamed	119
98	Patient Self-Management of Chronic Disease	The Irish College of General Practitioners Company Limited by Guarantee	Closed	181
100	Beating Breathlessness Asthma Society	Asthma Society of Ireland	Mainstreamed	182
105	Community based Pulmonary Rehab Programme	CHO 6	Mainstreamed	131
111	Telemedicine for CF	Saolta University Healthcare Group Galway University Hospital	Mainstreamed	193

Appendix 1 cont.

Project ID	Project Name	Lead Organisation	Current Status	Summary on page
115	Changing Gears	Age & Opportunity	Mainstreamed	152, 153
121	My Slainte Community Lifestyle Programme	Croí -The West of Ireland Cardiac and Stroke Foundation Company	Closed	132, 133
123	Online Citizen Health Guides	HSE	Closed	183
132	Establishment of Oxygen assessment clinics in Primary Care Donegal	CHO 1	Mainstreamed	201
133	Development of a Respiratory Team for Co Monaghan	CHO 1	Mainstreamed	194
134	Jigsaw Online	National Centre for Youth Mental Health Company Limited by Gua	Extended to Facilitate Completion of review (Delay due to COVID-19)	65
135	Promoting physical activity programmes for people with neurological conditions in the community	The Multiple Sclerosis Society of Ireland	Mainstreamed	158
137	SMILE Supporting Multimorbidity selfcare	Carlow Emergency Doctors-On-Call Limited by Guarantee	Mainstreamed	89
140	WellComm Active Well Communities Connect Project 2	Cork Local Sports Partnership Company Limited By Guarantee	Mainstreamed	159, 160
153	End to end implementation of the Model of Integrated Care for Type 2 diabetes within 2 CHOs	Chronic Disease Commissioning Team, Primary Care Strategy and Planning	Mainstreamed	112
154	Development and Implementation of a Digitally Enhanced HSE Type 2 Diabetes Self-Management Education Programme	Chronic Disease Commissioning Team, Primary Care Strategy and Planning	Mainstreamed	134
155	National Self-Management Education IT System Implementation and Expansion	Chronic Disease Commissioning Team, Primary Care Strategy and Planning	Mainstreamed	184

Project ID	Project Name	Lead Organisation	Current Status	Summary on page
156	Development and Implementation of a National Diabetes Prevention Self-Management Education Programme by 2021	Chronic Disease Commissioning Team, Primary Care Strategy and Planning	Mainstreamed	135
159	End to End Respiratory Model at 2 Sites	St Michael's Hospital Dun Laoghaire	Mainstreamed	113, 114
161	Assistive Technology Mobile Community Service	Central Remedial Clinic	Closed	69
162	Adult Social Prescribing for Individual Resilience and Empowerment	Bray Area Partnership Company Limited By Guarantee	Mainstreamed	120
164	COPD Integrated Care Project	University Hospital Waterford	Mainstreamed	98
165	Integrated Ambulatory Care Heart Failure Project	University Hospital Waterford	Mainstreamed	70
167	Waterford Thriveabetes Project	University Hospital Waterford & CHO 5	Mainstreamed	195
169	Individual Placement and Support	Mid-West Community Healthcare	Mainstreamed	151
171	My Home MHCIS	HSE Community Healthcare West Mental Health	Mainstreamed	107
173	Integrated Care for Older People Model for falls prevention and management	CHO 1 & Sligo University Hospital	Mainstreamed	90
175	Expansion of the Model of Diabetes Integrated Care throughout Sligo Leitrim West Cavan	CHO 1	Mainstreamed	115
177	Selective Laser Trabeculoplasty for Community Ophthalmic Service Donegal	CHO 1 Community Health Organisation Area 1	Mainstreamed	62
180	Turn2me 360 Online Stepped Care Mental Health Pilot for Young People and Their Families	Turn2Me Company Limited by Guarantee	Extended to Facilitate Completion of review (Delay due to COVID-19)	66, 67

Appendix 1 cont.

Project ID	Project Name	Lead Organisation	Current Status	Summary on page
181	Inclusion Health Specialist Outreach Team	St James Hospital	Mainstreamed	136
183	Post Diagnostic Support worker for people with dementia Inishowen	CHO 1 Older Persons Services	Mainstreamed	166
184	Improving Access to Healthcare: Spread and Scale-up of a HSE Health Passport for individuals with an Intellectual Disability in acute hospital and primary care settings	HSE CHO 1	Mainstreamed	76
185	Extension of Stanford Chronic Disease self-mgt to all of CHO 1	HSE Community Healthcare Organisation Area 1	Mainstreamed	142-144
186	Donegal Primary Care Optometrist	CHO 1	Mainstreamed	63
190	Integrated Foot Protection Service for residents of Community Healthcare East	CHO 6	Mainstreamed	77
199	Initiate Specialist Medical Retina services and intravitreal injections in Community Ophthalmics Service, Co Donegal	CHO 1, Primary Care Division Donegal	Mainstreamed	64
202	Supporting Pregnant Women to Quit and Stay Quit - A Codesign Community Based Integrated Approach	South East Community Healthcare (HSE CHO 5)	Mainstreamed	174
203	Urology Pathway- Proof of Concept Project	Saolta University Healthcare Group University Hospital Galway	Mainstreamed	81
205	Western Alzheimer's Befriending Service	West of Ireland Alzheimer Foundation	Mainstreamed	167
216	Development of the physiotherapy led Pulmonary Rehab services in primary care Co Mayo	Mayo University Hospital/Primary Care	Mainstreamed	58
219	Stanford Chronic Disease Self-Management Programme in CHO 2	HSE Community Healthcare West (CHO2)	Mainstreamed	142-144

Project ID	Project Name	Lead Organisation	Current Status	Summary on page
220	Implement a structured exercise programme for people with Diabetes	Community Healthcare West Physiotherapy Department	Mainstreamed	161
221	Integrated Population based Falls Model for Mayo	CHO 2 & Mayo University Hospital	Mainstreamed	168
222	Osteoarthritis Knee Pathway	CH02 Community Healthcare West	Closed	83
223	Smoke Free Start	HSE National	Mainstreamed	175
233	The Exercise Effect - Integrating Exercise Practitioners into the Irish Mental Health Service	Sports Active Wexford	Mainstreamed	162, 163
237	Heart Failure Virtual Consultation Service with clinical nurse specialist support in the community	St Vincent's University Hospital - Ireland East Hospital Group	Mainstreamed	91
247	CIT Dublin North City and County Community Oncology Service	HSE CHO Dublin North City and County (CHO 9)	Mainstreamed	121
248	Development of Community based Integrated Diagnostic and Care Initiative Cardiology	Beaumont Hospital	Mainstreamed	71
251	Developing a Pathway of Community Care Supports for People with Epilepsy in Ireland	Epilepsy Ireland (Brainwave The Irish Epilepsy Association)	Closed	137
252	HealthEIR: A Journey to Improving Health and Wellbeing Through Community-Based Social Self-Care	Royal College of Surgeons in Ireland	Mainstreamed	185
253	Cork Kerry Health & Wellbeing Community Referral	National Forum of Family Resource Centres Company Limited By Guarantee	Mainstreamed	122
255	Urgent Ambulatory Care and Virtual Ward for the Older Person	CHO 4	Mainstreamed	92
263	AgeWell Programme	Third Age Foundation Company Limited By Guarantee	Mainstreamed	169, 170

Appendix 1 cont.

Project ID	Project Name	Lead Organisation	Current Status	Summary on page
267	Rehabilitative Palliative Care	Mater Misericordiae University Hospital	Mainstreamed	203
269	Mullingar Frailty Intervention Team (MFIT)	CHO 8 & Ireland East Hospital Group	Mainstreamed	197
278	Facilitating Integration of Childhood Obesity Services in Primary Care Through Education	Royal College of Surgeons in Ireland	Extended to Facilitate Completion of review (Delay due to COVID-19)	204
280	Skin Cancer Prevention	National Cancer Control Programme	Mainstreamed	186, 187
284	Social Prescribing for improved Health and Wellbeing	CHO 1	Mainstreamed	147
286	Integrated psychological care for the older adult in Longford Westmeath	Midlands Louth Meath CHO	Mainstreamed	68
287	Empowering Communities to support language Development in young children	Midlands Louth Meath CHO	Mainstreamed	123
305	Community Based Integrated Respiratory Service	CHO 8	Mainstreamed	138
308	HealthSENSE app	UCD & Smartlab CLG	Closed	191
311	Integrated Pulmonary Outreach in South Tipperary	South Tipperary General Hospital & CHO 5	Mainstreamed	99
320	Promoting cultural sensitivity in community mental health services in Ireland	Mental Health Reform	Closed	188
322	Inclusion Health Primary Care: Demonstration of an Integrated Care approach into a scalable model	CHO 7 HSE Homeless Health Link Team	Mainstreamed	93
323	Mobile Telemedicine for Rapid GP Access to Specialist Opinion: A “Virtual” elective orthopaedic clinic	University Hospital Waterford	Closed	84

Project ID	Project Name	Lead Organisation	Current Status	Summary on page
324	The Establishment of Novel Clinical Pathways for Orthopaedic Outpatient Referrals, integration of local community services and multidisciplinary triage	University Hospital Waterford	Mainstreamed	85
328	Therapy Led Primary Care Hand Therapy Clinic	Our Lady's Hospital Navan Child & Family Centre	Mainstreamed	86
334	Stool Bank Ireland	RCSI	Closed	139, 140
338	Prevention is better than cure - Community Mothers Programme	National College of Ireland	Mainstreamed	189
343	A Podiatry led pathway for timely provision of footwear and orthotics in the community	CHO 3	Mainstreamed	78, 79
352	StrokeLINK Innovating Stroke Support	Mater Misericordiae University Hospital	Mainstreamed	102
364	Integrated Respiratory Rapid Response Team	Naas General Hospital/CHO 7	Mainstreamed	100
366	Keeping people with severe epilepsy independent	St James Hospital	Mainstreamed	124
370	The LAMP Project - Social Prescribing Integration in the Acute Care Sector	St James Hospital	Mainstreamed	125
371	A pathway to empower patients to engage with antimicrobial stewardship	St James Hospital	Closed	190
375	Integrated care for patients presenting with leg ulcers in Dublin South, Kildare, and West Wicklow	Adelaide and Meath Hospital, Including the National Children's	Mainstreamed	126
376	ANP for development of male LUTs and benign urology	Adelaide and Meath Hospital, Including the National Children's	Mainstreamed	82
377	Heart Failure Service Integrated Care Project	Tallaght University Hospital	Mainstreamed	72
378	Integrated Community Chest pain clinic TUH	Adelaide and Meath Hospital, Including the National Children's	Mainstreamed	116

Appendix 1 cont.

Project ID	Project Name	Lead Organisation	Current Status	Summary on page
382	Frailty Programme	CHO 5 & Wexford General Hospital	Mainstreamed	198
383	Development of Respiratory Services for Chronic Obstructive Pulmonary Disease (COPD) patients in Co. Wexford	Wexford General Hospital	Mainstreamed	141
388	Wicklow Frailty First Response Team	St Vincent's University Hospital (partners include NAS, St Colmcille's & UCD)	Mainstreamed	94
392	Beaumont Hospital/National Ambulance Alternative Care Pathways Project	Beaumont Hospital Board	Mainstreamed	95
407	Smart triage of kidney and lung transplant patients	Beaumont Hospital Board	Mainstreamed	127
413	Stanford Chronic Disease Self-Management Programme in Community Healthcare East	HSE Community Healthcare East	Mainstreamed	142-144
416	Heart Failure Improving Patient Outcomes and Health Service Efficiency by Comprehensive and Innovative Integration of Care Across the Continuum of Healthcare Settings	Portiuncula University Hospital/ Primary Care Galway & CHO 2	Mainstreamed	128
418	The roll out Chronic Disease Self-Management Programme	Midlands Louth Meath CHO	Mainstreamed	142-144
427	Advanced Nurse Practitioner in Tissue Viability	Midland Regional Hospital Tullamore	Mainstreamed	80
430	Cardiology Advance Nurse Practitioner Heart Failure	Midland Regional Hospital Portlaoise	Mainstreamed	73
435	COPD Outreach Service	Midland Regional Hospital Portlaoise	Mainstreamed	101
463	Pain management education programme	Sligo University Hospital, Saolta University Healthcare Group	Mainstreamed	87
468	Electronic ordering for GP lab tests	Saolta University Healthcare Group	Closed	117

Project ID	Project Name	Lead Organisation	Current Status	Summary on page
469	Galway University Hospital Community Cardiac Diagnostics	Galway University Hospital	Mainstreamed	74
129 A	Donegal Heart Failure Integrated Care Service	Letterkenny University Hospital	Mainstreamed	103
129 B	Sligo/Leitrim/W. Cavan/Sth. Donegal/Roscommon Heart Failure Integrated Care Service	Letterkenny University Hospital	Mainstreamed	75
277 A	ALONE BConnect; linking healthcare, social care and community care together using technology and services	ALONE	Mainstreamed	199
277 B	Service Co-ordination for Older People	ALONE	Mainstreamed	171, 172
340 A	Accelerating Integrated Care for Older Persons	HSE ICPOP	Mainstreamed	104, 105
340 B	Accelerating Integrated Care for Older Persons	HSE ICPOP	Mainstreamed	106

Appendix 2
Summaries of individual projects

Increased access to care, reduction in waiting times for patients

29 SIF funded projects; across a range of specializations including Urology, Ophthalmology, Social inclusion, Diabetes Care, Mental Health, Heart Failure and Orthopaedics; had a primary high-level outcome to reduce waiting times and/or increase access to care. The average operational period of the various services at the time of this report is 13.5 months. To date **26,091** patients have been treated, **4,823** additional beneficiaries (health professionals trained, families supported etc.) supported, **61,521** tests have been delivered, various wait times have been reduced by up to 6.5 years and various waiting lists have been reduced by **7,856**.

Project 29

Introduction of Molecular Laboratory in Microbiology

Reduction in waiting time for test results for enteric diseases and respiratory infections, including COVID-19

Who is delivering this project?	Where?	Operational Period:
Mercy University Hospital (MUH)	Mercy University Hospital, Cork	16 months

What is this project about?

A molecular system allows for the rapid, cost-effective identification of pathogens responsible for enteric diseases and respiratory infections. The new Molecular Testing Platform leads to quicker testing turnaround times. The introduction of this technology is of particular benefit to patients of Irritable Bowel Disorder and Chronic Obstructive Pulmonary Disease. Results within hours aids in the differentiation between microbiological disease and sudden intensifications of symptoms associated with these chronic conditions and allow rapid, appropriate interventions.

Target Population:

The target groups for this project are Gastrointestinal Patient Cohorts (MUH is a Gastro Tertiary Centre), Paediatric patient cohorts (infectious viral gastro), elderly patients (e.g. C.difficile) and respiratory patients (e.g. SARS-COV2 RNA detection). The technology is delivered in Mercy University Hospital, Cork.

Project outputs & outcomes:

- 52,340 samples were tested, far in excess of the 7,100 target.
- 97% (49,195) of all respiratory tests were reporting within 24 hours, compared with an 80% test target.
- 89% (1,407) of enteric tests were resulting within one-routine day, compared with an 80% test target.
- 2-day reduction to 1 day in wait time for results of enteric tests. Target was 2.
- 5-day reduction to 1 day in wait time for results of respiratory tests, which exceeded the target of 2.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 216

Development of the physiotherapy led Pulmonary Rehab services in primary care Co Mayo

Reduced Waiting Times for Access to Pulmonary Rehabilitation Programmes

Who is delivering this project?	Where?	Operational Period:
Community Healthcare West (CHO 2)	Mayo	7 months

What is this project about?

This project focused on the development of the physiotherapy led Pulmonary Rehabilitation services in primary care in Co. Mayo. It improved access to Pulmonary Rehabilitation (PR) at locations more accessible for patients in primary care. As part of the holistic management of patients within the Respiratory Integrated Care (RIC) service, those that are suitable are referred to a primary care-based PR programme led by the RIC Senior Physiotherapist.

Target Population:

The target group for this project are all participants assessed and enrolled in the PR programme who have a chronic lung condition.

Project outputs & outcomes:

- Project provided 4 virtual telehealth supported PR programmes to 32 participants across County Mayo; delivered by 2 Physiotherapists.
- Pre assessments were offered to 50 patients with 32 enrolled in the programmes.
- Waiting time for a PR programme reduced from 3.5 years to 1.5 years.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 57

Integrating online STI testing with public STI services: A pilot to assess feasibility and impact.

More Comprehensive Sexual Health Information and Service Options Provided Together with Improved Access to STI Testing and Reduced Waiting Times

Who is delivering this project?	Where?	Operational Period:
HSE Sexual Health & Crisis Pregnancy Programme	Online service, to be piloted in Dublin, Cork and Kerry	12 months

What is this project about?

This project provides an online service to those with less complex sexual health needs thus reducing waiting times, and more appropriately using available public STI clinic staff resources. The project improves service user access to STI testing and treatment in the pilot project areas. It also promotes self-management of service users through online access to comprehensive sexual health information, signposting to services and remote clinical support. An online STI testing service in Ireland allows asymptomatic individuals to order STI testing kits via an online platform, allowing them to test for STIs at home. The integration of the online STI testing service with established public STI clinics, allows for individuals testing positive to be fast-tracked into clinics for treatment, ensuring a seamless individual experience.

Target Population:

The target group for this project are the sexually active population, especially those at higher risk of negative sexual health outcomes.

Project outputs & outcomes:

- 13,749 tests were delivered. Target was 8,000.
- 9,181 test kits were returned, 734 (8%) reactive results confirmed.
- Project achieved a 79% (11 days) decrease in waiting times for test results. Target was 79%.
- 97% (8,924) of patients received their test results within 72 hours (previous waiting time for test results was 2 weeks). Target was 95% (8,722).

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 84

North Dublin Integrated Community STI Service

Improved Sexual Health and Wellbeing thanks to Community Based Service

Who is delivering this project?	Where?	Operational Period:
Mater Misericordiae University Hospital, UCD School of Medicine, Summerhill Primary Care Centre, Grangegorman Primary Care Centre	North Inner City Dublin	16.5 months

What is this project about?

This project established, delivered and evaluates a community based, consultant-led Sexual Health and Wellbeing Service in Dublin's North Inner City. The project is a partnership between the Mater Misericordiae University Hospital and the UCD School of Medicine. The Summer Grange clinic is moving sexual testing and treatment out of the hospital setting and into the community. The clinic has opened free sexual health testing and treatment clinics in two primary care centres based in north inner-city Dublin. More complex cases will still be referred to the Mater hospital clinic. The sexual health service includes:

- Walk-in clinic at each PCC one day a week as well as GP referral appointment slots.
- Education and prevention service offered at each patient visit.
- Urgent referral service to Mater STI clinic for community patients.

Target Population:

The target is a very diverse population of service users in terms of age, background and general health/wellbeing.

Project outputs & outcomes:

- Urgent referrals to Mater STI clinic for community patients were seen within 24 hours. Previous wait time was 72 hours.
- 2,752 total patients presented to clinics. Target was 720.
- All service users with confirmed infection receive discussion around partner notification/contact tracing. Many service users opt for self-directed partner notification while provider referrals also completed by Mater Hospital Sexual Health Advisor. Analysis of 1000 service users shows attendance of 116 individuals as a result of partner notification however source of referral not recorded.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 79

Implementation of Integrated Eye Care Team CHO 7 & Royal Victoria Eye & Ear Hospital

Implementation of Integrated Eye Care to Reduce Waiting List by one year

Who is delivering this project?	Where?	Operational Period:
Community Healthcare Dublin South, Kildare and West Wicklow (CHO 7)	Dublin South, Kildare and West Wicklow	11 months

What is this project about?

This project increased capacity to deliver eye care in a patient focused, cost effective manner by establishing one community based, integrated eye care team in CHO 7, to move the service away from an over-reliance on hospital delivered care. Integration of acute and community care services is essential to rebalance access and delivery of high-quality, consistent, efficient, and effective care.

Target Population:

The target group for this project are adult patients with chronic disease and adult patients requiring pre- and post-operative cataract care.

Project outputs & outcomes:

- 1789 patients have been offered treatment, 1547 were for face-to-face clinics and 242 were virtual clinic appointments.
- Waiting times were reduced by 1.5 years (33%) from baseline of 4.5 years. Target was 1 year.
- Hospital OPD waiting list was reduced by 1789 (89%) clients in year 1, who were transferred from the acute hospital settling to primary care.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 177

Selective Laser Trabeculoplasty for Community Ophthalmic Service Donegal

Community Ophthalmic Service for Donegal reducing need for Clinical Visits

Who is delivering this project?	Operational Period:
Community Health Organisation Donegal, Sligo, Leitrim, West Cavan (CHO 1)	17 Months

What is this project about?

Selective laser trabeculoplasty (SLT) is an outpatient procedure performed in a single treatment in the clinic which treats the trabecular meshwork, the internal drainage channel of the eye, to allow for increased drainage and reduction in pressure in the eye. This project developed an SLT service for patients with glaucoma and ocular hypertension in the Donegal Community Ophthalmic Service.

Target Population:

The target group for this project are patients in Donegal, under 60 years old, medical card holders and patients with referrals from opticians.

Project outputs & outcomes:

- 56% (48.3 days) reduction in the waiting times for Donegal patients achieved against a target of 10% (8.6 days).
- 92 patients with glaucoma and ocular hypertension in Donegal have been treated using Selective Laser Trabeculoplasty (SLT) rather than using eye drops or being referred to Sligo University Hospital. Target was 72.
- Reduction of 76 referrals to Sligo University Hospital for SLT against a target of 72.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 186

Donegal Primary Care Optometrist

Improving the quality of life and independence for the population of Donegal with ophthalmic conditions

Who is delivering this project?	Where?	Operational Period:
Community Health Organisation Donegal, Sligo, Leitrim, West Cavan (CHO 1)	Donegal	10 months

What is this project about?

This project improves the quality of life and independence for the population of Donegal with ophthalmic conditions. It transfers children from the Community Medical Ophthalmologist to the Optometrist, thus freeing up their time to see adult patients from both the Acute and Primary setting.

Target Population:

The target group for this project are as follows:

- Children of the service especially those referred from the pre-school and school vision screening service receive a more timely and coordinated Ophthalmic service.
- Adults that were on new and recall waiting lists for Ophthalmic care have timelier access to care provided by Ophthalmologists.
- Adults on the cataract waiting lists are receiving more timely access to surgery as the nurses who would have worked with the Ophthalmogist providing paediatric care which is now being done solely by the Optometrist are reassigned to providing pre-assessments and biometry's for patients on cataract waiting list and improving this flow.

Project outputs & outcomes:

- The number of patients awaiting an initial or review appointment with the Community Ophthalmic service has decreased by 80% (1898), exceeding the target of 20%.
- 30% (1901 patients) of target patients have been seen to date by the Optometrist.
- Increased capacity of the Community Ophthalmic Physicians to provide treatment and care to patients with complex eye conditions by 2325.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 199

Initiate Specialist Medical Retina services and intravitreal injections in Community Ophthalmic Service, Co Donegal

Increasing capacity and reducing waiting times

Who is delivering this project?	Where?	Operational Period:
Community Health Organisation Donegal, Sligo, Leitrim, West Cavan (CHO 1)	Donegal	5 months

What is this project about?

This project has established the first specialist medical retina and intravitreal injection service outside of an existing Ophthalmic Unit setting, with community-based service delivery. Medical retina conditions include common ocular diseases such as Diabetic Macular Oedema, Age Related Macular Degeneration and Retinal Vein Occlusions.

Target Population:

The target group for this project are people in Donegal with a new or existing diagnosis of Diabetic Medical Retinopathy. This condition is not age specific and the patients' range in age from 20 to 86 years old.

Project outputs & outcomes:

- 8 Intravitreal Injections per month delivered to date.
- 80 patients cared for in a setting closer to home to date, minimising the risk of no shows for appointments.
- Average of 12.4 new medical retina clinic assessments and management plans delivered in St Conals Ophthalmic Clinic, Letterkenny per month.
- There has been Increased capacity in Sligo University Hospital to see an additional 26 (130 in total) patients per month against a target of 30 patients per month.
- 2-week reduction in waiting times for the 6 patients who have received their Medical Retina Assessment reduced from 12-weeks.
- The existing patient pathway for Donegal patients is now reduced by 1 step; prior to the project's patients were referred into the service for assessment by the Community Ophthalmic Physician and if required referred to the Consultant Ophthalmologist for treatment. Post project commencement all referrals are sent directly to the Consultant Ophthalmologist. This has freed up 70 Community Ophthalmic Physician appointments and administration.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 134

Jigsaw Online
Greater accessibility to mental health support for young people

Who is delivering this project?	Where?	Operational Period:
Jigsaw Youth Mental Health	Online	27 months

What is this project about?

Youth mental health support services across primary and secondary care are under-resourced and over-stretched. Areas such as integrated service provision, e-mental health, school supports and services operating outside 9am to 5pm are limited in scale and ambition. Jigsawonline.ie, launched in April 2019, is an innovative digital platform, rolled out on a phased basis, with the specific aim of increasing mental health literacy for adults who wish to support the mental health needs of young people, and offer young people themselves a safe, confidential and easy-to-access mental health information and support system. With the rise of digital communication, an unprecedented opportunity exists to engage young people to utilise technologies promoting and supporting their mental health and wellbeing.

Target Population:

The target group for this project are as follows:

- Young people (aged 12-25) experiencing mild-moderate mental health challenges (across the Republic of Ireland).
- Parents and guardians seeking support in protecting the mental health of young people in their lives (across the Republic of Ireland).
- Educators (primary and post-primary) seeking support in their role as a supportive adult in the lives of their students (across the Republic of Ireland).

Project outputs & outcomes:

- Project designed and delivered an online mental health service for young people and their families achieving 1,344,587 unique views exceeding the target of 250,000.
- 2,888 one to one online therapeutic sessions were delivered to young people aged 12-25 exceeding the target of 250.
- 2,888 therapeutic sessions for young people who are seeking support immediately were delivered via an online live chat exceeding the target of 1,000.
- 145 live online group chats were provided to 598 young people covering key mental health topics, exceeding the targets of 100 group chats involving 500 young people.
- 16,012 interactive sessions were delivered to over 17,576 people from across jigsaw audiences exceeding the target of 5,000 sessions delivered to 6,000 people.
- 672,294 views to access to out of hours online youth mental health supports and services, exceeding the target of 83,000.

This project has been extended to facilitate further review in 2022.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 180

Turn2me 360 Online Stepped Care Mental Health Pilot for Young People and Their Families

Accessible Mental Health Support for Young People and their Families

Who is delivering this project?	Where?	Operational Period:
Turn2Me	National/Online	19 months

What is this project about?

This service empowers young people and their families to develop and engage with a professional mental health service that is theirs, that they can be proud of and share with their peers. Benefits of this service include:

- Reaching and engaging young people and their families when and where they need it most - delivering the right care at the right place and the right time by the right team.
- Opening up referral pathways to aid in the reduction of acute care waiting list times for young people accessing mental health supports by offering rapid access online to mental health professionals.
- Removing barriers to access by making a vital mental health support accessible to young people and their families across the country right from their own home.
- Reaching vulnerable young people and their families who would not otherwise engage with mental health supports.
- Building capacity in parents and caregivers to manage their own mental health and support the mental health of their children at home.
- Supporting young people and their families to stay well through early intervention, integrative, preventative, cost effective mental health support and ongoing supports across the lifespan.
- Providing an innovative Irish contribution to the growing international evidence based on eMental Health.

This fully online service provides an immediately accessible, cost effective professional mental health service ensuring public funding is utilised where it is needed most: client care.

Target Population:

The target group for this project are young people aged 12-17, parents and couples across Ireland presenting with a wide range of mild to moderated mental health issues.

Project 180 cont.

Project outputs & outcomes:

- 23% (38) of participants state they would have attended CAMHS or other HSE mental health services if Turn2Me youth and families pilot service had not been available, while 28% (48) felt they would have attended other community mental health services.
- 80% (136) of young people who completed their counselling had their presenting issue resolved and crises prevented. Target was 75%.
- 1,057 individual counselling sessions were provided online for 170 young people.
- 129 couples and family counselling sessions were provided online.
- 160 group support sessions were provided online for 1,990 young people.
- 177 group support sessions were provided online for 1,770 parents/caregivers.

This project has been extended to facilitate further review in 2022.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 286

Integrated psychological care for the older adult in Longford Westmeath

Placing the client at the centre of an integrated system to meet their needs

Who is delivering this project?	Where?	Operational Period:
Community Healthcare Organisation Midlands, Louth, Meath (CHO 8)	Longford – Westmeath	17 months

What is this project about?

This project has developed a dedicated psychology service to those aged over 65 living in Longford- Westmeath. It reflects an integrative approach to care of the older adult population between Primary Care Psychology, GP practice and the Geriatrician service in the Midland Regional Hospital in Mullingar and is also based on partnership talks and interagency working with the relevant voluntary agencies. There is a dedicated community-based psychology service at primary care level with close links to the acute hospital services (including providing a service in the inpatient stroke unit and the memory clinic), promoting the right care in the right place at the right time for this fast-growing demographic.

Target Population:

The target group for this project are older people, who have chronic health conditions (specifically stroke and dementia), many of whom have co-morbid mental health needs and their carers.

Project outputs & outcomes:

- 26 new patients have had access to neuropsychological assessment as part of the Memory Clinic service. Target was 24.
- 20 people with stroke have been referred to the service.
- 29 new people have been referred for memory assessment.
- There was an 95% (84) increase in the number of referrals of over 65's against 2019 data. Target was 50%.
- 79% (6-month) reduction in wait-time for patients referred from 8 months to 7 weeks. Target was 79%.
- 20 patients in the stroke unit/acute hospital beds have received psychology assessment/intervention. Referral pathway did not previously exist.
- 3 clearly defined and documented pathways for clients have been developed.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 161

Assistive Technology Mobile Community Service
Enhancing Independent Living for People with Disabilities

Who is delivering this project?	Where?	Operational Period:
Central Remedial Clinic (CRC)	National	15 months

What is this project about?

The Assistive Technology & Specialised Seating (ATSS) department provides an advisory and recommendation service for people with disabilities covering Environmental Control, Specialised Seating, Communication systems and Computer Access. Assistive Technology (AT) is a diverse field, incorporating a range of technologies, devices, systems and applications that are used to enhance the independent living of people who have physical limitations or cognitive impairments. In ATSS people are assessed for integrated systems, providing solutions to functional difficulties for enhancing independent living and chosen activities. This project equips one hi-tech mobile support vehicle which is used in outreach assessments covering all regions of the Republic of Ireland. The mobile unit will provide ATSS assessment teams with the facilities to assess and support people with disabilities in their own environment, thereby saving time and long exhausting journeys for clients and families to centre-based services. This promotes independence for clients as the mobile unit ensures clients know how to effectively use their equipment in the management of their care.

Target Population:

The target group for this project are children and adults with complex physical disabilities whether congenital or acquired.

Project outputs & outcomes:

- Nationwide service provided 590 interventions to complex clients in local environments. exceeding the target of 460.
- 252 clients received an intervention exceeding the target of 216.
- Project achieved a reduction of 16% (252) in waiting list figures.

This project has concluded operations and closed out.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 165

Integrated Ambulatory Care Heart Failure Project
Improving quality of life for patients with Heart Failure

Who is delivering this project?	Where?	Operational Period:
University Hospital Waterford (UHW)	Dungarvan/West Waterford	18 months

What is this project about?

This Integrated Ambulatory Care Heart Failure Project has improved the quality of life of patients with Heart Failure (HF), through:

- Improvements in access to diagnosis and quality of service delivery, delivered mainly in an appropriate primary care setting.
- Hospital avoidance and supported discharge through tailored transition strategies and follow up care.

Target Population:

The project was targeted primarily at patients with Heart Failure in the Dungarvan/West Waterford area.

Project outputs & outcomes:

- Capacity and access to diagnostic Echocardiograms for acute/emergency patients at UHW improved, with echocardiogram waiting times reducing from 3 days to 1 day. Target was 1 day.
- Wait times for referral and diagnosis reduced to 4 weeks from 18 months. Target was 4 weeks.
- Outreach Cardiac Diagnostic Service with 1751 patient out-patient appointments delivered, exceeding the target of 700.
- Outreach Cardiac Diagnostic Service impacted 161 individual patients.
- Outreach Cardiac Rhythm Management for immobile/long stay patients in nursing homes with additional 132 patients. Target was 50.
- Same day Diagnostic Echocardiograms in primary care delivered to 301 patients. Target was 300.
- Developed an Integrated Model of Heart Failure care, delivered in the main in an appropriate primary care setting receiving 75 referrals. Target was 40.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 248

Development of Community based Integrated Diagnostic and Care Initiative Cardiology

Reduction in referral and follow-up waiting times for Heart Failure Patients

Who is delivering this project?	Where?	Operational Period:
Beaumont Hospital	Beaumont Hospital and six GP practices in North Dublin City and County.	13 months

What is this project about?

Increased access to diagnostic tests for heart failure (HF) leads to a reduction in diagnostic delay which reduces the number of referrals to both emergency and out-patient departments and reduces unnecessary hospital admissions. This project hired one Clinical Nurse Specialist (CNS) to work 80% in the community and 20% in the hospital setting. The establishment of Community CNS for HF to provide and develop structured care for patients helps to develop links between primary care and secondary care to manage this growing problem.

Target Population:

This project was targeted at patients with Heart Failure and was delivered at Beaumont Hospital and six GP practices in North Dublin City and County.

Project outputs & outcomes:

- Provided early diagnosis of heart failure in community for 59 patients with a new diagnosis of heart failure, exceeding the target of 30.
- Provided education for 59 patients with heart failure on their condition & self-care management strategies exceeding the target of 30.
- Reduced new Heart Failure specific GP referrals to Cardiology Consultant outpatient clinics by 7.5% (45), exceeding the target of 5% (30).
- 94% (210 day) decrease in wait times for access to diagnostics & specialist cardiology consultant opinion for patients referred to the community HF CNS clinic from 225 days to 15 days. Measurement of time from GP referral to echocardiogram- as measured on dataset. Target was 30%.
- 90% (203 days) decrease in wait times Cardiology Consultant opinion from 225 days to 22 days – as measured on dataset. Measurement of time from GP referral to Cardiology Consultant opinion. Target was 30%.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 377

Heart Failure Service Integrated Care Project

Bringing together the full range of heart failure services in the Primary Care Centre (PCC) setting

Who is delivering this project?	Where?	Operational Period:
Tallaght University Hospital	Tallaght University Hospital catchment area	15 months

What is this project about?

This project established integrated partnerships to bring together the full range of heart failure services in the Primary Care Centre (PCC) setting. It developed Hubs at Tallaght PCC and Naas General Hospital, then moving out to the surrounding PCCs.

Target Population:

The target group for this project are patients with a diagnosis of heart failure, requiring intervention for signs and symptoms of deterioration, or requiring optimisation of proven disease modifying heart failure therapies.

Project outputs & outcomes:

- 351 diagnostic tests carried out to date.
- New diagnosed HF patients receive ECHO within 1 week from receipt of GP letter, reduced from 18 months exceeded the target of 4 weeks.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 430

Cardiology Advance Nurse Practitioner Heart Failure
Improving patient access to Heart Failure clinics and services

Who is delivering this project?	Where?	Operational Period:
Midland Regional Hospital Portlaoise	Catchment area of Midland Regional Hospital Portlaoise	9 months

What is this project about?

The introduction of an Advanced Nurse Practitioner (ANP) in Cardiology and Heart Failure has improved patient access to Heart Failure clinics and services. The ANP provides an assessment, diagnostic and screening role in relation to Heart Failure (HF). This helps to reduce waiting times and increase throughput of patients. The ANP assesses, admits, treats and discharges patients, assisting in achieving the goals of the National Clinical Programme for Heart Failure (NCPHF).

Target Population:

The target group for the project are patients aged 16 years and over with new or transient heart failure, chronic heart failure with episodes of decompensation, a diagnosis of heart failure requiring assessment and education for self-care management and optimisation of disease modifying medications.

Project outputs & outcomes:

- 305 patients were seen at the Cardiology outpatient clinic over the duration of the project, exceeding the target of 72.
- Prior to commencing this project there was 307 patients on the waiting list, however since commencing there has been 518 new referrals, therefore increasing the waiting list.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 469

Galway University Hospital Community Cardiac Diagnostics
Reduced Waiting Times for Cardiac Diagnostics

Who is delivering this project?	Where?	Operational Period:
Galway University Hospital and Saolta Hospital Group.	Five Primary Care settings in the Galway University Hospital catchment area; St Francis PCCC, Galway City; Tuam PCCC, Tuam; Gort Health Centre; Croi House, Galway City and Claremorris PCCC, Mayo.	7 months

What is this project about?

The delivery of a Community Cardiac Diagnostics Service, providing direct referral for GPs will reduce referrals to both outpatient and acute services. This project delivers a Community Cardiac Diagnostics Service in up to five Primary Care/ Health Centres providing GP open access referrals to echocardiography (echo) and heart monitors. This service also supports the early diagnosis of heart failure (HF), an important element in reducing mortality, morbidity and hospitalisations. The National Heart Failure Programme recommends that patients with suspected HF should have a blood test (BNP), and if this is abnormal an echocardiogram should be performed in <2-6 weeks. It is expected that there would be 30,000 presentations annually of which 46% will have an abnormal BNP, therefore 13,800 echocardiograms will be required annually just for this patient population. This project supports the delivery of current and expanded community HF services, integrated with hospital services. The service is integrated into the Clinical Information Systems in GUH, with clear appropriate care pathways to deal with findings.

Target Population:

Patients being seen by GPs — mix of chronic and new presentations and their GPs

Project outputs & outcomes:

- Delivered 38 diagnostic slots per week in the community over 5 centres, 937 in total.
- OPD waits reduced by 4 weeks for Cardiac Diagnostics from 33 weeks to 29 weeks.
- 78% (731) of investigations in <6weeks, HF in <2 weeks with data collection via database.
- 88% (820) of patients managed by GP with acute or OPD referral within 30 days monitored on PAS, exceeded the target of 70%.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 129B

Sligo/Leitrim/W. Cavan/Sth. Donegal/Roscommon Heart Failure Integrated Care Service

Providing structured review care and management for individuals living with heart failure in primary care

Who is delivering this project?	Where?	Operational Period:
Sligo University Hospital	Sligo, South Donegal, Leitrim, West Cavan/Roscommon	3 months

What is this project about?

This project enables the extension of cardiac diagnostics and establishment of a review Heart failure Integrated Care Service in Co Sligo/Leitrim/W. Cavan/South Donegal/Roscommon. This service provides structured review care and management for individuals living with heart failure in primary care. The availability of review Heart Failure Integrated care clinics in the community setting enables early diagnosis and optimization of cardiac health with fast tracking of unstable patients for treatment. This ultimately will improve health outcomes for people with heart failure. This is achieved through Specialist Candidate Advanced Nurse Practitioner led clinics, early access to extended Cardiac Diagnostic Services in Primary Care and Consultant and GP led management between Primary and Secondary Care.

Target Population:

This project is targeted at people suffering from chronic disease, specifically heart failure living in rural areas.

Project outputs & outcomes:

- 274 diagnostic tests in project period achieved.
- 81 stable review patients with heart failure received specialist nurse input regarding evidence-based medication, education on their condition and self-care management strategies.
- Waiting list times for new referral heart failure patients reduced from 5 weeks to 2 weeks. Target is 2 weeks.
- Attendance rate for Community Cardiac Diagnostics up to 95%. Target was 94%.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 184

Improving Access to Healthcare: Spread and Scale-up of a HSE Health Passport for individuals with an Intellectual Disability in acute hospital and primary care settings

Improved patient supports for people with Intellectual Disability

Who is delivering this project?	Where?	Operational Period:
HSE Community Health Organisation Donegal, Sligo, Leitrim, West Cavan (CHO 1)	HSE Community Health Organisation Donegal, Sligo, Leitrim, West Cavan (CHO 1)	20 months

What is this project about?

This project embedded a standardised national health passport for individuals with an intellectual disability who access healthcare services. The Health Passport is the "patient safety communication tool" for individuals with an Intellectual Disability to enable their voice to be heard and to facilitate healthcare professionals to make the required reasonable adjustments for their safety, healthcare and wellbeing.

Target Population:

The Health Passport is targeted at people with intellectual disabilities, and their family/carers in the Donegal, Sligo/Leitrim and West Cavan region, accessing primary, acute and community healthcare. The unanticipated beneficiaries include older persons, people with cognitive impairment, people with literacy issues, people with Mental Health issues, stroke patients, primary school children with autism and additional needs.

Project outputs & outcomes:

- 4,522 HSE health passports were issued to patients in Donegal and Sligo/Leitrim exceeding the target of 400.
- 919 people with Intellectual Disability their families/carers have been supported by the HSE Health Passport team to improve communication pathways between health care staff and people with Intellectual Disability, exceeding the target of 400.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 190

Integrated Foot Protection Service for residents of Community Healthcare East

Patient-centred diabetes management and foot care

Who is delivering this project?	Where?	Operational Period:
Community Healthcare East	Community Healthcare East catchment area-Wicklow, Dun Laoghaire, Dublin South East	15 months

What is this project about?

This project expanded integrated foot protection services across disciplines and sectors, around patients, preventing them from losing their legs to avoidable amputation. The project expanded care currently being provided to Wicklow residents across CHE by providing one point of entry to the Foot Protection service for patients. There are 5,163 patients identified as being at risk of ulceration and amputation. The project ensures continuity of care and a single point of entry for residents of Community Healthcare East (CHE). The project also allows for the expansion of identification and intervention of "At Risk" foot complications such as infection, PVD and foot deformity.

Target Population: The project is targeted at the following:

- Residents of Dublin South and Dublin South East region, screened by their GP or hospital Diabetes Consultant led team as being 'At Risk' of diabetes foot related amputation, requiring Community Podiatry assessment of the skin, wounds, vascular, neurological and MSK complications and management of foot in line with the Integrated National Model of care for the Diabetic Foot.
- Residents of Dublin South and Dublin South East region who require podiatry assessment of skin, wound, vascular, neurological and MSK complications for the overall management of an 'at risk foot' or foot ulceration related to long term conditions outside of diabetes.
- Any resident of Community Healthcare East who required physiotherapy MSK and rehab assessment and intervention related to the lower limb.

Project outputs & outcomes:

- Rapid access Podiatry Clinics have provided 830 face to face appointments to manage a total of 172 presentations of patients requiring assessment and shared care of active wounds outside of level 4 hospital.
- 1330 residents identified as at-risk of foot complications within year 1 of this service being mainstreamed.
- Community ulcer prevention service was made available to residents of Dun Laoghaire and South Dublin where there wasn't one before delivering 1346 Community Podiatry ulcer prevention appointments (1017 virtual and 329 face to face).
- 9-month wait for ulcer prevention devices reduced to 6 weeks. Target was 6 weeks.
- Patient Journey steps for device prescription reduced from 6 to 2. Target was 2.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 343

A Podiatry led pathway for timely provision of footwear and orthotics in the community

Further development of a podiatry led pathway which should help ensure equitable and timely access, and reduction in hospital admissions whilst providing best quality care for patients.

Who is delivering this project?	Operational Period:
Podiatry Service HSE Community Health Organisation Midwest (CHO 3)	13 months

What is this project about?

The objective of this project was to identify and initiate a preferred pathway for the provision of orthotics and footwear that would provide equitable and timely access. These measures resulted in improved service user experience and fewer hospital visits. This project employs an innovative approach of a podiatry led pathway for provision of footwear and orthotics developed in Co Clare.

Target Population:

The target group for the project was:

- MSK waiting list patients in CHO 3, waiting at least 4 years– 50% of which included children or adults with physical, intellectual or special educational needs.
- Diabetes patients with an active foot ulcer.
- Diabetes patients, coupled with other comorbidities.
- Vulnerable adults under social inclusion services e.g. homeless or addiction services.
- Individuals with sarcopenia, fragility and falls risks.
- PVD.
- CVA/TIA.
- Immunosuppressed patients.
- Patients with mental health issues who presented with foot ulceration post prolonged sustained periods of pacing/walking in inappropriate shoes.
- Vulnerable adults with neurological conditions e.g., Spina Bifida, MS, Motor Neuron.
- Palliative Care patients.

Project 343 cont.

Project outputs & outcomes:

- 800 patients assessed during the project's operation. Target is 800—1,000.
- Current waiting list for footwear and orthotics substantially reduced by 80% (800) exceeding the target of 75% (752).
- 12-month time frame for meeting service user needs achieved in Clare, reduced from 48 months. Target was 12 months.
- Reduction in the number of active ulceration acute hospital referrals by 83% (185) within the cohort exceeded the target of 5% (11).

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 427

Advanced Nurse Practitioner in Tissue Viability

Implementation of a Registered ANP in Tissue Viability aims to improve patient outcomes

Who is delivering this project?	Where?	Operational Period:
Midland Regional Hospital Tullamore	Midland Regional Hospital Tullamore	6.5 months

What is this project about?

The implementation of a Registered Advanced Nurse Practitioner (ANP) in Tissue Viability in Midland Regional Hospital Tullamore has assisted with possible admission avoidance. The Registered ANP (RANP) manages wounds early which results in improved patient outcomes and reduced length of stay or hospital avoidance. The risk of community/hospital acquired infections, pressure ulcers or development of sepsis can also be prevented. The project provides expert advice and consultation on complex wounds including advanced clinical assessment, Doppler assessment, arterial toe pressure index measurements (ATP), manual lymphatic drainage, diagnosis and advanced treatment of lymphoedema, nurse prescribing and other advanced nursing interventions. By providing a holistic, evidence based and expert clinical assessment, the project provides health promotion education, self-management of chronic wound conditions and screening for prevention of long-term complications of chronic illnesses which affect the tissues, including diabetes, lymphoedema and chronic ulceration and wounding.

Target Population:

The target group for this project are older people, vulnerable population, people with chronic health conditions/disease, and people with mental health issues.

Project outputs & outcomes:

- RANP had 67 patient attendances.
- 31 outpatients reviewed by Candidate ANP (cANP).
- Waiting list for leg ulcer review reduced from 132 weeks to 48 weeks.
- All inpatients seen within 24-48 hours of referral.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 203

Urology Pathway — Proof of Concept Project

Advance Nursing Practitioner helping to reduce waiting times for Urology appointments

Who is delivering this project?	Where?	Operational Period:
Saolta Hospital Group	Saolta Hospital Group catchment area	16 months

What is this project about?

This project designed a Lower Urinary Tract Symptoms (LUTS) Care Pathway, which is delivered in the hospital-based Urology Clinic by three Advance Nurse Practitioners (ANP), hired specifically for this project. The LUTS Care Pathway project established ANP clinics to review patients from consultant review waiting lists and created capacity for new patients to be seen by a consultant. These services run five days a week to address increasing waiting lists and surveillance of urological patients with chronic benign conditions. The Urology Pathway Project is a flagship project for the Saolta Group and the National Elective Care Team to build an elective model of service delivery across inpatient, day case and OPD services. It can be replicated across all Hospital Groups, and across many other specialties such as Ear, Nose and Throat, Ophthalmology, Orthopaedics etc.

Target Population:

The target group for the project are patients on the outpatient waiting list with lower urinary tract symptoms.

Project outputs & outcomes:

- 56 patients were reviewed per week at hospital-based nurse led clinic which is held 5 days per week. The target was 50 patients per week. Total reviewed to date is 3,632 patients.
- 31% (1,980 patients) reduction in Urology Consultant OP waiting list exceeding the planned target reduction of 17%. A further 1,760 patients were removed from the Consultant review waiting list.
- 95% (3,540) of patient visits through the LUTS service were seen directly at the ANP-led clinics, compared with the original target of 85%. 5% (200) patients were seen at a consultant led clinic with cANP supported clinics.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 376

ANP for development of male LUTs and benign urology

Provision of an Advanced Nurse Practitioner (ANP) for the development of an integrated referral pathway for male Lower Urinary Tract Symptoms (LUTS) and development of a secondary care nurse-led urology clinic for benign urological symptoms

Who is delivering this project?	Where?	Operational Period:
Tallaght University Hospital (TUH)	Tallaght University Hospital (TUH)	15 months

What is this project about?

Tallaght University Hospital currently provides urology services for 71% of all urology activity within the Dublin Midlands Hospital Group (DMHG) catchment area and also accepts referrals from a wider catchment area. TUH aims to be the principal DMHG provider of general and complex adult Urology Services. With an increasing ageing population, referrals are likely to increase further in the future. The LUTS ANP delivers an increasing volume of urological care in the primary care setting. This initiative enhances care in the community, helps meet TUH Outpatient Waiting time targets and results in a reduction in the number of TUH Urology Outpatient visits per patient. This project delivers a secondary care nurse-led urology clinic for patients with LUTS, with an ANP working between the hospital setting and GP practice, as well as an agreed referral pathway for LUTS patients requiring acute management.

Target Population:

The target group for the project are men over the age of 18 years complaining of lower urinary tract symptoms (LUTS). These symptoms can be chronic and severely effect daily quality of life for these patients, often restricting their ability to leave their home comfortably and with confidence. Ireland's ageing population has directly impacted the number of patients living with LUTS. It is estimated the overall prevalence of any LUTS to be 63%–83% in adult men, increasing with age, therefore men presenting with LUTS will continue to increase in time.

Project outputs & outcomes:

- 1389 patient reviews/assessment (649 new patients and 745 return patients) have been carried out to date. Telephone assessment clinics are in full operation for new and return patients.
- Waiting times for patients on the LUTS waiting list has decreased from 7 years to 6 months.
- 95% (568) reduction of patients on the LUTS OPD waiting list due to the delivery of ANP service. This exceeded the target of 40% reduction in the waiting list in 2019 (595 total waiting list).
- 94% (205) reduction of annual overall referrals, exceeded the target of 15% (24).
- 6% (41) reduction of ED attendances by people with chronic urological conditions, who were treated by GPs instead. This reduction exceeded the target reduction of 1 – 1.5%.
- 33% (1) reduction in the number of visits per patient among the cohort directly referred to the ANP led Nurse clinic.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 222

Osteoarthritis Knee Pathway

Osteoarthritis Knee Pathway will reduce Orthopaedic waiting

Who is delivering this project?	Where?	Operational Period:
Saolta Hospital Group and Community Healthcare Organisation Galway, Mayo and Roscommon (CHO 2)	15 locations in the CHO 2 region.	12 months

What is this project about?

Under current practice, osteoarthritis (OA) knee referrals frequently bypass primary care and go directly to secondary care hospitals. When a patient comes to the top of the waiting list, the treatment offered to many is physiotherapy, which can be provided in a primary care setting. An OA knee pathway ensures that patients complete physiotherapy in primary care before onward referral to orthopaedics. Patients are offered an appointment within two to three weeks of a GP referral.

Target Population:

The primary target group for the pathway is patients with a diagnosis of osteoarthritis of the knee. Osteoarthritis is reported to affect roughly 13% of the over 50 population in the Republic of Ireland. International clinical guidelines state that the majority of OA knee cases can, and should, be managed successfully in the community with diet, exercise and education. However, 78% of patients who were transferred from the acute hospital to the pathway have never seen a physiotherapist and 98% have never seen a dietician in the primary care setting.

Project outputs & outcomes:

- 138 patients attended attend the physiotherapy sessions.
- 11% (84) reduction in the number of patients on knee orthopaedic waiting list.

This project has concluded operations and closed out.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 323

Mobile Telemedicine for Rapid GP Access to Specialist Opinion: A "Virtual" elective orthopaedic clinic

Using technology to bring specialists and primary care closer together with the use of a custom made secure and GDPR compliant mobile application

Who is delivering this project?	Where?	Operational Period:
University Hospital Waterford	University Hospital Waterford catchment area	15 months

What is this project about?

This project aims to address the Orthopaedic Elective Outpatient Waiting List in University Hospital Waterford (UHW) where patients can wait three or more years to see an Orthopaedic Specialist. Technology enables us to bring specialists and primary care closer together with the use of a custom made secure and GDPR compliant mobile application. Through the App, GPs can refer their clients directly to an orthopaedic specialist and receive feedback on the recommended course of action within 48 hours. This can act as a rapid access telemedicine-like resource to specialist opinion to help GPs deliver non-urgent care in the community, which is convenient for patients and helps them avoid the acute hospital setting. The queries are responded to by Orthopaedic consultants and triage physiotherapists, and the expert advice is specific to individual patient cases.

Target Population:

The target group for the project are patients with any orthopaedic condition.

Project outputs & outcomes:

- This project was severely impacted by Covid-19 and the HSE cyber-attack.
- The project developed an Orthopaedic telemedicine app which can be replicated for other medical and surgical specialities which will result in accelerated access to an Orthopaedic consultant opinion to assist with decision-making on referrals and to aid with prioritization of referrals.
- The project established a new service delivery model for orthopaedic complaints which has been rolled out in 2 pilot GP practices and the process has started to expand to all GPs in Waterford.
- 6 GP practices now enrolled, submitting 10 queries. 100% resulted in referral avoided with advice for alternative conservative treatments.
- Wait for GP queries shortened to 48 hours, achieving target, (measured using the App response time) for the 6 users so far. The queries are responded to by Orthopaedic consultants and MSK triage physiotherapists, and the expert advice is specific to individual patient cases. Currently the wait time for patients is three or more years to see an orthopaedic specialist if deemed routine or eighteen months if deemed urgent on referral triage.

This project has concluded operations and closed out.

Project 324

The Establishment of Novel Clinical Pathways for Orthopaedic Outpatient Referrals, integration of local community services and multidisciplinary triage

Reduction in Physiotherapy and Orthopaedic out-patient wait times for patients with osteoarthritic knees

Who is delivering this project?	Where?	Operational Period:
University Hospital Waterford	Waterford City, Dungarvan, Wexford Town, New Ross	15 months

What is this project about?

As part of a waiting list initiative, the Musculoskeletal Triage and Orthopaedic Department in University Hospital Waterford rolled out a Pilot Osteoarthritis (OA) Knee Pathway within the South Eastern Region. The Pilot OA Knee Pathway delivers a significant improvement to patient care by facilitating quicker access to orthopaedic intervention for patients most in need, and a shift of patient care to a community-based setting for a large percentage of patients who do not require specific orthopaedic intervention. This reduces the rate of referrals into orthopaedics and facilitates a reduction in the orthopaedic out-patient waiting list. Patients referred to the Rapid Access Knee Clinic are seen within 4 weeks of referral and listed for injection or surgery on the day.

Target Population:

The target group of the project are patients with knee osteoarthritis in Waterford City, Dungarvan, Wexford Town and New Ross.

Project outputs & outcomes:

- The MSK physiotherapist saw 551 patients during the pilot 1-year project period which exceeded the target of 400.
- 261 patients offered physiotherapy and removed from waiting list in Waterford to date.
- 185 patients offered physiotherapy and removed from waiting list in Wexford to date.
- 26 patients per month referred to Primary Care Knee classes in Waterford/Wexford as first line of referral for OA knees, target was 23.
- 11 patients referred to Rapid Access Clinic via GP/Primary Care Knee classes during the project All referred patients seen in Rapid Access Clinic within 4 weeks of referral.
- 27% reduction in total number of clients with OA knees referred to Orthopaedics from Waterford/Wexford GP surgeries registered with the OA Knee.
- Wait time to access Orthopaedic Consultant for patients with OA Knees referred through the OA Knee Pathway in Waterford/Wexford has been reduced from 3 years to 13 months from initial Knee Class referral by GP to appointment in Rapid Access Clinic with Consultant.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased access to care, reduction in waiting times for patients cont.

Project 328

Therapy Led Primary Care Hand Therapy Clinic

Reduction in length of waiting time from GP to first contact for specialist hand review compared to current pathway

Who is delivering this project?	Where?
Community Health Organisation Laois/Offaly, Longford/Westmeath, Louth and Meath (CHO 8)	The target population are residents of the Meath and South Louth area referred by their GP directly to the service, or to the Orthopaedic Shared Waiting List at Our Lady's Hospital Navan.

What is this project about?

This project is redirecting patients from long term hospital waiting lists to primary care-based clinics to provide early management of conditions, thereby providing the right care, in the right place, at the right time. In the Meath area there is currently an approximate 24-month hospital waiting list for patients with hand conditions to see an Orthopaedic Consultant. This project reduces the time from GP to first contact by a specialised service and reduces the delayed presentation for conservative management. This project benefits the service user in a timely manner, as well as providing a streamlined integrated care pathway from the GP, through to the Primary Care therapy services for early conservative management, and subsequently on to acute/secondary/tertiary care settings if or when appropriate.

Target Population:

The target group for this project are service users with specific hand conditions at the Primary Care point of entry in their healthcare journey. Conditions include: Carpal Tunnel Syndrome, Osteoarthritis of the hands, Dupuytren's Disease, De Quervain's Tenosynovitis, Trigger Finger, Ganglions, and Work Related Upper Limb Disorders.

Project outputs & outcomes:

- 330 patients (new and wait listed) treated during the project exceeded the target of 274.
- Triage of 56 new and existing patients requiring specified hand surgery, the target was 50 patients.
- Wait time for hand specific referrals from GP to first contact has reduced from 20 months to 3 months, exceeding a target of 5 months.
- Project reduced the number of patients waiting by 202 patients or approximately 50%, achieving target.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 463

Pain management education programme

Moving management of chronic pain from the acute hospital to the community and into the home

Who is delivering this project?	Where?	Operational Period:
Sligo University Hospital	Sligo	16 months

What is this project about?

The focus of this project is moving emphasis away from pharmacological and interventional treatment in acute hospital-based consultant-led clinics when managing long-term, non-cancer pain. The project promotes focus on long-term self-management to achieve good functioning and quality of life in the primary care and community setting. It is innovative and non-pharmacological, teaching a wide range of skills to patients to manage chronic pain and improve their self-efficacy. 'Living well with chronic pain' is a community-based Pain Management Education Programme (PMEP) to be delivered on an outreach basis from Sligo University Hospital. Sligo University Hospital Pain Clinic has brought together a number of experts to work intensively with patients who have chronic pain. The PMEP aims to teach patients about their pain, to help them develop coping and movement skills, and thereby maximise their mobility and improve their quality of life.

Target Population:

The target group of this project are complex patients who experience severe chronic pain and complex comorbidities associated with chronic pain, the majority of whom have exhausted medical interventions. Chronic pain is extremely common in Ireland with a lifetime prevalence of one in three, with the majority of people having multiple pain sites (80%) and significantly more likely to be unable to work (12%) and experience clinical mental health difficulties- anxiety and depression (15%).

Project outputs & outcomes:

- 85 patients attended the Pain Management Education courses exceeded the target of 72.
- 353 patients were invited to a pre-education session exceeded the target of 240.
- 336 counselling and physiotherapy sessions were delivered.
- 16% (85) reduction in the pain clinic waiting list compared to the target of 10%.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2 cont.

Emergency Department attendances avoided/reduced (Unscheduled Care)

Seven SIF funded projects; including Citizen Empowerment and Health and Wellbeing, social inclusion, Heart Failure and Older Persons; had a primary high-level outcome to reduce emergency department attendances. The average operational period of the various services at the time of this report is 17 months. To date **5,230** patients have been seen, **2,546** emergency department attendances have been avoided and approximately **9,460** bed days have been avoided.

Project 137

SMILE Supporting Multimorbidity self-care

Self-care programme empowering people with multiple chronic conditions to get appropriate care at the right time

Who is delivering this project?	Where?	Operational Period:
Carlow Emergency Doctors on Call (Caredoc)	Carlow	22 months

What is this project about?

This project is a new, innovative way for citizens to proactively self-manage their care. The objectives are to prevent deterioration in participant conditions, empower citizens to engage with their own health within the community setting, and avoid hospital admissions. Caredoc, in conjunction with Netwell CASALA, introduced remote nurse triage support of older adults with multiple conditions, self-managing at home using wearable technology. Monitoring devices including blood pressure monitors, blood sugar monitors, oxygen monitors, weighing scales, and activity monitors are allocated to participants based on their requirements. Participants record their healthcare data at home and submit the readings from devices to a specifically designed software program. Participant alerts are monitored daily by the telephone triage nurse. Care is delivered in a more appropriate way as participants are monitored and empowered to maintain their health and well-being and directed to the appropriate clinician (e.g. nurse specialist, GP etc.) before their condition deteriorates or if there are any abnormal readings. Using gentle reminder motivational tools about medication management and understanding the importance of diet and exercise in their health management, has increased the quality of life for participants.

Target Population:

The target group for the project are people over the age of 65 in the Carlow area, with two or more conditions of Diabetes, COPD, Chronic Heart Failure and heart disease.

Project outputs & outcomes:

- 172 patients enrolled and are receiving an intervention of which 123 are using technology to track and report the self-management of their health.
- 49 patients received telephone support as opposed to technology so a comparable cohort could be analysed.
- 51% (63) reduction in unscheduled care episodes among participants measured by reduced number of trips to GP and ED by patient cohort. This exceeded the target of 20% reduction in unscheduled care episodes.
- Estimated 1,425 bed days avoided.

These projects have been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Emergency Department attendances avoided/reduced (Unscheduled Care) cont.

Project 173

Integrated Care for Older People Model for falls prevention and management

Minimising deconditioning and reduced mobility among older adults and maximising their functional independence within their homes

Who is delivering this project?	Where?	Operational Period:
Community Health Organisation Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan (CHO 1)	Sligo, Leitrim and South Donegal	10 months

What is this project about?

This project focused on minimising deconditioning and reduced mobility among older adults and maximising their functional independence within their homes. It also delivered evidence based progressively challenging strength and balance exercise classes that target the main falls risk factors of muscle weakness and gait, and balance impairment in older adults. The falls prevention team identifies the multi-factorial risks for individuals associated with a fall through a detailed Multi-factorial risk assessment (MFA) and provides a falls prevention service based on this assessment.

Target Population:

This project is targeted at people over 65 years old, living in Sligo, Leitrim or South Donegal who have a history of falling or a fear of falling. It targets clients who are on the Rockwood frailty scale between 0 to 6 and who can follow simple instructions.

Project outputs & outcomes:

- Weekly multifactorial assessment clinics established accommodating 30 patients per week, which exceeded the target of 20.
- 12-week Strength and Balance exercise programmes aligned to specialist falls clinics delivered in 3 accessible sites accommodating 141 clients which exceeded the target of 75 clients.
- 20 domiciliary home visits by therapy assistants for strength and balance exercises and re enablement type interventions delivered which exceeded the target of 15.
- 97% (93) reduction in overall number of patients attending ED as a result of falls which exceeded the target of 50% (48) reduction.
- In addition, the project achieved a 50% (2.9 days) reduction in average length of stay for frail older patients who have been admitted to Sligo University Hospital as a result of a fall which exceeded the target of 1-day reduction.
- Project estimates 203 bed days avoided over a 10-month period.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 237

Heart Failure Virtual Consultation Service with clinical nurse specialist support in the community

Reduction in referrals to ED/AMAU by GP's. Reduction in number of referrals to Specialist Cardiology OPD by GPs

Who is delivering this project?	Where?	Operational Period:
Ireland East Hospital Group (IEHG)	St. Vincent's University Hospital/ St Michael's (SVUH/SMH) and Community Healthcare East (CHO 6) and Mater Misericordiae University Hospital (MMUH) and/CHO Dublin North City & County (CHO 9)	18 months

What is this project about?

The objective of this project was to provide an efficient service for heart failure patients presenting to GPs in two sub-areas: St. Vincent's University Hospital/St Michael's (SVUH/SMH) and Community Healthcare East (CHO 6) and Mater Misericordiae University Hospital (MMUH) and/CHO Dublin North City & County (CHO 9). This extended service has provided improved treatment in the community through Clinical Nurse Specialist (CNS)-GP aided care, as well as saved traveling time for patients and families.

Target Population:

The project is targeted at heart failure patients from CHO6 and CHO9. The total population in the catchment area is estimated at 635,000, therefore considering HF prevalence of approximately 2%, we can estimate a total of 12,700 HF patients in the target population.

Project outputs & outcomes:

- 490 patient appointments held at the East Coast Heart Failure Virtual Consultation (VC) Service; which exceeded the target of 360 patients.
- 205 patient appointments held at the Dublin North Heart Failure VC Service; target was 210.
- 31 patients seen by the East Coast IC CNS; target was 25. 26 patients seen by the Dublin North IC CNS; target was 25.
- 100% (16) reduction in number of referrals to ED/AMAU by GP's as a result of the HFVC service against a target of 40%.
- 54% (372) reduction in number of referrals to Specialist Cardiology OPD by GP's as a result of the service against a target of 40-50% (baseline of 695).

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Emergency Department attendances avoided/reduced (Unscheduled Care) cont.

Project 255

Urgent Ambulatory Care and Virtual Ward for the Older Person

Community based Ambulatory Care Model of care for Cork City will reduce hospital admissions for older people

Who is delivering this project?	Where?	Operational Period:
Cork Kerry Community Healthcare (CHO 4)	Cork City	15 months

What is this project about?

This project has enabled a service model that is an alternative to an ED attendance and admission, where appropriate patients are streamed to the urgent ambulatory care centre based in St Finbarr's Hospital. They have their needs managed in this community setting, are assessed, diagnosed, and treated at home, and remain at home with the supports of a multidisciplinary, specialist older persons team.

Target Population:

The population of older people is growing in Cork City with a population of 23,847 over 65 years of age, according to Census 2016. Emergency Department (ED) attendances in Cork acute hospitals increased by 7% in 2018 with a predicted further 3.9% increase in 2019, and this is set to increase by 5.3 % in 2020. Occupancy rates and trolley figures in Cork hospital are some of the highest in the country, with 64% of hospital beds occupied by patients over 65 years of age.

Project outputs & outcomes:

- 2114 patients treated against a target of 2250. 20 patients per week (1236 in total), who would normally attend the ED in the Mercy University Hospital and the Cork University Hospital (combined), were redirected to the Assessment & Treatment Centre.
- Reduction of 4 attendances per day to ED (1269 in total) within patient cohort, which exceeded the target of 2 per day.
- Reduction of 20 hospital admissions per week (1269 in total) within patient cohort, which exceeded the target of 5 per week. Figures based on baseline of over 75s attendances in one year to ED in MUH and the CUH.
- Estimated 900 bed days avoided.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 322

Inclusion Health Primary Care: Demonstration of an Integrated Care approach into a scalable model

Improving health outcomes through the provision of inclusive and flexible healthcare to people who are homeless'

Who is delivering this project?	Where?	Operational Period:
HSE Social Inclusion Community Health Organisation Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West (CHO 7) in partnership with Thomas Court Medical Centre and Depaul Ireland	Dublin South, Kildare, and West Wicklow	24 months

What is this project about?

The HSE Social Inclusion team in Community Healthcare Dublin South, Kildare and West Wicklow directly commission a 'mainstream' GP practice (Thomas Court Primary Care Centre) to provide an enhanced service to the service users in long term homeless hostel accommodation. The pilot was initiated in 2016 as a local response to 'super utilisation' of acute care by this group. It was suggested that this was largely related to poor engagement with general practice as many of the care needs presenting acutely could have been effectively managed in the community at an earlier stage. The existing program has already had significant impact on the health outcomes for this group by delivering primary care clinics from both a named GP and a nurse within the hostel setting. This project will further enhance the tailored primary care approach to people experiencing homelessness.

Target Population:

The target group for this project are vulnerable groups who are homeless or precariously housed: hostel dwellers in the original project sites and homeless people in shielding accommodation that has been supported by the project. The Roma community and Travellers who have availed of the remote GP support are also part of the target group.

Project outputs & outcomes:

- 245 patients have received baseline physical health MOT, respiratory review and specifically tailored personal care plans (PCP), which exceeds the target of 200.
- 1889 GP consultations have taken place. 100% of patients with alcohol excess have had liver enzymes (GGT and ALT) measured annually and nutritional assessment with vitamin supplementation prescribed based on this; seizure disorders to have seizure management plan; smokers receive smoking cessation advice.
- 67% (56) reduction in acute admissions to St James's Hospital compared to a target 20% (16) reduction.
- 68% (57) Reduction in Emergency Department presentations in St James's Hospital compared to a target 20% reduction annually.
- Estimated 480 bed days avoided.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Emergency Department attendances avoided/reduced (Unscheduled Care) cont.

Project 388

Wicklow Frailty First Response Team

Reduction in Emergency Department Falls Admissions thanks to increased care in the home

Who is delivering this project?	Where?	Operational Period:
St Vincent's University Hospital	South Dublin and County Wicklow	11 months

What is this project about?

Patients with falls account for 20% of ambulance calls in the Wicklow area and almost all are transported to their local Emergency Department (ED). This project provides a skilled team to respond to calls involving older adults. It's a joint initiative of St Vincent's Hospital (SVUH), St Columcille's Hospital, National Ambulance Service and General Practice. Wicklow Frailty First Response Team establish a weekend service for low and moderate risk calls in Wicklow/South Dublin involving older people.

Target Population:

The target group for this project are frail older adults, many of which have chronic health conditions and co- morbidities such as Heart Failure, Diabetes, COPD etc.

Project outputs & outcomes:

- Treated 535 patients against a target of 624, bringing frailty expertise into patients homes and identifying falls risks.
- 487 patients that did not require admission to ED SVUH were managed in their own home, which exceed the target of 300.
- 415 patients referred directly referred to OPRAH (Older Persons Rapid Assessment Hub), which exceeded the target of 100.
- 91% (487) reduction in number of older people who fall and call 999 are conveyed to hospital achieved which exceeded the target of 50% (268) reduction (baseline of 535). This was measured using existing baseline data of 100% conveyance to hospital.
- Reduction of average length of stay for this cohort of admissions by 68% (15 days) achieved, which exceeded the target of 10% (2.2 days) (baseline of 22 days).

This project has been mainstreamed which means it will receive recurring funding annually.

Project 392

Beaumont Hospital/National Ambulance Alternative Care Pathways Project

The Ambulance Team treats patients at the scene as an alternative to ED conveyance

Who is delivering this project?	Where?	Operational Period:
Beaumont Hospital and the National Ambulance Service	Beaumont Hospital catchment area in North Dublin, serving a population of some 290,000 people.	14.5 months

What is this project about?

This service has focused on our Ambulance Team responding to 112/999 calls from low acuity elderly patients. The service operates 08:00 – 20:00, Monday – Friday (excluding bank holidays). The Ambulance Team treats patients at the scene as an alternative to ED conveyance, if appropriate. The follow-up team supports patients who remain at home by providing further assessment and interventions such as provision of equipment for the home and linking the patient in with appropriate community health and social care services provided through the HSE or voluntary agencies operating in the area.

Target Population:

The target group for this project are vulnerable older people (65 years and older) who have phoned 999/112 when generally unwell, after a fall, or with back pain, in their own home rather than transporting them to the Emergency Department (ED) for assessment. The project also extended its scope to offer relief to the caller with a blocked or displaced catheter, by managing them in their home or place of residence. It's delivered in the Beaumont Hospital catchment area in North Dublin, serving a population of some 290,000 people.

Project outputs & outcomes:

- Project reviewed 54 patients per month. 1046 new patients were seen, which exceeded the target of 740.
- 30 patients per month reviewed remained at home following assessment/intervention. Target was 15-28.
- Alternative, more appropriate care pathways were implemented in 65% of patients. Target was 60-80%.
- Appropriate pathways were identified early for 561 patients, target was 269.
- Emergency presentations to ED were reduced by 54% (561), against target of 25-40% and baseline of 1,046.
- Inpatient bed days were reduced by an estimated 6,452, target was 504.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2 cont.

Hospital admissions avoided; acute bed days reduced

10 SIF funded projects; across a range of specializations including Respiratory (COPD)/Asthma, Mental Health, Heart Failure and Older Persons; had a primary high-level outcome to reduce hospital admissions. The average operational period of the various services at the time of this report is 11 months. To date **4,507** patients have been treated, **808** hospital admissions have been avoided, **161** readmissions have been avoided and approximately **4,936.8** bed days have been avoided.

Project 41

Develop a Respiratory Integrated Care Programme for COPD in CHO/DNCC Beaumont Hospital (Level 4)

COPD Project will reduce Hospital and Emergency Department Admissions

Who is delivering this project?	Where?	Operational Period:
Community Healthcare Organisation Dublin North City & County (CHO 9)/ Beaumont Hospital	Dublin North City & County	9.5 months

What is this project about?

This project has introduced a Respiratory Integrated Care Team to CHO Dublin North City & County/Beaumont Hospital area. The Respiratory Integrated Care Team are supporting General Practice in diagnosis and management of patients with COPD/Asthma. Patients are being treated within primary care at an earlier stage of their disease, reducing dependence on the hospital's diagnostics services and removing the need for outpatient clinic assessments and follow up.

Target Population:

The target group for this project are older people with Chronic Respiratory conditions, mainly COPD.

Project outputs & outcomes:

- 227 pulmonary rehabilitation patients referred for assessment with 61 patients accessing Pulmonary Rehab (PR) programmes.
- Of the 17 service users followed up to end of June, 3 of the 17 had collectively a total of 8 Hosp/ED admissions in the 6 months prior to PR. These 3 people had zero admissions to hospital throughout the 6 months post PR programme.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Hospital admissions avoided; acute bed days reduced cont.

Project 164

COPD Integrated Care Project

Integrated COPD Care leads to early hospital discharge

Who is delivering this project?	Where?	Operational Period:
University Hospital Waterford (UHW)	Waterford City and Dungarvan	7 months

What is this project about?

This COPD Integrated Care Project addresses identified priority service gaps in Waterford Respiratory/COPD Services including the need for an integrated community-based approach to care. The projects aims to improve the quality of life of patients with COPD within an integrated service delivery approach, through:

- timely, efficient and accessible healthcare and support for COPD patients, delivered mainly in an appropriate primary care setting.
- hospital avoidance and supported discharge through tailored transition strategies and follow up care.

This combined hospital/primary care initiative is run collaboratively between University Hospital Waterford (UHW) and South-East Community Healthcare (SECH). It supports current and future capacity planning, with a focus on supporting the delivery of most COPD care in primary care and achieving a reduction in the total economic cost of managing patients with this common chronic condition.

Target Population:

People with COPD in Waterford City and County.

Project outputs & outcomes:

- The COPD Integrated Service was delivered to 172 patients and facilitated 686 patient appointments/encounters within specialist ambulatory care and early/supportive discharge clinics during this period.
- Project achieved a 43% (98) reduction in hospital admissions with patients supported to live well at home in their communities.
- This led to approximately 635.5 bed days being avoided against a target of 128.
- 30-day readmission rate for inpatients with a primary diagnosis of COPD discharged to the COPD Integrated Care Service was reduced from 9% to 7%.
- Average length of stay for all inpatient discharges with a primary diagnosis of COPD was reduced by 11% (0.82 days), from 7.4 days to 6.58 days.
- 97 inpatients (42%) were offered and availed of supported early discharge services exceeding the target of 70 (30%).

This project has been mainstreamed which means it will receive recurring funding annually.

Project 311

Integrated Pulmonary Outreach in South Tipperary

Community Based Integrated Pulmonary Care Reducing Length of Hospital Stay

Who is delivering this project?	Where?	Operational Period:
South Tipperary Hospital and South East Community Healthcare (CHO 5)	South Tipperary	9 months

What is this project about?

This project provides 'Early Supported Discharge' for patients in an integrated care approach which is aligned to the COPD Outreach Programme Model of Care. This project shifts care from the acute service to the community setting by bridging the gap between hospital and community. It does this by providing a safe transition home, enabling the patient to recuperate in their own environment with family support. A proactive smoking cessation intervention service has been developed. All patients will be seen at an initial appointment and then followed up weekly for 12 weeks, as per National Quit Programme guidelines.

Target Population:

The target group for this project are patients with a respiratory diagnosis (predominantly COPD), patients admitted to Tipperary University Hospital with a diagnosis of COPD and any smoker who expresses an interest in smoking cessation.

Project outputs & outcomes:

- 306 participants attended pulmonary rehabilitation classes over 9 months.
- 34 new patients in first 9 months completed the Pulmonary Rehabilitation Programme.
- 93 patients have attended Smoking Cessation Sessions to date.
- All patients were seen at an initial appointment and then followed up weekly for 12 weeks as per National Quit Programme guidelines.
- 24% (95) reduced admission rate annually exceeding the target of 20%.
- Readmission rates were reduced by 7% (5). The rate was determined by subtracting the number of discharges/admissions and the number of patients in the J40-J47 >35 years category as a percentage of admissions. Both values sourced from HIPE.
- Average Length of Stay for COPD patients was reduced by 2.82 bed days reduction in first 8 months exceeding the target of 1 day.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Hospital admissions avoided; acute bed days reduced cont.

Project 364

Integrated Respiratory Rapid Response Team

Establishing community based Integrated Respiratory Rapid Response in Kildare and West Wicklow

Who is delivering this project?	Where?	Operational Period:
Naas General Hospital/Community Healthcare Organisation Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West (CHO 7)	Kildare West Wicklow	9 months

What is this project about?

This project has established a community based Integrated Respiratory Rapid Response Team for Kildare and West Wicklow, providing an integrated care service between Naas General Hospital (NGH) and Community Healthcare Dublin South Kildare and West Wicklow. The team provides a new way of working to enhance the resources available to people in Kildare and West Wicklow (KWW) living with a long-term respiratory condition. It provides specialist respiratory services in local primary care centres in Athy, Newbridge, Blessington and Celbridge. Chronic Obstructive Pulmonary Disease (COPD) patients being treated and managed for their chronic disease by their GP are able to access respiratory specialist review and individual care plans in line with the National Clinical Programme for Respiratory Guidelines.

Target Population:

The target group for this project are patients living with COPD and other chronic respiratory disease in the Kildare, West Wicklow catchment area within Community Health Organisation Area 7 (CHO7).

Project outputs & outcomes:

- Average attendance of 36 patients per month exceeding the target of 32.
- 42% (416) reduction achieved in Naas hospital admission rate of patients with chronic respiratory disease per year among patient project cohort exceeding the target of 20% (196).
- 55% (71) reduction achieved in 90-day readmission rate for COPD patients exceeding the target of 25% (32).
- 0.7 days reduction in length of hospital stay among patients with chronic respiratory disease from 14 days to 13.3 days among patient project cohort in line with National Self-management Support Framework.
- 102 bed days avoided approximately.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 435

COPD Outreach Service

Integrated COPD management slows progression of disease

Who is delivering this project?	Where?	Operational Period:
Midland Regional Hospital Portlaoise (MRHP)	Midland Regional Hospital Portlaoise (MRHP)	7 months

What is this project about?

This project is about the effective and efficient management of COPD, using an integrated approach to prevent disease, slow disease progression, optimise quality and quantity of life and provide care in the most appropriate setting. This is achieved through the introduction of a COPD Outreach Service in the Midland Regional Hospital Portlaoise (MRHP). COPD Outreach is a hospital-at-home service. It has been reported that as many as one in four patients with an exacerbation of COPD would be suitable to be treated in a hospital at home setting.

Target Population:

COPD patients

Project outputs & outcomes:

- The COPD Outreach Service provided 6 promotional & educational sessions for patients and relatives and 42 for GP's & community nurses held exceeding the targets of 5 and 2 respectively in the Laois catchment.
- Increase in post discharge phone calls/patient direct contacts within 72 hours post discharge.
- 51 patients seen under early and/or assisted discharge programme.
- The 30-day readmission rate was reduced from 23.3% (73 of 313 patients) to 7.8% (4 of 51 patients) exceeding the target of 10%.
- Average length of stay improved by 32% (1.8 days) from 5.6 days to 3.8 days, exceeding its target of 10%.
- 211.8 bed days were avoided approximately.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Hospital admissions avoided; acute bed days reduced cont.

Project 352

StrokeLink Innovating Stroke Support

Stroke LINK provides improved patient experience and holistic support system in the community

Who is delivering this project?	Where?	Operational Period:
Mater Misericordiae University Hospital (MMUH)	North Dublin City and County	16 months

What is this project about?

StrokeLINK innovates care after stroke by providing a holistic support system that moves with the patient through the acute phase and into the community via personalised education and support tools. Complementary digital and more traditional (e.g. paper-based) tools have been co-designed with patient representatives, healthcare professionals, interaction designers and a software provider. The tools are customisable for patients in response to their specific needs at a particular moment in time.

Target Population:

The target group for the project are patients who have had a stroke or Transient Ischaemic Attack (TIA).

Project outputs & outcomes:

- The new service model was piloted in the 100 most frequently occurring GP practices to which MMUH stroke patients are discharged. This exceeded the plan of 10 practices.
- This enabled the project to reach 180 patients to date, exceeding the target of 100 patients.
- 95% (110) of stroke patients in the pilot group engaged with the CNS, new model of care and tools, exceeding the target of 80%.
- Of the 25 StrokeLINK patients for whom 3 months follow up data is available none have had a potentially preventable readmission to the Mater Hospital (i.e. 0%), there was a target of 10%.
- This means that each year 4 less people will suffer permanent disability or death and 12 will avoid medical emergencies because of the StrokeLINK interventions at the Mater Hospital alone.
- 82 bed days have been avoided approximately.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 129A

Donegal Heart Failure Integrated Care Service

Enabled the establishment of a Heart Failure Integrated Care Service in Co Donegal to provide structured care and management for individuals living with HF

Who is delivering this project?	Where?	Operational Period:
Community Health Organisation Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan (CHO 1)	Donegal	7 months

What is this project about?

This project has enabled the establishment of a Heart Failure Integrated Care Service in Co Donegal to provide structured care and management for individuals living with Heart Failure (HF). Approximately 3,200 people in Donegal (2% of the population) have a diagnosis of HF with a further 3,200 people having asymptomatic left ventricular dysfunction. HF is one of the most common reasons for hospital admission of the elderly, often requiring a prolonged stay. Each year 200-250 primary HF admissions account for between 2000 and 2500 bed days in Letterkenny Hospital. The availability of Heart Failure Integrated care clinics in the community setting enables early diagnosis and treatment and ultimately improves health outcomes for people with HF. This is achieved through Specialist Nurse led clinics, early access to Cardiac Diagnostic Services in Primary Care, and Consultant and GP led management between Primary and Secondary Care.

Target Population:

The target group for this project is adults over 18 years of age, living with Heart Failure in Co. Donegal.

Project outputs & outcomes:

- CNS Heart Failure Integrated Care established heart failure clinics in 4 identified GP practices in Co. Donegal. Target was 4.
- 259 diagnostic tests delivered over a 4-month period.
- 198 patients with heart failure received specialist nurse input regarding evidence-based medication, education on their condition and self-care management strategies within their GP practice. Target was 30.
- 34 unscheduled reviews at CNS/ANP clinics, avoiding hospitalisation.
- 272 bed days approximately avoided to date against a target of 182.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Hospital admissions avoided; acute bed days reduced cont.

Project 340A

Accelerating Integrated Care for Older Persons

Hospital avoidance through integrated care in the community

Who is delivering this project?	Where?	Operational Period:
HSE	CHO 5/St Lukes Kilkenny- North Kilkenny CHN, CHO 4/MUH/CUH-Bandon/Kinsale/Carrigaline and CHO 9/MUH/Beaumont- Ballymun (Scale up of existing sites x3)	13 months

What is this project about?

This project is part of a broader scaling of the Integrated Care Programme for Older Persons (ICPOP), Older Person Service Model and fits within the strategic objectives sponsored by the HSE and Sláintecare on Enhancing Community care. This provides an opportunity to align the development of integrated care for older persons with the emergence of the nine Community Health Network (CHN) learning sites. ICPOP is a multi-faceted approach to designing and delivering integrated care across local communities and hospitals, between providers, users and carers. The concept requires a complete change in how health and social care is delivered nationwide, with a strong focus on patient experience and quality of care. Health and social care systems recognise that sustainable strategies lie in a population-based health approach. The key cohort of this approach is older persons. At the essence of such change is a need to transition from an acute, episodic care to longitudinal, coordinated and integrated care models. This project established alignment with Community Health Network Learning Sites and transition to a locally based approach to integrated care delivery in each site. This delivered:

- Integration between older person services with end to end care pathways as outlined by ICPOP service design.
- Improved access to comprehensive needs assessment, as needs change with an aligned population and care planning approach.
- Community model development and support for older person pathways that will improve coordination in the local health ecosystem in its entirety to include NGOs, local authorities, and local communities.

Target Population:

This project was for patients over 70 years old.

Project 340A cont.

Project outputs & outcomes:

- 59 interventions such as referrals to exercise and nutrition education, social prescribing, housing adaptations.
- Provided case management for 395 older adults with complex care needs referred from GP and Acute Setting. Target was 180.
- 100 patients avoided hospital admission by being accepted onto the caseload in the clinic (CHO 4).
- 35 high care needs patients avoided hospital admission by being accepted onto the caseload in the clinic (CHO 4).
- Reduced the average length of stay by 0.5 days which translates to a reduction in cost of €26,500 approximately for the 53 admissions (CHO 5).
- 8 Patients (15%) were readmitted within 30 days of discharge (CHO 5). The expected readmission rate based on 2020 figures was 22% which would have translated to 12 patients. This was a reduction in 4 readmissions, at an average LOS of 8.5 days, which represents a monetary saving of € 34,000 approximately.
- The average readmission length of stay for patients previously treated by the Community Older Persons Priority Early Response (COPPER) team was reduced from 8.5 days to 5 days. This also denotes a 3.5-day reduction in the average length of stay translating to a saving of € 28,000 (CHO 5).
- This represents a total saving of €88,500 over the 6 months since the team's inception (CHO 5).
- 1388.5 bed days avoided approximately.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Hospital admissions avoided; acute bed days reduced cont.

Project 340B

Accelerating Integrated Care for Older Persons

Improving patients' experience through the provision of care in the community

Who is delivering this project?	Where?	Operational Period:
Community Healthcare Organisation Galway, Mayo and Roscommon (CHO 2)	Galway	7 months

What is this project about?

The main goal of the project was to provide comprehensive geriatric assessment and care for older people in Galway in a community setting, implementing the ICPOP 10 step Framework. This was achieved through the establishment of longitudinal integrated care pathways between the hub and the community with a particular focus on developing Falls, Frailty and Memory pathways. Through these new pathways, GPs and PHNs provided with an alternative to acute hospital/ED referral for where rapid access to specialist geriatric services (falls/syncope and memory with specialist HSCP support) is available. The Galway project is part of a much larger national strategic plan for older persons services and Community Health Network development.

Target Population:

Older people and their carers

Project outputs & outcomes:

- 1916 older persons were managed through service, receiving a comprehensive geriatric assessment including specialist physio, OT, MSW and nursing. Target was 1800 patients.
- 21 crisis admissions averted in 7 months of service operation.
- 399 reduced bed days approximately based on average length of stay of 19 days for a moderately frail person and approximate bed day savings of €400,000.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 171

My Home MHCIS

Mental Health, Community Integration & Support — Integrating Mental Health, Social Care & Housing in Local Community

Who is delivering this project?	Where?	Operational Period:
HSE Community Healthcare West Mental Health. However, the project will adopt a collaborative approach between partners including HSE Mental Health Services, Galway Simon Community, Roscommon and Galway County Councils, and Approved Housing Bodies	Galway and Roscommon	24 months

What is this project about?

This project delivers a new housing-led, community integrated recovery focused model in Galway/Roscommon Mental Health Services. This involves the assessment of housing needs of all residents in mental health congregated settings referred to the project, and the provision of a package of supports which enable a proportion of this cohort to live independently, becoming full participants in their communities. My HOME MHCIS provides a comprehensive assessment of the housing and support needs of residents in mental health congregated settings referred to the project, and provides intensive, individualised psychosocial support, that enables a proportion of this cohort (proposed initially 10 — 15 per county), to transition into accommodation which is suited to their needs and is of their choosing.

Target Population:

The target group of the project are older people, vulnerable population, people with chronic health conditions/disease, and people with mental health issues.

Project outputs & outcomes:

- 20 mental health service users transitioning from hostel or inpatient facility to their own home in the community were provided with housing support against a target of 15-20 and 34 individuals were provided with floating support by 3 Housing Support Workers against a target of 30-36.
- A package of support was provided to 35 individuals which enabled a proportion of this cohort to live independently and become full participants in their communities, exceeding the target of 15-20.
- 95% (19) reduction in inpatient admissions as no participants were admitted to hospital. Target was 50%.
- There was one 3-month admission to hospital. In 2018 this person spent 8 months in hospital. This equates a 5-month reduction, or 150 reduced bed days.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2 cont.

Increased Integration of Care, e.g. home outreach/community referral rather than referral to acute location

Eight SIF funded projects; across a range of specializations including Respiratory (COPD)/Asthma, Social inclusion, Headache/Migrane, Diabetes Care, Gastrointestinal, Heart Failure and sexual health; had a primary high-level outcome to increase integration of care. The average operational period of the various services at the time of this report is 12 months. To date **4,870** patients have been seen, **1,945** patients were treated in the community, **54** GP practices are now referring into integrated service and **190** emergency department attendances were avoided.

Project 2

Sustain and expand TRY

Reducing future health need though early intervention by a peer mentor network

Who is delivering this project?	Where?	Operational Period:
St Teresa's Gardens Regeneration Board and the Donore Community Drug and Alcohol Team	St Teresa's Gardens, Basin Lane Flats and Oliver Bond Flats areas of Dublin.	24 months

What is this project about?

TRY implements an outreach and bridging model. Workers are peer mentors who make contact with the target group in community settings, on the street, in the flat complexes, building relationships by acting as role models. This model of working is predicated by intensive outreach and informal street-based activities. Bridging young people towards appropriate mainstream support services requires the workers to mediate between the young people and services they need. Over time, workers hand-hold the young people as they cross to a more constructive life-path involving healthy positive relationships, a positive relationship with drugs and alcohol and a positive regard for and by their community. As many of the participants do not identify themselves as drug addicts, it is interesting that the workers can challenge this perception and move participants into treatment. Identifying issues and responses at this stage will reduce future treatment needs.

Target Population:

TRY targets vulnerable young people aged 14 to 26 years who are in a chaotic condition of drug and alcohol misuse, mental health issues, and educational and employment deficits dealing drugs in the St. Teresa's Gardens, Basin Lane Flats and Oliver Bond Flats areas of Dublin. TRY aims to move some of its target group into peer mentor roles to continue and expand this work with hard-to-reach and marginalised young people.

Project outputs & outcomes:

- 3,288 cumulative weekly contacts with individuals engaged in anti-social behaviour made exceeding the target of 1,057.
- 288% (101) increase in attendance from an extremely marginalised cohort, into mainstream services (health, education, training and employment) against a target of 20% (31) and a baseline of 26.
- 180% (14) increase in engagement in drug rehabilitation programmes exceeding the target of 20% (6).

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased Integration of Care, e.g. home outreach/ community referral rather than referral to acute location cont.

Project 40

Student Sexual Health Service (Athlone Institute of Technology)
Prevention of STIs through an Innovative Nurse Led Service

Who is delivering this project?	Where?	Operational Period:
Athlone Institute of Technology	Athlone Institute of Technology	15.5 months

What is this project about?

Athlone Institute of Technology is delivering a comprehensive student sexual health service to meet the needs of its growing student population – 61% of whom are aged 18-24 and are classified as 'high risk' for sexually transmitted infections (STIs). This project is being delivered directly to students on campus in a geographical area that was previously underserved. The project is supported by a full-time Advanced Nurse Practitioner in Sexual Health, who provides a complete cycle of care to students including assessment, testing, treatment and appropriate follow up. A specialist GP provides clinical governance and support. In addition to clinical services, health promoting educational campaigns are provided to the campus community supporting positive sexual health and enhancing awareness of STIs and the availability of services.

Target Population:

The target group for this project are students attending Athlone Institute of Technology - predominately aged 19-24 years.

Project outputs & outcomes:

- 5,500 students of Athlone Institute of Technology had access to comprehensive and age-appropriate sexual health education and/or information, with access to appropriate prevention and promotion services with special attention to subpopulations most at risk. Target was 5,500.
- 1,373 students availed of sexual health consultations at the student health centre exceeding the target of 350.
- 7,980 free condoms and lubricant provided exceeding the target of 5,500.
- 232 referrals for contraception services exceeding the target of 100.
- 18306% (1,373) increase in students attending sexual health appointments exceeding the target of 50%. This was verified by attendance rates captured and compared to baseline data pre-service implementation.
- 173% (30) increase in number of persons diagnosed with a sexually transmitted infection who are supported to notify their partners the exceeding the target of 50%. This was verified by records maintained to identify the numbers of persons diagnosed with a sexually transmitted infection who are supported to notify their partners thus reducing negative health outcomes and helping break the chain of infection and was compared to the pre service implementation baseline which indicates that 0% of persons were supported with partner notification.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 61

Towards Selfcare in Headache

Shifting the balance of care from the acute hospital setting and into the community by offering holistic, patient-centred care, at the lowest level of complexity

Who is delivering this project?	Where?	Operational Period:
HSE Clinical Strategy & Programme Division	It has provided a new service delivery model for headache in four pilot sites nationally	13 months

What is this project about?

This project involves shifting the balance of care from the acute hospital setting and into the community by offering holistic, patient-centred care, at the lowest level of complexity. The purpose is to reduce the reliance on secondary/tertiary care, harness existing resources within the community network (e.g. pharmacies), and to promote a programme of self-care and self-management for those with chronic disorders. The project has established new protocols for management of headache, that provide for trained nurse prescribers who work alongside neurologists with expertise in headache, and in collaboration with GPs, the Migraine Association of Ireland and local pharmacies.

Target Population:

The target group for the project are patients with headache disorders.

Project outputs & outcomes:

- A new Service Delivery model for Headache has been developed in 3 Pilot Sites.
- 85 pharmacists are participating in the programme, exceeding the target of 20 Pharmacists.
- Over 369 patients referred to community pharmacy to date exceeding the target of 200.
- Audit complete, includes 2,517 patients' details.
- There was a significant improvement in new: return ratio in the headache clinic in St James Hospital, it is currently 3:1 compare to prior setting for people with headaches (pwH) in General Neurology Clinic of 1:2.
- It became apparent that setting up an alternative referral pathway was a better option in the majority of sites. Headache clinics have now been established with rapid access in Tallaght and St James hospitals with approx. 36 rapid access slots per month.
- 300% (3) increase in nurse led headache clinics was achieved. Only 1 existed previously and there is now 3.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased Integration of Care, e.g. home outreach/ community referral rather than referral to acute location cont.

Project 153

End to end implementation of the Model of Integrated Care for Type 2 diabetes within 2 CHOs

Resourcing two Community Health Networks with integrated diabetes care teams to support general practice in delivering diabetes care in the community

Who is delivering this project?	Where?	Operational Period:
HSE (Chronic Disease Commissioning Team, Primary Care Strategy and Planning)	Tuam, Abbeyknockmoy, Athenry, Loughrea Community Health Network in CHO 2 and Northwest Cork Community Health Network in Cork Kerry Community Healthcare (CHO 4)	8 months

What is this project about?

This project was involved in end-to-end implementation of the model of integrated care in two community health networks: Tuam, Abbeyknockmoy, Athenry, Loughrea in Community Healthcare West (CHO 2) and Northwest Cork Community Health Network in Cork Kerry Community Healthcare (CHO 4). All GP Practices within these networks will be able to access these specialised integrated diabetes care services which traditionally would only have been available in a hospital setting.

Target Population:

People with a diagnosis of Type 2 Diabetes residing within CHO 2 and CHO 4 were the primary target group in this SIF-153 project.

Project outputs & outcomes:

- 163 new patients seen either in-clinic or as a virtual consultation in CHO2 exceeding the target of 64.
- 32 new patients seen either in-clinic or as a virtual consultation in CHO4.
- 348 return patients seen either in-clinic or as a virtual consultation in CHO2 exceeding the target of 93.
- 111 return patients seen either in-clinic or as a virtual consultation in CHO4 exceeding the target of 93.
- 106 new patients seen 1:1 per dietitian in CHO2 exceeding the target of 80.
- 89 new patients seen 1:1 per dietitian in CHO4 exceeding the target of 80.
- 155 return patients seen 1:1 per dietitian in CHO2 exceeding the target of 48.
- 153 return patients seen 1:1 per dietitian in CHO4 exceeding the target of 48.
- Number of GP's accessing CNS Diabetes Integrated Care Service increased from 5/11 to 10/11 (CHO2).
- Improved access to Diabetes education for Health Care Professionals with plans developed for both networks.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 159

End to End Respiratory Model at 2 Sites
Caring for respiratory patients in the community

Who is delivering this project?	Where?	Operational Period:
The Chronic Disease Team supported by the Nursing Care Plan (NCP) Respiratory is delivering this project with the assistance of two sites: CHO 8 Community Health Network (CHN) Longford & Central Westmeath linked to Mullingar Hospital and CHO 6 CHN North East Wicklow linked to St Michaels Dun Laoghaire	CHO 8 CHN Longford & Central Westmeath linked to Mullingar Hospital and CHO 6 CHN North East Wicklow linked to St Michaels Dun Laoghaire	4 months

What is this project about?

The Integrated Care team delivers flexible, coordinated services for COPD patients in the community, reducing demand on hospital services. Improved access to diagnostic facilities in the community allows for the timely, accurate diagnosis of respiratory conditions and earlier instigation of appropriate management plans. The project provides access to a specialist service nearer patients' homes (in GP practices or primary care centres), thus reducing time and travel demands for patients and their carers.

Target Population:

The target group for the project are people living with chronic respiratory disease such as COPD or asthma living in Northeast Wicklow and Longford/Westmeath.

Appendix 2: Increased Integration of Care, e.g. home outreach/ community referral rather than referral to acute location cont.

Project 159 cont.

Project outputs & outcomes:

- 30 new patients seen by the Clinical Nurse Specialist (CNS) in 3 months (target is 122 per year).
- The Pulmonary Rehabilitation (PR) service decreased the lack of availability of PR from 74% and 79% of GMS patients with COPD in North East Wicklow and Longford/central Westmeath, to 63% and 36% respectively. Of the 707 patients admitted with AECOPD, 337 availed of PR exceeding the target of 168.
- 120 patients seen in Spirometry service with community diagnostic services integrated with each local hospital Pulmonary Function Laboratory (St. Michael's & Mullingar Hospital) over 3 months against a target of 450 per annum.
- The project inherited a waiting list initially of 176 patients, within six months they have significantly reduced the waiting list by 46% to 102 patients.
- Wait times in Longford were reduced by 107 weeks from 301 weeks to 194 weeks.
- Wait times in Westmeath were reduced by 27 weeks from 285 weeks to 258 weeks.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 175

Expansion of the Model of Diabetes Integrated Care throughout Sligo/ Leitrim/West Cavan

Integrated community diabetes care in Sligo/Leitrim/West Cavan

Who is delivering this project?	Where?
Community Health Organisation Donegal, Sligo/Leitrim/ West Cavan, Cavan/Monaghan (CHO 1)	Sligo/Leitrim/West Cavan

What is this project about?

This project aimed to expand the current Diabetes Integrated Care Service to provide equitable access for all GP Practices in Sligo/Leitrim/West Cavan, providing care closer to home for patients with Type 2 Diabetes, optimising the person's quality of life in line with the Sláintecare vision. It aimed to develop formal links with Community Hospitals and Nursing Homes to support management of diabetes and encourage self-management by residents leading to a reduction in admissions, reducing length of stay in acute care, and support the development and implementation of Clinical Practice Guidelines for long term care residents with diabetes in collaboration with Integrated Care Service for Older People (ICPOP). This project also aimed to increase the capacity to deliver Structured Patient Education, which is a key component of self-management support, to empower individuals and their families to take an active role in their diabetes management.

Challenges:

This project was significantly delayed due to the COVID-19 pandemic and recruitment difficulties. It was agreed that, as the project was delayed, the CNS Integrated Care post, which is a core post for this project, would be recruited as part of the mainstreaming of this project through the Enhanced Community Care (ECC) programme.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Increased Integration of Care, e.g. home outreach/ community referral rather than referral to acute location cont.

Project 378

Integrated Community Chest Pain Clinic Tallaght University Hospital

Shifting chest pain care from the Emergency Department to the community, providing hospital avoidance measures

Who is delivering this project?	Where?	Operational Period:
Tallaght University Hospital (TUH)	Tallaght University Hospital (TUH)	18 months

What is this project about?

Chest pain is a principal presenting symptom of coronary heart disease and places a significant burden on the Emergency Department (ED). Patient presentations with chest pain to Tallaght University Hospital ED rose from 5% of all ED presentations in 2009 to 9% in 2019, of which 31% were referred after an initial visit to the GP, 78% were low risk and 70% were subsequently discharged. This project has set up a chest pain clinic in the community which is an integrated component of the pre-existing TUH advanced nurse-led chest pain service. It is managed by an Advanced Nurse Practitioner (ANP) ensuring clinical autonomy and caseload management. The ANP assesses non-acute chest pain patients referred by their GP in the community, thereby leading to emergency department avoidance. This service provides an alternative referral route for GPs to the community, instead of the Emergency Department and uses advanced nurse practitioner competencies.

Target Population:

The target group for the project are General Practitioners in the local surrounding area of TUH who assess patients with non-acute chest pain, and patients who attend their GP with non-acute chest pain.

Project outputs & outcomes:

- 618 patients referred to Integrated Community Chest Pain Clinic by GP's exceeding the target of 400.
- 17% (190) reductions of patients referred by GPs to TUH ED with low-risk chest pain achieved against a target of 10-20%.
- 109% (35) of GP practices utilising a direct link with an expert RANP in excess of the target of 75% (24).
- The waiting time for a new appointment in TUH Cardiology has now reduced from 6 months to 6 weeks.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 468

Electronic Ordering for GP Lab Tests

Electronic Ordering for General Practitioner Laboratory Tests reduces laboratory administration and errors

Who is delivering this project?	Where?
Galway University Hospital (GUH)/Saolta Hospital Group	Galway University Hospital GP catchment area.

What is this project about?

The Saolta University Health Care Group comprises seven hospital sites with six laboratory divisions, serving both hospital and local GP needs. Approximately 40% or 5.8 million tests in GUH alone were from GP or community patients. All these requests arrive on handwritten forms and have to be manually entered into the laboratory system. This project has set up new centralised electronic processing systems for specimen reception and replaced manual laboratory requests with electronic orders by GPs, through a system called HealthLink. The system has been delivered to two GP surgeries, and eight laboratory staff at GUH have received training on the system. Turnaround time for haematology samples have been reduced from three to two working days, and biochemistry turnaround time have been reduced from five to two working days for electronically ordered samples.

Project outputs & outcomes:

- While much preparatory work has been completed, the project was severely impacted by Covid-19 and the HSE cyber-attack. As a result of Covid-19, all Lab IT resources and HealthLink resources were re-deployed.
- The project has noted that once HealthLinks commence work and the pilot has been developed and implemented, this can be replicated easily for other GP practices, in collaboration with HealthLinks. It is also noted that other laboratories within Saolta can then also replicate the work and implement electronic ordering for GPs in their communities which would require additional IT staff resources for each site to implement as it is rolled out.

This project has concluded operations and closed out.

Appendix 2 cont.

Reduced referrals, or more appropriate referrals to relevant health specialists within the community

Ten SIF funded projects; across a range of specializations including Oncology, Epilepsy, Social Prescribing, Diabetes Care, Mental Health, Heart Failure and Orthopaedics; had a primary high-level outcome to reduce referrals. The average operational period of the various services at the time of this report is 19 months. To date **4,079** patients have been treated, and referrals have been reduced by **10,277**.

Project 94

Trauma Assessment Clinic (TAC)
Reducing unnecessary referrals

Who is delivering this project?	Where?	Operational Period:
National Clinical Programme for Trauma and Orthopaedic Surgery (NCP TOS), Royal College of Surgeons in Ireland	Letterkenny University Hospital, Cork University Hospital, University Hospital Waterford, Connolly Hospital Blanchardstown and Midland Regional Hospital at Tullamore.	28 months

What is this project about?

This project promotes the Trauma Assessment Clinic (TAC) pathway of care by implementing virtual clinic programmes. The TAC pathway is a safe and efficient means of delivering trauma care. It promotes patient empowerment but without compromising clinical care and marries current available technology with up to date best clinical practice.

Target Population:

The target group for this project are patients who sustain a fracture as a result of trauma. 55,000 new fracture patients attend annually in outpatient fracture clinics, averaging 2.6 return visits per patient. The TAC offers a novel care pathway for patients with simple, stable injuries. TAC embodies the provision of safe, patient centred, efficient and cost-effective treatment via a multidisciplinary team (MDT) approach.

Project outputs & outcomes:

- 1,820 patients availed of the service over 12 months.
- 70% (482) reduction in unnecessary fracture clinic referrals of which is in excess of the target of 38% (261). With the introduction of virtual TAC clinics there was a significant amount of education completed on each site in relation to education leaflets for patients and staff creation and completion of referral forms to TAC.
- 58% (6,380) reduction in actual fracture clinic attendances in adult hospitals compared to a target of 38% (4,180).
- 27% (2,915) of patients were seen directly by physiotherapist with direct discharge to community physiotherapist.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Reduced referrals, or more appropriate referrals to relevant health specialists within the community cont.

Project 162

Adult Social Prescribing for Individual Resilience and Empowerment

Social prescribing project which will reduce barriers for individuals to become involved in health and wellbeing activities

Who is delivering this project?	Where?	Operational Period:
Bray Area Partnership	Bray and Greystones, North Co. Wicklow	21 months

What is this project about?

The Adult Social Prescribing for Individual Resilience and Empowerment (ASPIRE) Project aims to address the wider social and economic determinants of health by adopting a Social Prescribing model. Social prescribing will empower citizens to manage their own health and wellbeing through community support thereby reducing GP visits. Currently, ASPIRE service provides individual (phone/online/face-to-face) and group (online/face-to-face) supports. It also helps individuals determine which virtual, online and phone support, training, activities, group meetings and online wellbeing resources may be available to them, based on their needs and preferences.

Target Population:

The target group for this project is the community as a whole, and particularly those in the community experiencing limited social contact. ASPIRE is delivered in the Bray, Greystones and North Co. Wicklow area.

Project outputs & outcomes:

- 79 individuals have been referred from multiple sources and supported to participate in the programmes so far, exceeding the target of 50.
- A co-produced individual plan developed and agreed with 46 participants.
- 52 caseload individuals completed a six-week activity programme, target was 30.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 247

CIT Dublin North City and County Community Oncology Service

Increasing Oncology/Haematology Day Unit Capacity through the development of community-based nurse led Oncology service

Who is delivering this project?	Where?	Operational Period:
Community Health Organisation Dublin North City and County (CHO 9)	Dublin North City and County	13 months

What is this project about?

The project provides expert care to cancer patients outside the hospital setting. This enables the expansion of the Community Intervention Team (CIT) Community Oncology Service to increase the number and type of treatments it can deliver to patients in the CIT clinic, in collaboration with the Mater Misericordiae University Hospital (MMUH). This reduces pressure on acute hospital Cancer Care Directorate services. The aim of the project is to provide expert care to cancer patients outside the hospital setting. The development of the CIT Community Oncology clinic with the addition of an Advance Nurse Practitioner (ANP) role shifts the focus to an integrated model of care. This service provides community-based treatments for at least 25 patients who would normally have to attend a Day Oncology/Haematology Unit.

Target Population:

The service is open to oncology patients receiving active treatment and is accessible to all ages, genders, nationalities and socio-economic backgrounds. It is an inclusive and accessible service to patients aged over 16 years receiving specific oncology treatments.

Project outputs & outcomes:

- 107 patients choose to have treatment in the community clinic who would normally attend a Day Oncology/Haematology Unit, exceeding the target of 25.
- 14 oncology patients have been treated with Transtuzumab (Herceptin), target was 7.
- 93 patients have been treated with other medication, available on HIGH tech prescription, target was 18.
- 710 attendances to CIT oncology service instead of in the Hospital Day Oncology Unit, target was 310.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Reduced referrals, or more appropriate referrals to relevant health specialists within the community cont.

Project 253

Cork Kerry Health & Wellbeing Community Referral

Linking people with non-clinical supports within the community to improve physical, emotional and mental wellbeing

Who is delivering this project?	Where?	Operational Period:
National Forum of Family Resource Centres	Family Resource Centres in Cork (4) and Kerry (2)	19 months

What is the project about?

This pilot project for Cork Kerry Health & Wellbeing Community Referral (CKH&WBCR) service is based within six Family Resource Centres (FRC) and builds upon the experience of the service based in Listowel FRC. CKH&WBCR is a means of enabling GPs and other frontline healthcare practitioners to refer patients to a link worker who can provide them with a face to face conversation during which they can learn about the possibilities and options available to them. They will explore hobbies and the benefits of participating in them and will assist and support participants in attending these activities. People with social, emotional or practical needs are empowered to find practical solutions.

Target Population:

The target group for the project was for people who are socially isolated or have a lack of social support and people who are socially excluded. Almost 10% of referrals received were for Refugees/Asylum Seekers.

Project outputs & outcomes:

- Project received 446 referrals to date. Target was 300.
- GPs referred 3% (14) of patients.
- 77% (358) of participants availing of supports were supported for mental health difficulties, target was 60%.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 287

Empowering Communities to support language Development in young children
Community supports for young children with delayed language skills

Who is delivering this project?	Where?	Operational Period:
HSE Community Health Organisation Midlands Louth Meath (CHO 8)	Laois/Offaly	12 months

What is this project about?

Referrals of children under the age of 5 years represent a significant proportion of referrals to Speech and Language Therapy (SLT) services nationally. Many of these children present with delayed language skills. Data suggests that approximately 6% of 2-5 year olds experience language difficulties. Children experiencing disadvantage have more difficulties which may present as more severe and pervasive in nature. This project builds capacity within communities to support young children to acquire age-appropriate language skills. It works with parents and pre-school staff to facilitate language development in their own local context. The project works with communities to design and deliver change that meets their specific needs.

Target Population:

The target group of the project are preschool teachers, parents of young children, teachers, community workers and librarians.

Project outputs & outcomes:

- A Hanen Teacher Talk training programme and evaluation was developed and rolled out in 17 pre-schools in Laois Offaly.
- 34 pre-school staff in Laois Offaly have been trained in Hanen Teacher Talk. Target was 20.
- 60 parents have been coached in coaching sessions in preschools. Target was 50.
- Project reduced the referral rate for specialist SLT services by 20% (32). Target was 10% (16).

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Reduced referrals, or more appropriate referrals to relevant health specialists within the community cont.

Project 366

Keeping People with severe epilepsy independent

Extending the clinical pathway beyond ED by using remote and virtual care using electronic patient record (EPR) and portal technology in order to start to prevent admissions rather than reduce them at the source leading to reduced ED visits

Who is delivering this project?	Operational Period:
St James's Hospital	21.5 months

What is this project about?

Epilepsy is the most common neurological disease of young people and one of the most common medical reasons for admission through ED. In 2013 there were over 1000 ED attendances and 436 admissions with an average length of stay (LOS) of 5 days. This figure has dropped to less than half that with the use of an integrated pathway designed by the epilepsy team in St James's Hospital.

Target Population:

This project targets epilepsy patients, especially the long term homeless and those with an intellectual disability living in residential care. The project targets these specific patient groups aimed at reducing the dependence of patients with severe epilepsy on the ED by intervening earlier in the patient journey to prevent ED presentations.

Project outputs & outcomes:

- Project achieved target of managing the epilepsy care needs of 314 patients with intellectual disability who are in residential care with epilepsy by remote and virtual care using the EPR and portal technology.
- 61% (36) reduction in OPD visits among target patients with intellectual disability who are in residential care with epilepsy, target was a 60% reduction.
- ED visits were reduced by 29% (167) among homeless target group, exceeding the target of 30%.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 370

The LAMP Project - Social Prescribing Integration in the Acute Care Sector

Improving patient outcomes through social prescribing

Who is delivering this project?	Where?	Operational Period:
St James's Hospital	St James's Hospital catchment area	20 months

What is this project about?

The goal of this project was to actively link users of the acute hospital system with existing local supports for their health and wellbeing, in order to improve outcomes and reduce dependence on the hospital system. The objective was to implement a complete Social Prescribing system for St James's Hospital. The LAMP project has established a project team to promote and deliver Social Prescribing integration in the Acute Care Sector in the catchment area and will update the social prescribing database. 3,900 patients from Medicine for the Elderly, Respiratory Medicine and the Emergency Department will be issued social prescriptions.

Target Population:

The target group for this project are people over the age of 65 years attending the care of the older person's services in The Mercer's Institute for Successful Ageing in St James's Hospital including:

- people with dementia and their family members.
- participants who were experiencing social isolation and loneliness.
- participants recently discharged from hospital who were physically and mentally more vulnerable and consequently in need of additional support.
- participants with mental health issues such as anxiety and depression.

Project outputs & outcomes:

- 90 patients were issued social prescriptions from cohorts drawn from Medicine for Elderly, Respiratory Medicine and the Emergency Dept.
- 33% (26) reduction in service utilisation through social prescribing exceeding the target of 26% (21).
- 51% (81) uptake compliance with dispensed social prescriptions achieved.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Reduced referrals, or more appropriate referrals to relevant health specialists within the community cont.

Project 375

Integrated care for patients presenting with leg ulcers in Dublin South, Kildare, and West Wicklow

Development and support of more widespread availability of expertise for leg ulcer treatment in the community.

Who is delivering this project?	Operational Period:
Tallaght University Hospital (TUH) and Community Healthcare Organisation Dublin South, Kildare and West Wicklow (CHO 7)	21 months

What is this project about?

This project has established a collaborative service to facilitate leg ulcer clinics in primary care centres, led by TUH in partnership with Community Healthcare Dublin South, Kildare and West Wicklow. The service enables integrated care between the community and hospital to be further developed in order to improve the care of leg ulcer patients. The prevalence of leg ulcers in the community is approximately 1% and the majority of patients are managed in the community using compression bandaging. Community nurses who see patients may not have expertise and treatment may vary. For community nurses with some expertise, there remains a challenge in managing patients who fail to progress, have diabetes (a growing cohort), have mild-moderate arterial disease, or who present with a suspected malignancy. Currently, referral to TUH is indicated for more complicated patients from areas where special expertise on the care of leg ulcers is not readily available. Those with low-risk cellulitis are referred to either their GP, out-of-hours service or local ED when this could be managed at community nurse-led clinics following agreed protocols. There is currently only one vascular surgery centre catering for a population of 500,000 in South-west Dublin, West Wicklow and Kildare.

Target Population:

The target group for this project are people with chronic health conditions (diabetes, lymphoedema, ulcerated post-op wounds).

Project outputs & outcomes:

- 414 new patients have been seen.
- 47% (414) decrease in direct patient referral to TUH Vascular team for leg ulcer management exceeding the target of 20%.
- Vascular OPD attendances reduced by 1302 compared to a target of 970 appointments per year. This represented an overall reduction of 17%.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 407

Smart triage of kidney and lung transplant patients

Self-management mobile App for kidney and lung transplant recipients using remote monitoring

Who is delivering this project?	Operational Period:
Beaumont Hospital and Mater Misericordiae University Hospital	26 months

What is this project about?

Kidney and lung transplant survival requires the continuous monitoring of patient-reported symptoms and laboratory data. Routine hospital attendance by transplant patients requires significant healthcare utilisation costs. Post-transplant, patients are reviewed on a regular basis. This traditional approach results in significant patient burden and inefficient use of healthcare resources. There is an unmet need for high quality, remote, community-based monitoring of kidney and lung transplant patients. patientMpower Ltd. have developed a self-management mobile App for kidney and lung transplant recipients. The App can record both subjective data (patient-reported symptoms) and objective data from connected devices (blood pressure, lung function, weight, etc.). Patients can monitor trends in their data through the App, while the transplant centre can review the data in real time and act on important signals.

Target Population:

The target group for this project are all recent and future renal transplant patients (excluding paediatric) and all lung transplant patients.

Project outputs & outcomes:

- 92 new kidney transplant patients provided with kidney remote monitoring equipment.
- 3 new lung transplant patients provided with remote monitoring equipment.
- Outpatient appointments were reduced by 75% (800) due to technology intelligently triaging follow-up of transplant patients against a target of 66% (710) and baseline of 1,076.
- €774,400 in core costs reduced by 28% (€215,280) approximately.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Reduced referrals, or more appropriate referrals to relevant health specialists within the community cont.

Project 416

Heart Failure Improving Patient Outcomes and Health Service Efficiency by Comprehensive and Innovative Integration of Care Across the Continuum of Healthcare Settings

Improving patient outcomes through integrated care for heart failure

Who is delivering this project?	Where?	Operational Period:
Portiuncula University Hospital (PUH) & Community Healthcare West	PUH, Ballinasloe PCC, Portumna PCC, Mountbellew PCC and Monksland PCC	9.5 months

What is this Project about?

Portiuncula University Hospital (PUH) and Community Healthcare West (CHO2) continue to work together to improve services for patients diagnosed with Heart Failure (HF). The project includes development of three integrated services which are Community Cardiac Diagnostics Services, Integrated Heart Failure Nursing Service, and Heart Failure Virtual Clinics (HFVC). This means that every patient with HF symptoms is diagnosed correctly, in a service close to their home, without delay, in a cost-efficient manner.

Target Population:

The target group for this project are patients with Heart Failure or suspected Heart Failure in the East Galway region.

Project outputs & outcomes:

- Community cardiac diagnostics service has been developed and delivered with displacement of 529 echocardiograms from PUH Cardiac Investigations Department to Community so far. Target was 400 within 12 months of service being fully operational.
- 6% (2) reduction in PUH Cardiology OPD appointments for patients with heart failure.
- Average length of stay of patients admitted with primary diagnosis of heart failure was reduced by 27% (1.77 days). Target was 10% (0.67 days) and baseline was 6.57 days.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2 cont.

Improved health status

36 SIF funded projects; across a range of specializations including chronic disease management, mental health, physical activity, older persons and smoking cessation; had a primary high-level outcome to improved health status. The average operational period of the various services at the time of this report is 15.5 months. To date **13,086** patients have been treated and have experienced a variety of improved health outcomes.

Appendix 2: Improved health status cont.

Chronic Disease

Nine SIF funded projects, specialising in chronic disease management, had a primary high-level outcome to improve health status. The average operational period of the various services at the time of this report is 10 months. To date **1,031** patients have been treated. Patients have seen improvements in strength (up to **72%**), quality of life (up to **42%**), and physical activity levels (up to **96%**) and reduced levels of anxiety (up to **90%**), depression (up to **80%**) and stress (up to **92%**).

Project 105

Community based Pulmonary Rehab Programme

Improved quality of life thanks to Pulmonary Rehabilitation in the community

Who is delivering this project?	Where?	Operational Period:
Community Healthcare Organisation East (CHO 6)	Community Healthcare Organisation East (CHO 6).	10 months

What is this project about?

This project delivers a structured pulmonary rehabilitation programme in the community setting to those diagnosed with respiratory conditions causing functional disability such as COPD and Asthma. It aims to empower individuals living with symptoms of such conditions, despite medical treatment, to manage their condition daily. The programme provides individuals with a safe environment to build regular exercise into their lifestyle, staying healthier in their own community, and to be able to identify and prevent symptoms that can aggravate their condition thereby reducing hospital attendance.

Target Population:

The target group for this project are people with obstructive lung diseases such as Asthma and COPD with daily breathlessness that affects their daily living.

Project outputs & outcomes:

- 53% (8) of participants achieved Minimal Clinically Important Difference (MCID) improvement on the CAT - COPD Assessment Test. Target was 50%.
- 39% (7) of participants achieved MCID improvement on the mMRC - Modified Medical Research Council Dyspnoea scale. Target was 35%.
- 42% (8) of participants achieved MCID improvement in anxiety on the HADs – Hospital Anxiety and Depression scale. Target was 20%.
- 31% (6) of participants achieved MCID improvement in depression on the HADs – Hospital Anxiety and Depression scale. Target was 20%.
- 44% (8) of participants achieved MCID improvement in the BORG scale (prescribes workload during muscle training sessions and measures the clinical significance of the rehabilitation outcome). Target was 35%.
- 42% (8) of participants achieved MCID improvement in the CRQ – Chronic Respiratory Disease Questionnaire (measures quality of life in patients with chronic respiratory disease). Target was 35%.
- 56% (10) of participants achieved MCID improvement in 6MWT – 6 Minute Walk Test. Target was 50%.
- 72% (13) of participants achieved MCID improvement in 5 Times Sit-to-Stand. Target was 50%.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Project 121

My Slainte Community Lifestyle Programme
Improving patient outcomes through digital health

Who is delivering this project?	Where?	Operational Period:
Croí, the West of Ireland Cardiac & Stroke Foundation	As the programme is being delivered virtually its reach includes Galway, Mayo and Sligo	27 months

What is this project about?

MySláinte is an innovative, community-based, multidisciplinary lifestyle intervention, designed to improve risk factors across a wide spectrum of chronic diseases, both cardiovascular and non-cardiovascular chronic diseases like diabetes, cancer, lung disease and kidney disease. This programme offers a new and alternative way of delivering preventive care through a virtual platform making it accessible for people to access from the comfort of their home. Utilising specific behavioural change techniques and self-monitoring tools the programme places a strong emphasis on self-management, where patients are empowered to become active participants in their own care. The goal is to equip individuals with the knowledge, skills, and confidence to make changes to their lifestyle in a realistic way that can be sustained long-term.

Target Population:

The target group of the programme include individuals affected by cardiovascular disease, this includes heart disease, stroke, and peripheral artery disease. Many of these patients are living with multiple other chronic conditions such as chronic kidney disease, arthritis, cancer, and diabetes. The majority of participants were male (81%) which is not unusual for cardiac rehabilitation programme and the age range was between 35 and 84 years with the average age being 63 years.

Project 121 cont.

Project outputs & outcomes:

- Project developed and delivered a virtual model of MySlainte to 75 participants, focusing on those affected by cardiovascular disease. Target was 75.
- Croí MySlainte delivered a comprehensive risk factor management and lifestyle modification programme to 75 patients. Target was 75.
- The virtual MySlainte is more accessible to those living in remote locations, 43 patients being from outside of Galway. Target was 30.
- Project obtained comprehensive, comparative outcome data between baseline and end of programme for 64 patients.
- Project achieved a 68% (41) improvement in physical activity levels (based on 7-day physical activity recall and achieving recommended physical activity guidelines) and improvement of 2.1 METs on functional capacity testing. Targets were 20% and 1.5 METS respectively.
- Project had 1 smoker who quit following specialist smoking cessation support.
- Project achieved a 3% (1 kg/m2) reduction in BMI, (target 2%) with over half (57%) of participants losing more than 2% of their bodyweight, and 23% losing 5% or more.
- Project achieved a mean 41% (1.57mmol/l) improvement in cholesterol. Target was 10%.
- Project achieved a mean 44% (<130/80mmHg n=42) improvement in blood pressure. Target was 10%.
- Project achieved a mean 7% (HbA1c <48mmol/l) improvement in glucose control.
- 23% reduction in anxiety, as well as reductions in depression, alcohol intake of those involved in pilot.

This project has concluded operations and closed out.

Appendix 2: Improved health status cont.

Project 154

Development and Implementation of a Digitally Enhanced HSE Type 2 Diabetes Self-Management Education Programme

Increasing access, delivery and uptake of Diabetes Self-Management Education

Who is delivering this project?	Where?	Operational Period:
HSE (Chronic Disease Commissioning Team, Primary Care Strategy and Planning)	National	6 months

What is this project about?

It is estimated that Type 2 diabetes (T2DM) affects over 200,000 individuals and costs up to 18% of the healthcare budget with approximately 10,000 new cases annually. Costly long-term complications can be prevented or delayed by intensive glycaemic management. Diabetes Self-Management Education (SME) is a fundamental component of optimal care, showing improved glycaemic control, psychosocial and behavioural outcomes.

Target Population:

The target group for this project are individuals with Type 2 Diabetes their families and carers.

Project outputs & outcomes:

- Pilots were completed at 4 pilot sites by 290 individuals. Target was 200.
- Outcome data is being analysed..

This project has been mainstreamed which means it will receive recurring funding annually.

Project 156

Development and Implementation of a National Diabetes Prevention Self-Management Education Programme by 2021

Development of a national, evidence-based, targeted diabetes prevention programme which aims to prevent and delay onset of diabetes in high-risk individuals

Who is delivering this project?	Where?	Operational Period:
HSE (Chronic Disease Commissioning Team, Primary Care Strategy and Planning)	National	6 months

What is this project about?

This project is a national, evidence based, targeted diabetes prevention programme. The project involves collaboration with digital and academic partners to enhance access, implementation, evaluation, and outcomes. The project team includes input from a comprehensive range of experts, including clinical, academic and behaviour change who contribute to the design, development, and implementation of this National Diabetes Prevention Programme. The programme is aligned with general practice contractual reforms and the Model of Integrated Care for Patients with Type 2 Diabetes.

Target Population:

The target group for the project are those identified as high risk of developing Type 2 Diabetes and more explicitly those with a diagnosis of Pre-Diabetes.

Project outputs & outcomes:

- Pilots delivered to 20 participants and 10 educators so far.
- Development of a national, evidence based, targeted Type 2 Diabetes prevention programme which has the potential to reduce the number of individuals who develop Type 2 Diabetes.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Project 181

Inclusion Health Specialist Outreach Team

Delivering care to homeless and other socially excluded people

Who is delivering this project?	Operational Period:
St James's Hospital	14 months

What is this project about?

This project delivers care to homeless and other socially excluded people in a way that meets their needs, both improving chronic disease outcomes and reducing avoidable admissions of homeless adults in St James's Hospital (SJH) and Mater Hospital. Socially excluded groups (e.g. homeless people, prisoners, drug-users, asylum-seekers, Travellers, individuals with chronic psychiatric conditions) have complex health needs, experience poor outcomes across a range of indicators (chronic disease, morbidity, mortality, self-reported health), and use a lot of healthcare resources per capita (ED visits, inpatient bed days). The pilot Inclusion Health Service in St James's Hospital has developed an innovative model of integrated care with community providers of health and social care, which has demonstrated remarkable savings in bed-days and length of stay for homeless adults in the SJH catchment area.

Target Population:

The target group for the project are people experiencing homelessness with complex physical health, mental health, substance use issues. Target conditions include HIV/HCV, diabetes, epilepsy, vascular/coagulopathy, COPD, complex skin and soft tissue or bone infection, to be expanded as required.

Project outputs & outcomes:

- Of the 84 individuals enrolled with the programme, 57 have been engaged in care planning with 48 (89%) engaged in active care plans, 26 (30%) have been discharged and 6 (11%) not engaged or not contactable.
- There is a 90% improvement in patient's outcome compared to the target of 10%.
- 1,690 reduced bed days to date against a target of 1,000, this is a reduction of 40% compared to a baseline of 4,274 bed days.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 251

Developing a Pathway of Community Care Supports for People with Epilepsy in Ireland

Epilepsy pathway empowers service users to manage own condition

Who is delivering this project?	Operational Period:
Epilepsy Ireland (Brainwave The Irish Epilepsy Association)	14 months

What is this project about?

The project delivers joint education programmes to people with epilepsy. Training on a "checklist" for caring for people with epilepsy is being delivered to individuals, and training on engagement is being delivered to GPs. People with Epilepsy are being supported in the self-management of their condition, thereby reducing demand on the acute care system. This innovative project demonstrates how a joint approach between staff based in hospital, primary care and the community can work together, complement each other's work, minimise duplication, make best use of scarce resources thereby maximising value for money, while improving the level and depth of contact with People Living with Epilepsy. The project facilitates a shift in care.

Target Population:

The target group for the project are people with epilepsy.

Project outputs & outcomes:

- Delivered joint education programmes to 317 people with epilepsy. Target was 120.
- Training for people with epilepsy on 'checklist' delivered to 52 individuals. Target was 50.
- 175 participants responded to the survey, delivering the results below:
  - 89% (156) of participants reported more awareness of epilepsy and greater control over their condition through the provision of information, education, self-management and self-care supports.
  - 92% (161) of participants reported improved self-reported stress levels/personal confidence and wellbeing levels due to engagement in programme and enhanced links to local Community Resource Officers.

This project has concluded operations and closed out.

Appendix 2: Improved health status cont.

Project 305

Community Based Integrated Respiratory Service
Improving respiratory care in the community

Who is delivering this project?	Where?	Operational Period:
Midlands Louth Meath Community Health Organisation	Co. Meath	4 months

What is this project about?

The model of care outlined by the National Respiratory Clinical Programme includes both Pulmonary Rehabilitation and Pulmonary Outreach as the cornerstone of care for individuals with respiratory disease. Traditionally both of these services are provided from acute services. This proposal moves services into the community, lessening the reliance on acute services. The service provides non-acute respiratory care and exacerbation support for patients living in Co. Meath with a chronic lung condition.

Target Population:

The target group are those with Chronic Obstructive Pulmonary Disease. Patients with other respiratory diseases have also benefited from the service i.e. patients with Bronchiectasis, Pulmonary Fibrosis, Asthma (including Asthma COPD Overlap syndrome), Obesity Hypoventilation Syndrome and patients with post Covid Lung changes. Most of the patients are older and vulnerable with other chronic health conditions.

Project outputs & outcomes:

- The CommBRIT provided 2071 interventions to 93 people living with respiratory disease in the Meath area. Target was 120.
- A minimum clinical importance difference (MCID) of -0.8 points in the participants perceived anxiety and depression at programme completion stage as measured on the Hospital Anxiety and Depression Scale achieved.
- A MCID of -0.1 in participants health status on completion of Pulmonary Rehabilitation as measured on the COPD Clinical Questionnaire (CCQ) was achieved.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 334

Stool Bank Ireland

Providing safe Faecal Microbiota Transplants (FMT) to Irish hospitals to treat refractory or recurrent Clostridioides Difficile Infection (rCDI)

Who is delivering this project?	Where?
RCSI Hospitals Group	National

What is this project about?

This project was funded to establish Stool Bank Ireland to provide safe Faecal Microbiota Transplant (FMT) to Irish hospitals to treat refractory or recurrent Clostridiodes Infection (rCDI), and to create a national registry. From 2012-2017 there were 11,047 CDI cases in Ireland, of which 971 were recurrent, and 143 deaths of patients with CDI. Patients with CDI spend significantly longer in hospital, on average an additional one to three weeks, which contributes significantly to additional hospital costs. CDI is also associated with an increased risk of hospital readmission. A team of clinicians (gastroenterology, clinical microbiology, surgery) and researchers (microbiome) from Beaumont Hospital, Cork University Hospital and APC Microbiome Ireland have come together to develop a national Stool Bank of safe, screened and accessible FMT material for use in Irish hospitals.

Target Population:

The target group for this project are patients with recurrent or refractory CDI. In general, older people, those with comorbidities and frequent hospitalizations are more likely to acquire CDI and suffer rCDI. This patient group has an increased frequency of morbidity and mortality associated with CDI.

Appendix 2: Improved health status cont.

Project 334 cont.

Project outputs & outcomes:

- There are 4 outputs and 2 outcomes associated with the project which were not achieved due to the EU GDPR legislation, changes in FMT regulations and the Covid-19 pandemic.
- The main outcome of the project has been to establish that the product cannot be sourced externally and in undertaking the groundwork for future manufacturing of FMT for use in Irish Hospitals.
- A Clinical and Scientific Stool Bank Representative Committee was established to provide oversight into health and safety standards required for FMT.
- Donor Screening Protocol including exclusion criteria were established.
- Memorandum of understanding of patients' data sharing from hospital sites to UCC established.
- Ethics submissions to all major public hospitals with a Gastroenterology Department where FMT would be performed were drafted to establish a National Registry of all FMT recipients. The majority of these submissions were approved or pending approval by project end date.
- A dedicated FMT room in APC Microbiome Centre in University College Cork was fitted and Stool Bank Ireland efforts on setting out the licensing requirements for manufacturing FMT.
- The work carried out with hospitals and specialists has showed an overwhelming support for both the establishment of Stool Bank service that could provide FMT samples and the establishment of a National Registry for FMT recipients.
- The project has provided statistics which show the impact that the product can have on the lives of patients and the longer-term costs savings for the health service.

This project has concluded operations and closed out.

Project 383

Development of Respiratory Services for Chronic Obstructive Pulmonary Disease (COPD) patients in Co. Wexford

Supporting and expanding existing COPD Outreach and Respiratory Integrated care (RIC) services with a specific focus on developing pulmonary rehabilitation (PR) networks

Who is delivering this project?	Where?	Operational Period:
Wexford General Hospital	North Co. Wexford	11 months

What is this project about?

This project was carried out by Respiratory Integrated Care and COPD Outreach Services. The aim was to improve treatment for patients with Chronic Obstructive Pulmonary Disease (COPD). The service demand for pulmonary rehabilitation in Wexford far outweighs the service capacity. This project supports and expands existing COPD Outreach and Respiratory Integrated care (RIC) services with a specific focus on developing pulmonary rehabilitation (PR) networks in Co. Wexford.

Target Population:

The target group for the project is respiratory patients based in north County Wexford and south County Wicklow.

Project outputs & outcomes:

- Project provided 11 cycles of Pulmonary Rehabilitation classes in Gorey per annum.
- Project provided rapid access to Pulmonary Rehabilitation post exacerbation, 10 rapid access slots per PR cycle. Target was 8.
- Offered a Pulmonary Rehabilitation service to 112 patients in a fully set up and functioning service.
- 96% (51) of participants achieved Minimal Clinically Important Difference (MCID) improvement in the one-minute sit to stand test.
- 90% (48) of participants achieved MCID improvement in the Modified Medical Research Council (mMRC) Dyspnoea Scale.
- 87% (46) of participants achieved MCID improvement in the COPD Assessment Test (CAT).
- 80% (42) of participants achieved MCID improvement in the Patient Health Questionnaire -9 (PHQ-9).
- 90% (48) of participants achieved MCID improvement in the General Anxiety Disorder -7 (GAD-7).

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Project (38, 78, 185, 219, 413 & 418)

Living Well

Improving health outcomes for people with chronic disease by teaching self-management techniques via the Living Well programme

Who is delivering this project?

There are six Sláintecare funded Living Well projects. These are delivered by:

- CHO Dublin North City and County (DNCC)
- South East Community Healthcare (SECH)
- Community Healthcare Organisation Area 1 (CHO1)
- Community Healthcare West in partnership with Mayo Centre for Independent Living (CHW)
- Community Healthcare East (CHE)
- Midlands Louth Meath CHO (CHO8)

What is this project about?

Living Well is a six-week Chronic Disease Self-Management Programme (CDSMP) delivered by trained facilitators. This Stanford model programme equips individuals with the necessary skills and confidence to manage their long-term health condition(s) effectively, in their everyday life. Living Well focuses on developing generic self-management skills including action planning, decision making, problem solving, health behaviour change, as well as exploring the social and emotional aspects of living with a long-term health condition. These core skills are essential for an individual to become a successful self-manager, and a partner in their healthcare, thereby improving their health outcomes. Living Well uses a structured, evidence-based, peer-led format. Over six weeks, participants learn skills and build confidence in managing symptoms such as fatigue, pain, shortness of breath and low mood. Participants are encouraged to set achievable goals, and to identify resources and supports so that they can manage their health on a daily basis, while doing the things they still need and want to do. Given the challenges of our ageing population, and increasing prevalence of chronic disease, this innovative model of care supports service-users to engage fully in a true partnership in their healthcare. Supporting self-management is a critical element of our journey toward building a sustainable health service. While traditionally, Living Well is delivered face-to-face in community-based venues, the current COVID-19 crisis has led us to explore alternative ways of reaching out and supporting participants. The programme is, therefore, delivered via online platform and supports vulnerable people who are trying to manage their long-term health conditions in such a difficult time, while contending with the challenges of cocooning, self-isolating and not having access to their usual healthcare supports i.e., GPs, Clinical Nurse Specialists, support groups etc.

Project (38, 78, 185, 219, 413 & 418) cont.

Target Population:

- The target group for this project are adults living with long-term health conditions including (but not limited to) COPD, asthma, diabetes, heart conditions, stroke, multiple sclerosis, arthritis, Crohn's disease, chronic pain and depression.
- Carers of someone with a long-term health condition.
- Adults living with long term health conditions in the following workplaces (HSE, GPs, Pharmacies, Local Authorities and An Garda Siochana).
- Adults living with Long Covid (as well as accessing standard programs, 3 programs specifically for the population are also being delivered).

Project outputs & outcomes:

Evaluation is embedded into the delivery of the programme at CHO level, supported by an independent research approach to assess the effectiveness of the online delivery model of the programme. A final evaluation report will be provided shortly.

The summary of Key findings from the final evaluation are:

1. The present high rate of completion of the online programme (92%) compares favourably with the average reported internationally for in-person programmes (75%).
2. 94% of participants were satisfied with the Living Well Programme.
3. In contrast to public health messaging to continue to attend healthcare appointments, one in three reported avoiding seeking GP or medical care when they should have due to fear of contracting COVID-19 at T1. Notably however, there was a statistically significant decrease in avoidance of seeking GP or medical care due to fear of COVID-19 from pre-Living Well to 6 months post-Living Well completion (T3).
4. There was a statistically significant decrease in GP attendance from pre-Living Well to 6 months post-Living Well completion. This finding likely indicates a positive effect of the programme to develop the practical skills and confidence of participants so they can manage their health condition better and have fewer requirements for medical appointments, which is consistent with evidence from in-person CDSMP delivered during routine care in Ireland (Hevey et al. 2020). However, it is difficult to ascertain the degree of the effect of programme on healthcare use as many participants noted they avoided healthcare appointments, particularly in the earlier stages of programme implementation, due to fear of Covid -19. This was in contrast to public health messaging at the time which encouraged people to attend their GP or A&E if they needed to do so. However, as noted above, there was a statistically significant decrease in avoidance of seeking GP or medical care due to fear of COVID-19 from pre-Living Well to 6 months post-Living Well completion.
5. There was a statistically significant increase in overall Quality of Life (QoL) from pre-Living Well to post- Living Well, and from pre-Living Well to 6 months post-Living Well completion.
6. Overall health related quality of life (HRQOL) statistically significantly increased from pre-Living Well to post-Living Well.
7. There was a statistically significant decrease in both levels of depression symptoms and depression case-ness from pre-Living Well to post- Living Well, and from pre-Living Well to 6 months post-Living Well completion.
8. There was a statistically significant increase in self-efficacy for managing health from pre- Living Well to post-Living Well, and from pre-Living Well to 6 months post-Living Well completion.

Appendix 2: Improved health status cont.

Project (38, 78, 185, 219, 413 & 418) cont.

9. There was a statistically significant increase in self-efficacy to do an online programme to support health from pre-Living Well to post- Living Well, and from pre-Living Well to 6 months post-Living Well completion.
10. There was a statistically significant decrease in the extent to which illness interfered in overall activities, in social activities, hobbies and work (where relevant) from pre-Living Well to post-Living Well, and from pre-Living Well to 6 months post Living Well completion.
11. There was a statistically significant increase in time spent walking from pre-Living Well to post-Living Well.
12. There was a statistically significant increase in overall time spent doing aerobic exercise from pre-Living Well to post-Living Well. There was no statistically significant increase in other exercise activities; however, engagement in such activities was impacted by restricted access to facilities during COVID-19 restrictions and fear of contracting COVID-19 during lockdown.
13. There was a statistically significant increase in participants' perception of support available to manage their health pre-Living Well to post-Living Well, and from pre-Living Well to 6 months post-Living Well completion.

These projects have been mainstreamed which means it will receive recurring funding annually.

Mental Health

Seven SIF funded projects, specialising in mental health, had a primary high-level outcome to improve health status. The average operational period of the various services at the time of this report is 17.5 months. To date **1,475** patients have been treated. Patients have seen improvements in well-being (up to **53%**) and quality of life (up to **92%**) and reductions in anxiety (up to **38%**), depression (up to **42%**), social interactions (up to **180%**) and social isolation (up to **95%**).

Appendix 2: Improved health status cont.

Project 15

Dublin 8 Social Prescribing Project

Health Support Within the Community to Improve Physical, Emotional and Mental Wellbeing

Who is delivering this project?	Where?	Operational Period:
Fatima Groups United Family Resource Centre	Areas supported by the Fatima Groups United Family Resource Centre in Rialto and the wider Dublin 8 area	23 months

What is this project about?

This project is an extension of the Dublin 8 Social Prescribing Project which was launched in February 2017. Thanks to the support of the Sláintecare Integration Fund, a Social Prescriber is now able to sit in the Rialto Medical Centre GP Practice to provide information and support to patients suitable for Social Prescribing. GPs in the Dublin 8 area, together with Dublin South City Mental Health Services and Mercer's Institute for Successful Ageing (MISA) based on St James's hospital campus, have been working closely with the project to date.

Target Population:

The following figures are reflective of the target group for the social prescribing project. Two thirds of participants are female, one-third is male. The age range of participants are from 34-82 years. The average age was 62 years with 64% living alone. The highest recorded employment status in the evaluation was "not working" and included not working due to redundancy, or disability. 32% of participants were retired while the remaining 15% were employed.

Project outputs & outcomes:

- 177 participants referred to the project.
- 31 sessions of various creative therapy (art and music) held which exceeded the target of 20.
- 29 week Personal & Community Development course for older people which exceeded the target of 10.
- 53 social outings have taken place which exceeded the target of 30.
- 186 stress management programmes were delivered which exceeded the target of 20.
- Anxiety scores decreased from 12 to 10.
- Depression scores decreased from 8 (clinical case level of depression) to 6.86 (non-clinical case level).
- WHO-5 Wellbeing increased from baseline of 48% to 63%. Target was 60%.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 284

Social Prescribing for improved Health and Wellbeing
Shifting care to the community through social prescribing

Who is delivering this project?	Where?	Operational Period:
HSE Community Health Organisation Donegal, Sligo, Leitrim, West Cavan (CHO 1)	Counties Cavan, Monaghan, Sligo and Leitrim	14 months

What is this project about?

This projects aim was to develop and roll out a Social Prescribing service in partnership with the community and voluntary sector. Social Prescribing links individuals to non-medical sources of support in their community and promotes a strong partnership between GPs, Hospitals, Primary care clinicians, Family Resource Centres and, where they exist, Community Health Fora. This project shifts care away from acute hospitals and General Practice to the community, increases supports to people who are feeling vulnerable, isolated, and lonely, and increases access to resources and services which protect mental wellbeing.

Target Population:

The target group for this project are people who are feeling vulnerable, isolated, lonely, those with mild to moderate grief loss and/or anxiety.

Project outputs & outcomes:

- 782 individuals have been supported through this project.
- 729 patients improved health and wellbeing which exceeded the target of 640.
- The average score for participants at the beginning of their engagement was Anxiety 7.6 and Depression 5.9. When reviewed after 12 weeks scores were on average for Anxiety 4.75 and for Depression 3.4.
- The target of 10 for the In Vivo evaluation has been exceeded and further participants have been identified.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Project 24

Linkworkers to support the coordination of health and social care for patients living in disadvantaged communities

Patients living in disadvantaged communities to benefit from linkworkers to support the coordination of health and social care

Who is delivering this project?	Where?	Operational Period:
RCSI Department of General Practice	Disadvantaged communities in Dublin, Limerick, Waterford and Cork	18 months

What is this project about?

People living in deprived areas often develop multiple health problems at a younger age than the general population, and mental health problems are more common in this group. A link worker intervention can potentially address some of the challenges for these patients. Patients with complex health and social problems are being referred by their GP to meet with a link worker based in their practice. They jointly come up with a plan to help improve their health, for example, joining a walking group or other social support. Although there are many pilot social prescribing link worker programmes, there is still limited evidence to show whether this type of intervention is cost-effective and whether link workers providing social prescribing can actually improve peoples' health and wellbeing. In Ireland, there is increasing interest in link workers and social prescribing and there are plans to expand social prescribing efforts in the 2021 Programme for Government.

To provide important evidence to support the successful rollout of link workers providing social prescribing this project conducted a randomised trial of GP practice-based link workers providing social prescribing for people with multimorbidity in areas of disadvantage. The trial took place between July 2020 and January 2021 across 11 intervention sites, covering 13 GP practices in areas of disadvantage in Cork, Dublin, Limerick and Waterford. Ten linkworkers were hired and trained as part of the trial.

Target Population:

The target group for this project are people with 2 or more ongoing health conditions (multimorbidity) and who are on 5 or more medications. GPs were asked to recruit participants they knew to have psychosocial problems such as isolation.

Project outputs & outcomes:

- The trial took place between July 2020 and January 2021 across 11 intervention sites, covering 13 GP practices in areas of disadvantage in Cork, Dublin, Limerick and Waterford.
- Ten linkworkers were hired and trained as part of the trial.
- 207 patients in deprived areas received Link worker social prescribing.
- A 9 month follow up with patients has also been conducted and all the results will be combined into one paper, which will be available in coming months.

This project has concluded operations and closed out.

Project 23

Community Living Mental Health Recovery Co-Ordinator

Increasing social inclusion of clients with mental ill health through expansion of peer support programme

Who is delivering this project?	Where?	Operational Period:
HAIL Housing Association for Integrated Living	Greater Dublin Area	17 months

What is this project about?

This project has developed a Peer Support Programme offering community-based support to tenants and clients with severe and enduring mental ill health. It encourages meaningful and sustained recovery in a clients' own home.

Target Population:

The target group of the project are persons with mental health issues at risk of homelessness. Most common diagnosis reported include schizophrenia, bipolar disorder, BPD, Anxiety disorders and Generalised Anxiety Disorder, Post traumatic stress disorder and depression.

Project outputs & outcomes:

- 9 new Peer Support Volunteers trained and there is now a team of 16 peer support volunteers which exceeded the targets of 7 and 14 respectively.
- Increased the number of clients supported by peers to 70 which exceeded the target of 60.
- 2,179 peer supports visits to tenants which exceeded the target of 1,008.
- Client social interactions increased from 5 per week to 14 per week, which exceeded the target of 11 per week.
- 95% (84) of clients reported decrease in social isolation which exceeded the target of 68% (60).
- 91% of clients feel more able to manage their mental health as a result of engaging in the service.
- 91% of clients felt less anxiety/depression as a result of engaging in the service.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Project 73

Individual Placement and Support Adult Community mental health teams
Sustaining employment for those with mental health difficulties

Who is delivering this project?	Where?	Operational Period:
HSE Community Health Organisation Dublin North City and County (CHO 9)	Four areas in HSE CHO Dublin North City and County – North Strand, Kilbarrack East, Cabra and West Blanchardstown	13 months

What is this project about?

Individual Placement and Support (IPS) is an evidence-based approach to supported employment for people with mental health difficulties. It is an approach focused on finding a real-job and supporting a person and their employer. IPS has delivered a personalised approach to supporting the individual to find and keep competitive employment. By providing the necessary supports to access and maintain competitive employment, IPS transfers benefits to the service user:

- being able to maintain accommodation in their local community.
- evidence demonstrates that increased isolation leads to greater risk of relapse of mental health conditions.
- positive self-esteem and positive self-image and role identity all impact on mental health.

Target Population:

The project is targeted at Adult Mental Health Service Users who are unemployed.

Project outputs & outcomes:

- 98 participants have availed of the service so far.
- A score of 96 (fair fidelity range) was achieved in IPS fidelity scale which exceeded the target of 74. The IPS Fidelity Scale is a measurement tool of 125 items against which services are scored, the higher the score, the higher the fidelity. The Scale was developed over a number of years with Dartmouth Medical School in the United States.
- 44% (43) of participants have achieved competitive employment which exceeded the target of 20%.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 169

Individual Placement and Support
Sustaining employment for those with mental health difficulties

Who is delivering this project?	Operational Period:
Mid-West Community Healthcare	18 months

What is this project about?

Individual Placement and Support (IPS) is an evidence-based approach to supported employment for people with mental health difficulties. It is an approach focused on finding a real job and supporting a person and their employer. The IPS model integrates employment supports into Community Mental Health Services as part of mental health service delivery. This project facilitates the integration of IPS in to three Mental Health teams across the Mid-West. The project is a relatively new way to deliver services in Ireland. Occupational identity and a valued role in society have been demonstrated to have a positive impact on mental health. Traditionally, society has accepted that people with mental health difficulties do not engage in competitive employment.

Target Population:

The target group for the project are people who have experienced mental health difficulties, are attending our Community Mental Health Teams and would like assistance in accessing employment or being supported in sustaining employment.

Project outputs & outcomes:

- 35 individual adult mental health service users were provided placement and support services.
- 29% (12) of service users receiving IPS obtained work in the open labour market.
- 100% (24) of participants who completed the questionnaire developed by Employability indicated the IPS service assisted with mental health recovery. Target was 75%.
- The project supported 3 people in returning to full-time education.
- The project supported 5 people in disclosing their mental health issues in the workplace.
- The project supported employers to raise awareness of mental health in the workplace.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Project 115

Changing Gears
Building resilience to prepare for later life changes

Who is delivering this project?	Where?	Operational Period:
Age and Opportunity	HSE Community Health Organisation Dublin North City and County	19 months

What is this project about?

Changing Gears is an Age and Opportunity course to support people in achieving transitions in later life as successfully as possible. The course focuses on building resilience to prepare for the changes faced in later life, focusing on self-management of health and wellbeing. The project empowers those who have experienced recent health challenges to reflect on how they could take control over their own health outcomes, promoting positive behaviours, preventing new or recurring periods of poor health and reducing the likelihood of repeated hospital stays.

Target Population:

The target group for this project are people over 50 years old with challenging health conditions. Some participants may have applied to take part as a way of alleviating the strain of Covid restrictions. Participants are referred from various settings in Community Health Organisation Dublin North City and County (CHO 9), including hospitals, primary care centres, day-care centres, and a prison.

Project 115 cont.

Project outputs & outcomes:

- 134 participants were identified, and their baseline data was collected which exceeded the target of 120.
- 8 online interventions were delivered.
- 60 participants were referred to FitLine service. Target was 60.
- 96% of participants demonstrated a higher level of health literacy and increased ability to make good health and lifestyle choices which exceeded the target of 30%.
- The Health literacy scale also measures how people interpret information about their health. The percentage of people who reported that it was 'very easy' to judge if information about health risks in the media is reliable increased from 17% to 35% between baseline and follow-up measurements. Similarly, the percentage who found it 'difficult' or 'very difficult' to judge media information reduced from 31% to 21%. The ability to link everyday behaviours with health is an important factor in promoting better, more healthy behaviours. The percentage who found it 'easy' or 'very easy' to make these judgements increased from 84% to 97%.
- 92% of participants self-reported more positively about health, quality of life, confidence and connectedness which exceeded the target of 30%.
- The level of confidence in the ability to cope with changes or challenges that may result from ageing increased to 91% in the follow-up survey while the percentage who reported that they felt confident maintaining social contacts increased 96%.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Physical Activity

Six SIF funded projects, specialising in physical activity, had a primary high-level outcome to improve health status. The average operational period of the various services at the time of this report is 15.5 months. To date **1,719** patients have been treated. Patients have seen improvements in cardiovascular fitness (up to **21%**), strength (up to **62%**), endurance (up to **33%**), flexibility (up to **29%**), balance (up to **19%**), power (up to **9%**), health empowerment (up to **100%**) and physical activity levels (up to **60%**) and reductions in weight (up to **3%**), pain (up to **18%**), anxiety (up to **36%**) and depression (up to **38%**).

Project 21

Primetime for Older Adults

Creating Opportunities for Older Adults to be Physically Active Ensuring Longer, Healthier, Independent Living with Reduced Risk of Falls and Frailty

Who is delivering this project?	Where?	Operational Period:
Laois Sports Partnership	Four locations in County Laois	11 months

What is this project about?

This project focused on creating more opportunities for older adults in Laois to be physically active under the supervision of skilled professionals who are equipped to deliver group physical activity sessions. Clinical exercise physiology and an education component increase participants' self-efficacy to manage their own clinical conditions. Prime Time for Middle Aged and Older Adults is a 12-week multimodal exercise programme incorporating aerobic exercise, strength and conditioning, flexibility, mobility and balance exercise. In addition to the training sessions, the participants also receive weekly resources, and education regarding the role of specific exercises in the treatment and management of their clinical conditions. The participants undergo a range of fitness tests, pre and post intervention, to assess improvements in cardiovascular fitness, strength, power, muscle endurance, balance, flexibility, and self-efficacy.

Target Population:

The target group for this project are middle aged (50-65yrs) and older (66-80yrs) adults in four locations in Laois. Most of these participants have at least one, but in many cases numerous chronic diseases and clinical conditions including type 2 diabetes, cardiovascular disease, high blood pressure, rheumatoid arthritis, osteoarthritis, osteoporosis and frailty.

Appendix 2: Improved health status cont.

Project 21 cont.

Project outputs & outcomes:

- Project delivered 24 training sessions per group which gave a total of 72 training sessions delivered (3 groups * 24 training sessions each) over the 12-week intervention. Target was 24.
- 213 middle and older aged adults in Laois participated in the intervention which exceeded the target of 100.
- Participant mental health self-efficacy increased from 46.2 to 49.9.
- Participant physical health self-efficacy increased from 44.6 to 49.
- Scores on the 6-minute walk test improved from 624.8 to 736.7, showing improved cardiovascular fitness.
- Scores on the sit to stand test improved from 26.6 to 35.4, showing improved lower body muscle endurance.
- Scores on the sit and reach test improved from 16.2 to 20.9, showing improved flexibility.
- Scores on the Y balance test improved from 21.4 to 25.4, showing improved right leg balance.
- Scores on the Y balance test improved from 22 to 25.3, showing improved left leg balance.
- Scores on the counter movement jump test improved from 147.9 to 161.6, showing improved power.
- Scores on the press up test improved from 25.6 to 30.3, showing improved upper body strength endurance.
- Scores on the IPAQ Test improved from 4.5 to 5.2, showing improved physical activity participation.
- Project also noted a reduction in medication for cholesterol, blood pressure and pain relief.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 56

Arthritis Rehabilitation through the Management of Exercise and Diet (ARMED)

Package of care delivered for Arthritis Rehabilitation

Who is delivering this project?	Where?	Operational Period:
Our Lady's Hospital Navan, Co. Meath	Meath	16 months

What is this project about?

This project delivers arthritis rehabilitation through the management of exercise, diet and coping skills to reduce pain and improve function in patients with arthritic knees. The study determines the suitability and feasibility of this programme to the Irish knee osteoarthritic population.

Target Population:

The target group for this project were persons with knee osteoarthritis, a chronic disease, and obesity on the primary and secondary care waiting lists.

Project outputs & outcomes:

- 80 patients participating to date with adaptations during Covid restrictions to move the programme online. Target was 32.
- 8 groups have completed the programme which exceeded the target of 4.
- Mean weight loss for the whole group was 3.3 kgs or 3.3% in 12 weeks.
- Patients experienced an 18% (9.3) reduction in pain measured by ESCAPE-pain evaluation programme which exceeded the target of an 8% (3.86) reduction.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Project 135

Promoting physical activity programmes for people with neurological conditions in the community

Shifting the focus from rehabilitation to a health-promoting physical activity model

Who is delivering this project?	Operational Period:
MS Ireland	21 months

What is this project about?

There are many benefits of exercise and physical activity for people with neurological conditions. Being physically active can reduce symptom severity, improve quality of life, and result in reduced healthcare service usage. Active Neuro shifts the focus from rehabilitation for new onset or worsening of symptoms, to a health promoting physical activity model for prevention. Rehabilitation is available to some patients through the Community Neuro Rehabilitation Team in Limerick that offers multidisciplinary rehabilitation, however onward referral options for continued activity to maintain benefits gained are limited. The stroke unit at University Hospital Limerick has an early support discharge team that provides home based rehabilitation, but similarly has limited onward referral options for continued physical activity. Combining resources and expertise will enable a greater range of programmes to be offered in a greater range of locations.

Target Population:

The target group for this project are patients with progressive neurological conditions (Parkinson's Disease, MS, Stroke, acquired brain injury, other neurological disorders).

Project outputs & outcomes:

- On-line interventions delivered to 440 participants which exceeded the target of 150.
- Created on-line community of practice for telehealth group exercise delivery for 94 healthcare workers which exceeded the target of 20.
- Strength maintained or improved in 82% of participants and improved in 68%, estimated by the 30 second sit to stand test, which exceeded the target of 60%.
- Hospital admissions were reduced from 14 to 9, saving 51 bed days approximately.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 140

WellComm Active Well Communities Connect Project 2

Empowering communities to maintain their health through physical activity

Who is delivering this project?	Where?	Operational Period:
Cork Sports Partnership	11 Community Health Networks across Cork	16 months

What is this project about?

Cork Sports Partnership has an established partnership with health services across Cork in developing, delivering and coordinating programmes at local level to empower and engage communities in maintaining their own health and wellbeing through physical activity. WellComm Active is a coordinated and integrated approach to delivering a number of HEAL programmes and interventions. WellComm delivers a variety of courses and activities including Project Weight Loss, Staying Fit for the Future, Healthy Food Made and Made 2 Move.

Target Population:

The target groups for this project are as follows:

- Older adults and those potentially at risk of falling or being injured, who are participating in the Staying Fit For the Future programme.
- Inactive, overweight, and obese individuals with underlying health conditions associated with their weight and inactivity taking part in the Project WeightLoss programme.
- Vulnerable populations, persons with mental health issues, persons with chronic disease and underlying diet related and other health conditions participating in the Healthy Food Made Easy programme.
- Older adults, inactive and sedentary individuals and those with underlying health conditions participating in the Made2Move programme.
- Persons with mental health issues and vulnerable populations as well as general populations participating in the Get Active Keep Well informational series.
- Other target groups include, but are not limited to: Cardiac rehab patients, COPE users, Headway users, Brothers of Charity users, Family Resource Centre users, Older Adult Groups, Men's Sheds, GAA Clubs, HSE/CKCH patients, Diabetes Ireland members.

Appendix 2: Improved health status cont.

Project 140 cont.

Project outputs & outcomes:

- 169 participants across 6 CHNs completed 23 Project Weight Loss programmes, which exceeded the target of 50 participants in 10 programmes.
- 490 participants reached over 10 CHNs completed 25 Staying Fit for the Future programmes, which exceeded the target of 250 participants in 8 CHNs completing 21 programmes.
- 187 participants across 11 CHNs completed 19 Healthy Food Made Easy programmes.
- 140 participants completed the Health Empowerment Scale (HES-SF). The mean score was 4.15, which shows the participants have a level of empowerment that is above average.
- For Project Weightloss there was a mean reduction of 1.81kg/m2 in BMI ($p<0.05$) in the 12 weeks from programme start to end.
- 100% of Project Weightloss participants agreed that their quality of life has improved after participating in the programme.
- 94% of Healthy Food Made Easy participants indicated a change in eating habits. 40% eating more fruit & vegetables and 18% reducing their fat intake. 34% noted they had learned how to make healthy meals and 22% noting they learned how to read food labelling.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 220

Implement a structured exercise programme for people with Diabetes
Increased Physical Activity for Self-Management of Diabetes

Who is delivering this project?	Where?	Operational Period:
Community Healthcare Organisation West (CHO 2)	Galway	7 months

What is this project about?

This new project called DESSIE strengthens the DESMOND programme by providing a structured exercise and physical activity programme. The goal of the project is to build on the success of the pilot by commencing the delivery of a structured exercise programme in Primary Care on an ongoing basis for people newly diagnosed with Type 2 Diabetes.

The Primary Care Physiotherapy service in Galway developed a pilot exercise programme for people with Type 2 Diabetes named DESSIE (Diabetes Education and Self-Management that Specifically Involves Exercise).

The exercise programme focuses on improving endurance, aerobic capacity and strength and conditioning. The aim of the programme is to improve a person's ability to self-manage their condition by becoming more physically active. They are provided with exercise diaries and pedometers to use outside of the class setting to encourage and enable them to develop a healthier lifestyle. Recognised clinical outcome measures are used to measure the impact of the programme on clinical indicators as well as Quality of Life.

Target Population:

The projects target group are patients with Type 2 Diabetes who require education regarding self-management of their chronic disease targeting improvements in physical activity levels, BMI, and Waist circumference. This Project also targets a cohort of chronic disease patients who previously had no access to Primary Care Physiotherapy services in the past.

Project outputs & outcomes:

- Developed and provided regular physical activity programme for people with Type 2 Diabetes, 4 groups with 44 participants. Target was 4 groups with 24 participants.
- Physical activity levels of participants increased by 56% (1889) against a target of 9% (299) and a baseline of 3329. Measured in metabolic equivalent of task (METs) using the International Physical Activity Questionnaire - Short Form (IPAQ-SF).
- Anxiety improved on average by 36% against a target of 34% and a baseline of 5.6. Measured using the Hospital and Anxiety Scale (HADS).
- Depression improved on average by 38%. Measured using the Hospital and Anxiety Scale (HADS).

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Project 233

The Exercise Effect - Integrating Exercise Practitioners into the Irish Mental Health Service

Improving Mental Health through Physical Activity

Who is delivering this project?	Where?	Operational Period:
Sports Active Wexford in partnership with the HSE Waterford/Wexford Mental Health Services and Waterford Institute of Technology	South County Wexford	22 months

What is this project about?

This project is a partnership between local Wexford HSE Mental Health Services, the Wexford local sports partnership, Sports Active Wexford and is underpinned by research from Waterford Institute of Technology. An Exercise Practitioner integrates physical activity interventions across all sectors of the mental health services in County Wexford: general adult mental health, older adults; and child and adolescent services. The types and prevalence of mental health conditions which participants of this project presented with were as follows; Mood Disorder (33%), Schizophrenia/Psychotic Disorder (30%), Anxiety Disorder (21%), Personality Disorder (18%), Eating Disorder (9%), Dementia/Cognitive Disorder (9%), ADHD (9%), Autism (9%), Trauma/Stress Related Disorder (6%) and Substance related Disorder (6%).

Target Population:

The target group for this programme are individuals from county Wexford who are current service users of the Mental Health Services:

- Children up to 18 years old suffering with mental health difficulties under the care of the South County Wexford Child and Adolescent Mental Health Team.
- Adults with Mental Health difficulties under the care of 2 Community Adult Mental Health Teams based in the South of the county – Summerhill (Wexford) and Maryville (New Ross).
- Individuals who present with mental health difficulty onset after the age of 65 living in the community and those in residential care in Mental Health Commission Approved Centre – Selskar, who requires specialised residential mental health under the care of the Wexford Psychiatry of Later Life Team.
- Individuals who have severe and enduring mental health difficulties who require specialised rehabilitation, residential care and assertive outreach care provided by the Wexford Rehabilitation and Recovery Team.

Project 233 cont.

Project outputs & outcomes:

- 76 participants were enrolled in the project to date.
- 60% increase in physical activity levels from 70 minutes per day to 112 minutes per day. Target was 40%. Measured using the SIMPAQ 7-day recall tool.
- 21% improvement in cardio-respiratory fitness (independent predictor of quality of life).
- 26% increase in level of community integration achieved through physical activity interventions. Project conducted 74 exercise sessions in the community.
- 16 participants engaged/made plans to engage in community physical activity programmes post intervention.
- Mental wellbeing and quality of life were reported to have been clinically improved through participation in the programme, verified by scores on validated and reliable tools.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Older Persons

Six SIF funded projects, specialising in physical activity, had a primary high-level outcome to improve health status. The average operational period of the various services at the time of this report is 17 months. To date **5,102** patients have been treated. Patients have seen improvements in wellbeing (up to **300%**), physical activity (up to **69%**), self-efficacy (up to **60%**) and self-reported health (up to **26%**) and reduced levels of social isolation (up to **15%**) and loneliness (up to **49%**).

Project 18

Sheds for Life

Helping Men to Enjoy Physical and Mental Health and Wellbeing to Their Full Potential

Who is delivering this project?	Where?	Operational Period:
Irish Men's Sheds Association	Sheds for Life programme will run across counties Waterford, Kildare, Limerick, Louth, Leitrim, Roscommon and Meath	20.5 months

What is this project about?

Sheds for Life (SFL) provides a positive, holistic approach to men's health that targets aspects of physical, mental, social and spiritual wellbeing by building on the existing health enhancing, supportive environment of a men's shed. Shed settings are effective in attracting marginalised men, reaching men who would typically not engage with health services, and Sheds for Life presents a unique opportunity to identify ways to engage with men. Men experience poorer health outcomes compared to women and are also least likely to engage with health services and programmes. SFL aims to deliver care in a more appropriate way by using gender-sensitive strategies that work for engaging men, such as delivering care in a familiar nonclinical setting, in a male only environment, and incorporating physical activity and health checks.

Target Population:

The primary target group of the Sheds for Life programme were shed members, who are predominantly older men, some of who are hard-to-reach group of men.

Project outputs & outcomes:

- The Getting Online training component was delivered remotely to 10 men, with a further 178 participating in the Sheds for Life Autumn 2021 online programme.
- 462 men received health screenings as part of the project.
- 174 men received follow up health screenings.
- 122 men reached via Sheds for Life Award event in Feb, 2020, 27 sheds represented.
- Mental wellbeing scores increased by 17% (30.92) exceeding a target of 5-10%. Measured by the SWEMWBS, an increase of 3 points or more is considered meaningful, project achieved 4.5.
- Moderate physical activity increased by 56% (4.348) per week exceeding a target of 10-15%. Measured via self-reported weekly moderate intensity exercise scale and days active/7 days.
- Physical Activity Self Efficacy scores increased by 22% (64.85) exceeding a target of 10% (58.49) (measured by Self Efficacy for Exercise Scale (SEE) scale).

This project has been extended to facilitate further review in 2022.

Appendix 2: Improved health status cont.

Project 183

Post Diagnostic Support worker for people with dementia Inishowen
Support for the Person with Dementia in Donegal

Who is delivering this project?	Where?	Operational Period:
Community Health Organisation Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan (CHO 1)	Inishowen, Donegal	12.5 months

What is this project about?

A post-diagnostic support worker helps people with dementia, and their family/carers to deal with the uncertainty and assistance required to make positive adjustments in their lives, through information sharing, education, and support.

Target Population:

The target group for this project are individuals in the earlier stages of their dementia, whose needs are different from those at more advanced stage of the disease. It is anticipated that linking individuals with an early diagnosis from their GP to the post diagnostic support worker will reduce the risk of a crisis occurring, thereby reducing admission to acute services, and supporting the person to maintain their identity.

Project outputs & outcomes:

- Developed and delivered specific counselling service to 13 individuals newly diagnosed with dementia.
- Provided Cognitive stimulation therapy to 14 individuals with dementia. Target was 12.
- Provided validation therapy to 18 family members which exceeded the target of 12.
- Alexa devices have been provided through Alone and installed in 11 participants' homes. Four referrals have been made to the Alone Telephone Call service.
- Provided 14 trial packs of memory aid technology for individuals with dementia and their family. Target was 8.
- 85% (11) of participants reported an increase in their knowledge and understanding of their condition which exceeded the target of 15% (2).
- 92% (12) of participants reported an increase in their awareness and understanding of how memory aids can support their daily life which exceeded the target of 20%.
- 15% (2) of participants reported a reduction in social isolation/or an increase in confidence to be more socially engaged against a target 10% (1).
- 39% (5) of participants reported that they feel better prepared for the future which exceeded the target of 20% (3).
- 67% (10) of family members/carers feel supported and confident in their role which exceeded the target of 10% (2).

This project has been mainstreamed which means it will receive recurring funding annually.

Project 205

Western Alzheimer's Befriending Service

Befriending people with Alzheimers in Galway, Mayo and Roscommon

Who is delivering this project?	Where?	Operational Period:
West of Ireland Alzheimer Foundation	Counties Galway, Mayo and Roscommon	21 months

What is this Project about?

To provide support to the significant amount of people on their waiting lists, Western Alzheimer's piloted a volunteer befriending service in Co. Galway in early 2019. The aim was to have befrienders in place in counties Galway, Mayo and Roscommon by year end. The objective was to match a suitable volunteer befriender with a compatible companion who has dementia. The befriender, who is trained and vetted, provides support ranging from companionship in the home to partaking in shared interests and social activities. The focus is on physical and mental wellbeing to ensure the person with dementia remains healthy and can continue to live in their own home for as long as possible.

Target Population:

The target group for this project is people who have a diagnosis of Dementia and who are living at home and for their carer(s).

Project outputs & outcomes:

- Advertising campaign reached 58 potential volunteer befrienders. Target was 50.
- 53 volunteer befrienders completed training. Target was 50.
- 47 families availed of the service.
- In the cases where service user feedback was provided, the satisfaction with the service was very high.
- Physical & Mental Health & Wellbeing of the primary carer increased by 3 points which exceeded the target of 2 points.
- Mental Health & Wellbeing of the befriender increased by 3 points against a target of 2, indicating the experience of befriending has contributed positively to the life and wellbeing of the volunteer.
- Understanding of Dementia by the befriender has increased.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Improved health status cont.

Project 221

Integrated Population based Falls Model for Mayo

Providing a population-based falls service for County Mayo

Who is delivering this project?	Where?	Operational Period:
Mayo University Hospital (MUH) and Community Healthcare Organisation West (CHO 2)	Mayo	7 months

What is this project about?

This project provides a population-based falls service for County Mayo. It shifts the focus of falls management from reactive hospital-based management to preventative community-based management to include:

- Falls Screening.
- Bone Health information sessions.
- Falls prevention classes expansion to county wide service.
- Establish links and referral pathways with fracture clinics for patients to easily access these falls prevention and bone health information sessions.

The need for population-based falls screening and bone health education is well identified. Falls prevention classes have been statistically shown to reduce the risk of death over the subsequent 12-month period and significantly reduce fall rates. Ideally if bone health can be established in the young population, and preserved through ageing, the consequences of falls will be less.

Target Population:

The target group for this project are older people, school age primary school children, and antenatal/postnatal groups.

Project outputs & outcomes:

- Developed and delivered bone health education school sessions to 100 attendees. Target was 80—100.
- Delivered bone health education virtual sessions to 1 ante/postnatal group with 13 participants. Target was 8-10 attendees.
- Developed and delivered 6 community-based step down OTAGA programme under direction of Physiotherapist with 20 participants.
- 90% (18) of participants improved their Timed Up and Go test (TUG) scores by at least 1 second, exceeding the target of 50% (10).
- 60% (12) of participants improved their Short Falls Efficacy Scale (Short FES-I) scores by 3 points or more exceeding the target of 50% (10).
- 60% (12) of participants improved their 30 Sec Chair Stand scores by 2 repetitions or more, exceeding the target of 50% (10).
- There have been no reported falls in any group for duration of programme.
- The classes have helped to improve self-efficacy and quality of life for the participants.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 263

Agewell Programme
Supporting people to enjoy a better older age at home

Who is delivering this project?	Where?	Operational Period:
Third Age Foundation	County Meath	24 months

What is this project about?

The over-60s population is expected to grow to over 1.3 million by 2031 and 1.8 million by 2046, with the most rapid growth segment being the over 85s. Those over 75 and living alone in their own homes are among the most vulnerable and most susceptible to falls, visits to Emergency Departments, admissions to hospital and transfer to long term care. AgeWell is an innovative new model of integrated care, supporting older people to remain safer and healthier in their own homes for as long as possible by disrupting the zero to crisis cycle. This is done by combining peer-based social engagement and mobile technology to improve health outcomes and wellbeing among older people. The purpose of AgeWell is to continually assess and respond to evolving health issues and appropriately escalate to the Primary Care teams (PCT) and other social and community services, to prevent problems becoming a crisis. AgeWell companions use a mobile-phone based health screening tool (created by gerontologists) to capture health, wellbeing and related information about clients. The system processes the information using referral algorithms to generate suggested actions for the care coordination team to explore with the client. Through this technology, evolving health, social and environmental problems are identified and addressed before they escalate and if needed, can be linked into the appropriate treatment, in the right place, at the right time. The core aim is to enable clients to remain living in their own homes and communities for as long as possible.

Target Population:

The target group of AgeWell is older people. Often these individuals are frail, isolated, living alone, vulnerable, and or with a range of complex health needs and age-related conditions. For this pilot the focus was on older people aged 65+ living in East Meath who would benefit from the supports that AgeWell provides in terms of ongoing monitoring, companionship, and health promotion to support them to remain safe and well in their own homes for longer. Client demographic data for the study group showed 75% of clients were over 80, 61% over 85, with a mean age of 84.

Appendix 2: Improved health status cont.

Project 263 cont.

Project outputs & outcomes:

- 12 AgeWell Companions were recruited and vetted achieved against a target of 8.
- 18 Continuous Professional Development (CPD) sessions were completed, which exceeded the target of 14 sessions.
- 74 clients enrolled and receiving the AgeWell weekly service and supports. This exceeds the target of 40.
- 5,765 check-ins/visits with clients and 10,600 plus phone calls completed. This exceeded the target of 848 visits and 1696 phone calls.
- 579 additional supports provided to clients throughout the pandemic including organising supplies, medications and repair/ maintenance services and supplies.
- 3,005 20/20 health assessments were completed. This exceeded the target of 424 assessments.
- 936 triggered referrals were created from the health assessments. This exceeded the target of 100 triggered referrals.
- 43% (23) reduction in loneliness from baseline of 40, measured using the UCLA Loneliness scale. The target was 40—60%.
- 32% (19.05) improvement in wellbeing from baseline of 14.4, assessed by the WHO 5 scale. Target was 30% (18.72).
- 31% (25.93) improvement in informational and emotional supports from baseline of 19.8, assessed by the MOSS 8 scale. This exceeded the target of 15 -20% improvement.
- 69% (76% of clients) improvement in self-reported physical activity from baseline (45% of clients) against a target of 5% (47% of clients).

This project has been mainstreamed which means it will receive recurring funding annually.

Project 277B

Service Co-ordination for Older People
Supporting Older People to age in their own homes

Who is delivering this project?	Where?	Operational Period:
ALONE	Donegal, Sligo and Leitrim; Mayo and Roscommon, Limerick, Cork and Kerry; Waterford; Dun Laoghaire and Wicklow; Dublin West, Dublin South City, Dublin South West, Dublin South Central	16 months

What is this project about?

This project provided funding to increase the capacity of ALONE to deliver nationally across its spectrum of services by the employment of additional staff and investment in support infrastructure during Covid-19 and beyond. The funding also includes provision for some additional staff for up to a six month period to respond to Covid-19, this includes communications, the operation of their helpline which is operating 12 hours a day 8am – 8pm, 7 days a week and working on leveraging partnerships.

Target Population:

Older people (60+) were the target group of this project.

Appendix 2: Improved health status cont.

Project 277B cont.

Project outputs & outcomes:

- The number of older unique people supported were 4106, with a total of 8697 support plan objectives completed. Target was 200 older people.
- 362 volunteers recruited and trained against a target of 200.
- 285,576 calls made to older people by our volunteers.
- 51,744 calls received to ALONE National Support Line.
- 5,133 practical supports delivered from the support line.
- 401 vulnerable adults received an enhanced level of contact and support.
- 32,951 units of practical support delivered from our staff and volunteers.
- 247 clients experienced increased financial independence against a target of 200.
- 1055 clients were supported to maintain independence against a target of 800.
- 82 clients secured tenancy in social housing against a target of 50.
- 624 clients experienced improved safety and security in the home against a target of 600.
- 223 clients experienced improved mobility in the home against a target of 150.
- 670 clients experienced reduced loneliness against a target of 450.
- 780 clients experienced improved emotional wellbeing.
- 485 clients experienced increased social participation.
- 491 clients experienced reduced financial anxiety against a target of 450.
- 29 clients experienced reduced risk of or prevention of elder abuse.
- 94 clients were prevented from becoming homeless.
- 809 clients experienced improved living conditions against a target of 700.
- 2205 clients experienced improved quality of life against a target of 2000.
- 249 clients experienced increased social independence against a target of 200.
- 35 clients were supported to sustain a tenancy.

This project has been mainstreamed which means it will receive recurring funding annually.

Smoking Cessation

Two SIF funded projects, specialising in smoking cessation, had a primary high-level outcome to improve health status. The average operational period of the various services at the time of this report is 19.5 months. To date **1,868** patients have been treated. 4 week quit rates at up to **79%** and 12 week quit rates at up to **68%** have been achieved.

Appendix 2: Improved health status cont.

Project 202

Supporting Pregnant Women to Quit and Stay Quit - A Co-design Community Based Integrated Approach

A project aimed at increasing access to smoking cessation programmes for pregnant women and their families

Who is delivering this project?	Where?	Operational Period:
HSE Community Health Organisation South East (CHO 5)	Carlow, Kilkenny, South Tipperary, Waterford and Wexford	24 months

What is this project about?

"Supporting Pregnant Women to Quit and Stay Quit", run by Southeast Community Healthcare (SECH) helps everyone involved in the journey of the pregnant woman to stop smoking. This project establishes an integrated smoking cessation service for pregnant women and their families. Smoking cessation clinics have been established in key areas, such as family resource centres, primary care centres and maternity hospitals.

Target Population:

The target group for this project are pregnant women, women planning to become pregnant, women who have had babies and all their extended families. An unintended consequence of the programme was the volume of referrals that were received from colposcopy units in UHW, WGH and STGH.

Project outputs & outcomes:

- Provided/referred to Quit.ie support to approximately 1,116 participants, exceeding the target of 500.
- CO monitored on approximately 1,325 pregnant women.
- 1,116 people (pregnant women + family if smoking within the home environment) referred to smoking cessation, exceeding the target of 500.
- 79% (233) of participants quit 4 weeks following engagement. The target was 25%.
- 68% (183) of participants quit 12 weeks following engagement. The target was 10%.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 223

Smoke Free Start
Optimising Stop Smoking Services across Community and Hospital Maternity Care in Ireland

Who is delivering this project?	Where?	Operational Period:
Tobacco Free Ireland Programme, Strategic Planning & Transformation, HSE	Dublin and Cork	15 months

What is this project about?

This project is a joint initiative between Tobacco Free Ireland Programme and the National Women and Infant Health Programme, which develops capacity and capability in a maternity setting to better diagnose and treat smoking during pregnancy. This project has developed and established dedicated smoking cessation services in two maternity settings in Ireland; the National Maternity Hospital, and Cork University Maternity Hospital, and their associated midwife led Domino schemes. This project has introduced routine breath carbon monoxide (BCO) monitoring during antenatal care in order to identify tobacco use among pregnant women which will increase the number of referrals to dedicated intensive cessation services.

Target Population:

The target group for this project are pregnant women receiving maternity care at Cork University Maternity Hospital and The National Maternity Hospital, and women using colposcopy services at CUMH and NMH.

Project outputs & outcomes:

- 100% of OPD midwifery staff were trained in online Making Every Contact Count (MECC) modules in CUMH and NMH which exceeded the target of 50%.
- 752 referrals were received.
- 75% (129) quit rate among women participating in programme quitting at 1 month, which exceeded the target of 30% (53). This was measured by the MN- CMS and Quit Manager electronic patient management system.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2 cont.

Health literacy — empowering citizens with the knowledge to manage their health

Fourteen SIF funded projects; across a range of specializations including respiratory (COPD)/asthma, social inclusion, digital health, diabetes care, and mental health; had a primary high-level outcome to increase health literacy. The average operational period of the various services at the time of this report is 18 months. To date **2,021** patients have been seen, **20,012** additional beneficiaries (health professionals trained, families supported etc.) supported, **52,408,821** online page views achieved, **2,086** health professionals attended chronic disease self-management training webinars and patients/ participants showed improvements in community involvement, quality of life, confidence and empowerment.

Project 8

HSE - Child Digital Health

Developing a suite of personalised digital supports, information, and signposting services to guide parents and parents-to-be through pregnancy, birth and early childhood

Who is delivering this project?	Where?	Operational Period:
HSE Communications Division	Online/Nationwide	20 months

What is this project about?

Building on the successful launch of MyChild, the HSE has developed a suite of personalised digital supports, information, and signposting services to guide parents and parents-to-be through pregnancy, birth and early childhood. These projects provide parents with the right health information, advice and support at the right time. They support parents to make informed choices in relation to their children's health and their own health.

Target Population:

The target group for this project are pregnant women, parents-to-be and new parents who are looking for accurate and quality health care information. The health guides, services listings and email programme support health care professionals including GPs. They can recommend this trustworthy source of information to their patients. The social group support breastfeeding mothers with a clinical moderator to assist with their needs.

Project outputs & outcomes:

- Reached 527,000 individuals ensuring that parents receive the right information at the right time during pregnancy and early childhood exceeding the target of 350,000.
- 68 additional child health information guides have been developed.
- Developed, implemented and evaluated an online breastfeeding social media support group for 35 group members.
- Online relationship established with 210,800 families achieved exceeding the target of 60,000, at a stage where their engagement with the health service starts to increase, building trust and confidence in healthcare.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Health literacy — empowering citizens with the knowledge to manage their health cont.

Project 9

HSE - Digital information, Signposting, and support for people with chronic conditions

Helping patients with chronic conditions, their families and carers through provision of digital supports

Who is delivering this project?	Where?	Operational Period:
HSE Communications Division	Online/Nationwide	13 months

What is this project about?

This project delivers new digital supports to patients, families and carers to help them live well with a chronic condition. It delivers a comprehensive online directory of self-management support services. It provides those living with a chronic disease, as well their families and carers, with online information guides on major chronic conditions and how to self-manage. People living with chronic disease can access personalised digital supports and signposting to guide them through the early stages of their journey with a chronic condition. This project develops expert supported social community for diabetes, as well as a proof of concept for use of closed social media groups to provide peer-to-peer and expert support for patients in Structured Patient Education Programmes.

Target Population:

The target group for the project are those who have chronic conditions - either newly diagnosed or living with their condition for quite some time, and their carers/family members and health care professionals.

Project outputs & outcomes:

- 111,209 individuals have visited online information guides on the four major chronic conditions and how to self-manage to date.
- Developed social media communities for 22 individuals with diabetes. Target was 20.
- 69% of visitors so far reported feeling better informed after reading the content.
- 95% of GPs said they would recommend the Type 1 diabetes content to their patients and 98% said they trust this content. Target was 70% GP willingness to signpost patients to the chronic conditions' information measured by a survey.
- €15,000 has been saved through the integration of the online content into chronic conditions into the new public HSE website.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 31

Expansion of Social Prescribing service in Waterford and mainstreaming of pilot service in Waterford Metropolitan area

Providing health service providers and community workers with an opportunity to link people with non-medical sources of support within the community to improve physical, emotional and mental wellbeing

Who is delivering this project?	Where?	Operational Period:
Sacred Heart Community & Childcare Project	Waterford City and County	26 months

What is this project about?

Waterford Social Prescribing Service began operating in April 2018 and provides health service providers and community workers with an opportunity to link people with non-medical sources of support within the community to improve physical, emotional and mental wellbeing. Thanks to funding from the Sláintecare Integration Fund, two full-time social prescribers have been employed, one to cover the Waterford City area, and one who covers Waterford County.

Target Population:

The target group for the project are those over 18 who may be experiencing mental health difficulties, long term health conditions, social Issues, loneliness and/or social isolation. We accept referrals from GP's, Primary Care Teams, Medical and Social care professionals and self-referrals.

Project outputs & outcomes:

- 501 clients referred.
- 6,033 contact sessions with the Coordinators exceeding the target of 1,000.
- 115 community services accessed by clients exceeding the target of 40.
- 57% (6.6) increase in community involvement exceeding the target of 35% (5.67), baseline was 4.2. This was measured using 'Pillar of Positive Health' Social and Societal Participation scores, recorded at point of referral and again at end of intervention.
- 48% (6.8) increase in improved quality of life and ability to self-manage exceeding the target of 33% (6.12), baseline was 4.6. Measured using the 'Pillars of Positive Health' Quality of life scores, recorded at point of referral and again at end of intervention.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Health literacy — empowering citizens with the knowledge to manage their health cont.

Project 48

LGBT Champions Programme

Addressing the inequalities of access to health and social care services experienced by older LGBT people

Who is delivering this project?	Where?	Operational Period:
LGBT Ireland	Across Ireland	27 months

What is this project about?

LGBT Ireland is a national charitable organisation that works to improve the rights, visibility and inclusion of older LGBT people and their family members. In 2018, LGBT Ireland launched the LGBT Champions Programme, an advanced training and support programme for health and social care staff working with older people. The programme aims to address the inequalities of access to health and social care services experienced by older LGBT people, by equipping staff to deliver care in a more appropriate way. The programme is designed to increase the visibility and awareness of older LGBT issues at all levels within the healthcare systems, so that older people encountering services know that they can be open and comfortable being who they are, improving the relationships with care providers, improving experience of care settings, and enabling more positive health and wellbeing outcomes.

Target Population:

The target group for this project are older LGBT people across Ireland.

Project outputs & outcomes:

- 12 online LGBT Champions training programme events were held for 86 Health and Social Care professionals and community workers working in services which are accessed by older people across CHO5. Target was 6 events for 60 professionals.
- Indirectly this has benefited approximately a further 250 Health and Social Care professionals through LGBT+ awareness raising activities undertaken by Champions in their services. Target was 180.
- 95% (57) of participants (100% of the 57 respondents) reported feeling 'Very Aware' of the specific issues facing older LGBT+ people in accessing healthcare, in post training evaluations following completion of the training programme. Target was 70%.
- 60% (36) of participants (63% of the 57 respondents) reported feeling confident to improve their own practice towards addressing the specific health and social care needs of LGBT+ people in their care, on completion of our training programme. Target was 60%.
- 90% (54) of Champions (95% of the 57 respondents) have achieved improvements in inclusivity measures within their service within six months of completing the training. Target was 50%.
- Project set up the LGBTI+ Older and Bolder Online Community with 262 members.

These projects have been mainstreamed which means it will receive recurring funding annually.

Project 98

Patient Self-Management of Chronic Disease

Provision of education on self-management of chronic illness to GPs

Who is delivering this project?	Where?	Operational Period:
Irish College of General Practitioners (ICGP)	Nationwide	15 months

What is this project about?

This project focuses on the provision of education on self-management of chronic illness to GPs and practice nurses. GPs are best placed to empower patients in self-management of their chronic conditions. Evidence shows that training GPs to help patients change their lifestyle makes a difference. According to Healthy Ireland Survey 2018:

- 74% of those surveyed visited their GP in past 12 months.
- Women (79%) are more likely to visit a GP than men (68%).
- Older age groups are more likely to visit a GP (94% of those aged 75).
- Those who are older also visit their GP more frequently.
- 35% consulted a nurse in a GP surgery in the past 12 months.
- 76% of all deaths in Ireland are due to chronic disease.

The ICGP developed and delivered an evidence-based education package to GPs and practice nurses on "Patient self-management of chronic disease".

Target Population:

The target group for the project are patients with a chronic illness.

Project outputs & outcomes:

- 2,321 GP's and Practice Nurses used eLearning module exceeding the target of 2,000.
- Successfully developed and delivered an education package to 2,000 "General Practitioners". Target was 2000.

This project has concluded operations and closed out.

Appendix 2: Health literacy — empowering citizens with the knowledge to manage their health cont.

Project 100

Beating Breathlessness Asthma Society

Nurse-led WhatsApp support for Asthma improves self-management of condition

Who is delivering this project?	Where?	Operational Period:
The Asthma Society	Nationwide/Online	19 months

What is this project about?

"Beating Breathlessness" provides easily accessible support, education, and information to people with Chronic Obstructive Pulmonary Disease (COPD) and asthma to help them better understand and manage their condition. This project involves a two-pronged approach to asthma and COPD education and self-management. Either component of the programme (or both) could be prescribed by a healthcare professional to a person following diagnosis, or recognition that a patient's condition is "uncontrolled". Patients could also self-select via the Asthma Society website - in a similar vein to the HSE's QUIT programme. The accompanying nurse-led chat service, via WhatsApp, will offer personalised information and support to people with asthma and COPD, as well as their parents or carers.

Target Population:

The target group for the project are people with asthma/and or COPD and is delivered nationwide and online.

Project outputs & outcomes:

- 12,315 WhatsApp patient chats have taken place to date. Target was 2,500.
- 140 patients attended the asthma webinar, 53 of which completed the post webinar survey. From this survey, we can convey that 45% of the asthma masterclass attendees were empowered to better manage their condition through the completion/ update of a self-management plan with their HCP. Target was 20%.
- 70% (19) of COPD patients feel empowered to better manage their condition through increased awareness of COPD management.

These projects have been mainstreamed which means it will receive recurring funding annually.

Project 123

Online Citizen Health Guides

An easy to understand online resource to empower people to self-care

Who is delivering this project?	Where?	Operational Period:
Communications Division HSE	National/Online	24 months

What is this project about?

300 online guides to common health conditions, medicines and hospital treatments have been published on the new HSE.ie website to meet the health information needs of Irish citizens, online. Online Citizen Health Guides support the current and future information needs of citizens by providing a reliable, single source of truth which can be republished across other healthcare systems, for example, the electronic health record.

Online Citizen Health Guides:

- empower citizens to take an active role in their health by providing easy-to-understand online information.
- help to improve National Patient Experience Survey results as 43% of people surveyed in 2018 wanted more information to manage their condition after they were discharged from hospital.
- reach a large audience as HSE.ie received over 15 million page views in 2018.
- help citizens check symptoms and understand a diagnosis.
- provide opportunities to cross-promote other health promotion guides which users may not actively seek out.

Target Population:

The target group for this project are the general public who are looking for accurate and quality health care information. These health guides support health care professionals including GPs. They can recommend this trustworthy source of information to their patients.

Project outputs & outcomes:

- Project has produced 300 guides to maintain and restore health, including 50 guides to medicines, each have been reviewed by at least one national clinical expert. Target was 300.
- Project has generated 51.7 million (including Covid19 content) page views to date, exceeding the target of 11 million.
- 100% of all content developed has remained at the agreed reading age of 11-14 years. Target was 95%.
- 97.8% of GPs surveyed reported they trusted a small sample of content produced recently (on type 1 diabetes).
- 69% average user satisfaction rating on health guides content from 01/01/2020 to the current date on Usabilla feedback tool.

This project has concluded operations and closed out.

Appendix 2: Health literacy — empowering citizens with the knowledge to manage their health cont.

Project 155

National Self-Management Education IT System Implementation and Expansion

Improving access to and evaluation of Diabetes Self-Management Education

Who is delivering this project?	Where?
HSE (Chronic Disease Commissioning Team, Primary Care Strategy and Planning)	National/Online

What is this project about?

This project implemented and further developed the National Self-Management Education (SME) IT System. The web-enabled system allows patients to find Diabetes SME courses near them and enrol online. The system also facilitates e-referrals from GPs and has Individual Health Identifier (IHI) integration to support better patient care. This system has the capability to collect booking, patient, and educator data which enables planning, monitoring and evaluation of services. The project provides innovative solutions for healthcare services to ensure they can continue to provide a high-quality and safe healthcare service for people living with diabetes.

Target Population:

The target group are people with chronic health conditions accessing group education and healthcare staff delivering chronic disease group education, including frontline, administrative and management. It's delivered online nationwide.

Project outputs & outcomes:

- A National Self-Management Education Database developed.
- 30 training manuals, 150 user manuals and 30 report manuals developed.
- 23 primary care staff have received training on how to use the National SME system to date.
- A National Self-Management Education IT Booking system called "Health Course Manager" has been developed and deployed to HSE servers.
- Proof of concept for addition of new programmes successful. Further development is required to enable systems administrator to add further courses and their associated reports.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 252

HealthEIR: A Journey to Improving Health and Wellbeing Through Community-Based Social Self-Care

Promotion of Healthy Behaviours through Community Services

Who is delivering this project?	Operational Period:
Royal College of Surgeons in Ireland, in collaboration with the National College of Art and Design, University College Dublin, and the TU Dublin School of Creative Arts	20 months

What is this project about?

HealthEir optimises the delivery of brief interventions in primary care by integrating innovative technology with a human-centred care delivery model. The majority of chronic diseases could be prevented by supporting people to make healthier lifestyle choices. A priority action of the Healthy Ireland implementation plan is to implement a brief-intervention based health behaviour change framework via the Making Every Contact Count initiative (MECC). While the benefits of brief interventions are well-established, GPs and pharmacists report challenges implementing them in their practice. Barriers reported include time pressures for both patient and health professional, limited training, difficulty integrating brief interventions into existing care delivery practices, and concerns about patient responses. HealthEir aims to overcome these barriers by employing a human-centred approach to design a new care model that integrates seamlessly with existing practices. HealthEir allows patients to identify their own health behaviour change priority via a user-friendly digital interface while they wait. This efficiently reframes unavoidable patient waiting as an opportunity for patients to learn about health behaviours and complete initial screening questions. HealthEir then guides health professionals through the remaining steps in brief intervention during the consultation, allowing them to use a directory of local services to connect the patient with appropriate supports tailored to their preferences and locality. Patients can assess their progress or explore other health behaviours during subsequent visits.

Project outputs & outcomes:

- 133 health related brief interventions achieved with pharmacy and GP service users over the pilot and implementation phases.
- 100% (12) of participating pharmacists and GPs provided structured brief interventions, using the MECC approach, for more consultations. This was measured by self-report before and after implementation of HealthEIR.
- 87% of users agreed that HealthEir was easy to use, 90% stated it supported their delivery of brief interventions and 85% claimed it was engaging for their patients.
- An evaluation of the model noted multiple benefits including:
  - It targets the behaviours that underpin chronic disease with evidence-based interventions.
  - It makes efficient use of existing healthcare resources, staff and infrastructure.
  - It reduces healthcare inequalities.
  - It reduces the burden on acute services by linking patients to appropriate community supports.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Health literacy — empowering citizens with the knowledge to manage their health cont.

Project 280

Skin Cancer Prevention
National Plan for the Prevention of Skin Cancer

Who is delivering this project?	Where?	Operational Period:
The HSE - National Cancer Control Programme	Nationwide	11 months

What is this project about?

Cancer prevention is a cornerstone of The National Cancer Strategy 2017—2022, offering a cost-effective, long-term approach for cancer control. The strategy includes a recommendation to develop a Skin Cancer Prevention Plan. This is the first national initiative of its kind, a landmark commitment to skin cancer prevention, aligning with the Healthy Ireland vision.

Over 11,000 cases of skin cancer are diagnosed per year in Ireland and this number is projected to nearly triple by 2051. The rising incidence will increase demand on the over-burdened acute healthcare diagnostics and treatment services. However, skin cancer is one of the most preventable cancers. The Skin Cancer Prevention Plan stems the rapid rise in cases of skin cancer in Ireland. This is part of a long-term plan to establish skin cancer prevention controls. Specific actions are designed to reach children, outdoor workers including agricultural and construction workers, as well as those who participate in outdoor activities, through relevant policy makers and networks, as well as the media. These include awareness raising through social media, engagement with public events to promote skin protection behaviours, incorporating skin protection messages into existing educational programmes, and creating resources to support organisations.

Target Population:

The target groups for this project are high risk groups: children and young people, outdoor workers, those who pursue outdoor leisure activities i.e. sport and tourism and sunbed users.

Project 280 cont.

Project outputs & outcomes:

- Project produced a briefing document on baseline measures of skin cancer preventive behaviours in the Irish population.
- Project produced evidence based key messages for skin cancer prevention, agreed and approved by the steering group.
- National communications plan on skin cancer prevention for 2021—2022 has been produced.
- 70,612 increase in public engagement with HSE-provided digital messaging (online/social media) on skin cancer prevention exceeding the target of 53,931.
- 6 programmes incorporating skin cancer prevention messages into educational programmes were developed. Target was 3.
- 6 sectors were engaged in delivery of pilot skin cancer prevention programme with outdoor workers organisations. Target was 3.
- Initial analysis of the survey shows a statistically significant increase in perceived importance of sunscreen in all genders and in perceived importance of avoiding midday sun exposure in females.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Health literacy — empowering citizens with the knowledge to manage their health cont.

Project 320

Promoting cultural sensitivity in community mental health services in Ireland

Improving take-up of community-based mental health services by high-risk groups of people from ethnic minority communities

Who is delivering this project?	Where?	Operational Period:
Mental Health Reform (MHR)	Cabra Community Mental Health Team	24 months

What is this project about?

Research has shown that people from ethnic minority groups experience significant challenges in accessing mental health supports that appropriately meet their needs. This project seeks, through the development and delivery of training in cultural sensitivity, to enhance the capacity of community mental health staff to address such needs. This project improves the take-up of community-based mental health services by ethnic minority communities and reduces their hospital admissions by piloting implementation of the Mental Health Commission (MHC) and MHR Ethnic Minority Guidelines.

Target Population:

The target group for the project are staff of the Cabra Community Mental Health Team and Mental Health Service Users from Ethnic Minority Communities.

Project outputs & outcomes:

- Training day delivered with 13 community mental health staff; target was 10–20.
- Self-rated knowledge after attendance (M=7.15; SD=1.28) was significantly higher than self-rated knowledge before attendance (M=6.15; SD= 1.28), t(12)= -3.34; p<.01.
- A framework and toolkit for the implementation of cultural sensitivity training for all CMHTs nationwide was developed.

This project has concluded operations and closed out.

Project 338

Prevention is better than cure - Community Mothers Programme
A standardised national model of programme delivery

Who is delivering this project?	Where?	Operational Period:
National College of Ireland	Ten communities across Ireland, Dublin Docklands, Dublin Loughlinstown, Kerry, Limerick, Tipperary North, Tipperary South, Laois/Offaly, Longford/Westmeath, Trim and Roscommon (Boyle and Ballaghaderreen)	19 months

What is this project about?

The Community Mothers Programme is an Irish-developed home visiting programme delivered in ten communities in Ireland, providing supports to parents in pregnancy and early childhood. The Community Mothers Programme supports and empowers parents in caring for their babies and young children while also encouraging them to look after their own health and wellbeing. Research shows that early support prevents the onset of problems later in life, reducing demands on acute health services. Approximately 63,000 babies are born in Ireland each year. About 38% are to first-time mothers.

Target Population:

The target group for this project are parents of infants from prenatal stage to 3 years old.

Project outputs & outcomes:

- Project has achieved its objective of creating an up-to-date, integrated, evidence-based best practice model to deliver the best possible service to infants and their families.
- The development of a standardised national model and dataset for the Community Mothers Programme is led by the National College of Ireland.
- 7 sites agreed an implementation plan for the dataset which commences in 2022.
- A learning and support network for Programme Sites to participate in has been established.
- Secured strong engagement and support from the HSE Public Health Nurse Service, National Healthy Childhood Programme, the HSE National Lead for Midwifery and HSE Health and Wellbeing.
- Capacity building training secured in Outcomes-Based Accountability to enhance the knowledge base in outcomes-focused working and the use of both population and performance outcomes.
- Identified additional training to inform the model development and trialling of potential core home visitor training model.
- Raised awareness of the Community Mothers Programme across different HSE and Tusla departments.
- The feedback from programme sites, parents who use the service and key stakeholders both locally and nationally has all been universally positive.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Health literacy — empowering citizens with the knowledge to manage their health cont.

Project 371

A pathway to empower patients to engage with antimicrobial stewardship
Encouraging Prudent Antimicrobial Prescribing

Who is delivering this project?	Where?	Operational Period:
St James's Hospital	Patients and staff of St James's Hospital	11 months

What is this project about?

By the year 2050, 10 million patients worldwide will succumb to antimicrobial resistant (AMR) infections. This figure will surpass the projected mortalities due to malignant disease and road traffic accidents combined. In recent years, Ireland has experienced rapid increases in the prevalence of multi-drug resistant infections which threaten patient safety. Increases in AMR are inextricably linked to antimicrobial overuse. Antimicrobial stewardship (AMS) is a multicomponent set of evidence-based interventions designed to reduce unnecessary antimicrobial use in healthcare settings. This project provides a package of interventions co-designed with patients, patient representatives and healthcare staff, which empowers patients to encourage and foster prudent antimicrobial prescribing.

Target Population:

The target group are patients prescribed antimicrobials in St James's Hospital.

Project outputs & outcomes:

- 18 patients engaged, including patient representatives and participants.
- 7 patient representatives engaged, depending on the attendances to the hospital patient representative meetings.
- 5 healthcare staff engaged from nursing and medicine specialities.
- Quantitative measurement of patient acceptability through a previously validated questionnaire showed participants agreeing that reading the materials made them less anxious about asking questions about antibiotic use with an average score of 4.06 out of 5.
- A theory development of methods to empower patients to become more involved with their hospital treatment. This theory could be applicable to other areas of healthcare delivery Qualitative analysis of focus group data. The unique deployment of behaviour change instruments and conceptual tools has enabled the construction of this theory. In essence, this theory is the "pathway" for patient engagement with antimicrobial stewardship.

This project has concluded operations and closed out.

Project 308

HealthSENSEapp
Citizen Engagement with Sláintecare through HealthSense App

Who is delivering this project?	Where?	Operational Period:
SMARTlab clg with the Inclusive Design Research Centre at UCD	Online/Nationwide	0

What is this project about?

Project ID 308 SMARTLAB was funded to develop a gamified proof of concept app to encourage new ways of thinking and feeling about health and wellbeing. The online game POC will show the potential for Irish citizens to become active in finding relevant and accurate health information and will encourage prosocial behaviour change to respond to the needs of a changing society. The mechanism is a rewards-based virtual treasure hunt where players collaborate. The gamified play builds upon Nudge theory to encourage positive behaviour change. This health education and communications tool explores the social (health) contract by promoting awareness, supporting the translation of that awareness into beliefs, and empowering individuals to make better choices. It is primarily a public participation tool to communicate, engage, and encourage active health citizenship as well as a medium of gathering research and behavioural data around decision making. Through collection of this behaviourally informed (totally anonymised) data, this application will help to inform policy, strategy and decision making that will translate into improved care and services.

Project outputs & outcomes:

The onset of Covid-19 was integrated into the development of the gamified app. The project redesigned and developed their app, developing a further social distancing game and texting service, Keepaway based on social distancing, geomapping and proof of concept web service design.

The project delivered on all its agreed outcomes:

1. Health Literacy: through this increased awareness, challenge the individual to translate health knowledge into belief and attitude.
2. Self-efficacy: through the experience of the gamified app empower individuals to make better choices about their own health and well-being.
3. Opportunity to engage health and social care staff in the development of the App.

This project has concluded operations and closed out.

Appendix 2 cont.

Facilitating timely hospital discharge, reduction in Average length of stay (ALOS)

Three SIF funded projects; across a range of specializations including Diabetes Care, Respiratory (COPD)/Asthma and Cystic Fibrosis; had a primary high-level outcome to reduce average length of stay. The average operational period of the various services at the time of this report is 13.5 months. To date **268** patients have been seen, average length of stay has been reduced by **7.75** days, **1.3** days and **1** day respectively and reduction of **132.75** bed days approximately.

Project 111

Telemedicine for Cystic Fibrosis (CF)

Facilitating early discharge and treatment outcomes for CF Patients

Who is delivering this project?	Where?	Operational Period:
Galway University Hospital	Galway University Hospital catchment area.	20 months

What is this project about?

Ireland has one of the highest rates of Cystic Fybrosis (CF) in the world with 1 in 2,500 live births. The cornerstones of CF therapy centres around disease modification, physiotherapy with airway clearance, adequate nutrition because of malabsorption and bacterial suppression with antibiotics (either inhaled, oral or intravenous (IV)). Telemedicine for CF has introduced physiotherapy-led airway clearance and exercise sessions delivered via telehealth to adults with Cystic Fibrosis. It is targeted at patients on home intravenous antibiotics and to those adults with CF who have commenced a course of oral antibiotics at home.

Target Population:

The target group for this project are people with Cystic Fibrosis.

Project outputs & outcomes:

- A videoconferencing platform has been established to deliver physiotherapy telehealth sessions to 50 adults.
- 1,392 sessions have been delivered to patients to date.
- 44 inpatient bed days approximately were avoided due to early discharge and average length of stay reduced to 4.25 days compared with the target of five days.
- A further 9 patients, after Physiotherapy Telehealth Review and discussion with CF Consultant, had planned hospital admissions de-escalated resulting in a potential reduction of a further 69.75 bed days approximately.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Facilitating timely hospital discharge, reduction in Average length of stay (ALOS) cont.

Project 133

Development of a Respiratory Team for Co Monaghan
Providing Pulmonary Rehabilitation closer to home

Who is delivering this project?	Where?	Operational Period:
Community Health Organisation Area 1 (CHO 1)	Co. Monaghan	10 months

What is this project about?

The development of a Community Respiratory Team for Co. Monaghan is improving the management of respiratory patients in the primary care setting. It provides an end-to-end model of care within a geographically accessible area, bringing safe quality care closer to patients and into patients' homes when required. The team provides a comprehensive respiratory assessment, early disease management, community-based pulmonary rehabilitation programmes, early supported discharge and assisted discharge with home visits as required.

Target Population:

The target group of the project are adults from 20 to 91 years old, living with a confirmed respiratory diagnosis in County Monaghan. The presenting conditions include asthma, bronchiectasis, COPD, dysfunctional breathing, and pulmonary fibrosis.

Project outputs & outcomes:

- 42 new patient respiratory assessments and management plans between 2 primary care locations. A further 20 new patient respiratory assessment and management plans were delivered in patients' homes, to people who were unable to travel to clinic.
- 6 participants were enrolled in Pulmonary Rehabilitation Programmes to date.
- 366 telephone consultations have been delivered to support respiratory patients with complex needs, exceeding the target of 100.
- Home visit service was provided for 19 patients to enable assisted discharge from hospital, in collaboration with Cavan Monaghan RCSI Hospital Group and Our Lady of Lourdes Hospital, Drogheda.
- This project permitted 19 Co. Monaghan patients with COPD, who meet the clinical criteria for assisted discharge, to go home 1 day early, at an approximate saving of €919 per patient totalling €17,461, based on 2019 HIPE data in Cavan Monaghan Hospital. This 1-day reduction achieves its target.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 167

Waterford Thriveabetes Project

Supporting and empowering people with Type 1 Diabetes in Waterford

Who is delivering this project?	Where?	Operational Period:
University Hospital Waterford (UHW) and South-East Community Healthcare (CHO 5)	Waterford	11 months

What is this project about?

The 'Waterford Thrive with Diabetes Service' Project focused on supporting and empowering people with Diabetes Type 1 to thrive. The establishment of this new innovative service provided specialist healthcare, support and self-management education, delivered mainly in an appropriate primary care setting. The aim of the project was to identify priority service gaps, including the need for integrated community-based Specialist Diabetes Services in Waterford.

Target Population:

The project was targeted at patients with Diabetes Type 1 in Waterford City and County. It was run collaboratively between University Hospital Waterford (UHW) and South-East Community Healthcare (SECH).

Project outputs & outcomes:

- Project delivered Dose Adjustment For Normal Eating (DAFNE) programmes to 24 participants and facilitated 963 patient clinic appointments/encounters.
- Senior Diabetes Specialist Dietitian and Specialist Diabetes CNS led DAFNE Structured Patient Education (SPE) established and delivered to 24 participants.
- Specialist Diabetes Supported Discharge and post-discharge follow-up service in Primary Care delivered to 27 patients.
- Specialist ambulatory review/support clinics in primary care achieved 699 patient clinic appointments.
- 30 patients with Type 1 Diabetes within UHW acute care services and outpatient department were identified and supported to move swiftly through the acute care system with the aid of supported discharge, tailored transition strategies and follow up care.
- Specialist MDT clinic support provided to 136 patients.
- Average length of stay was reduced by 1.3 days exceeding the target of 0.5 days.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2 cont.

Long term care avoidance

Three SIF funded projects specialising in Older Persons; had a primary high-level outcome to avoid long term care. The average operational period of the various services at the time of this report is **9.5** months. To date **2,963** patients have been seen, **166** patients avoided long term care and approximately **2,036** bed days have been avoided.

Project 269

Mullingar Frailty Intervention Team (MFIT)

Improve patient outcomes through early intervention and education

Who is delivering this project?	Where?	Operational Period:
Ireland East Hospital Group and Community Health Organisation Midlands Louth/Meath (CHO 8)	Longford/Westmeath	13 months

What is this project about?

Mullingar Frailty Intervention Team (MFIT) represents an interdisciplinary, integrated care approach to the management of older people living with frailty in Longford/Westmeath. The programme of work is supported by the Ireland East Hospital Group (IEHG) Service Improvement Team with a series of rapid improvement events and workshops involving participation from the acute and community settings. Key principles include the early identification of frailty, to facilitate a rapid response in order to deliver integrated care across hospital, post-acute and community services.

Target Population:

The target group for this project are the elderly, aged 75 and over who are frail, and their families and carers.

Project outputs & outcomes:

- 521 comprehensive Geriatric Assessments (GAs) were completed in the most appropriate setting for the service user, e.g. Primary Care Centres or home. The length of time taken to complete a CGA increased due to new infection control procedures, and additional time required to get collateral history due to carers/family members not being able to attend with the patient.
- Number of hospital admissions reduced by 11% amongst target group against a target of 5%. This represents a reduction from 72% (706/983) of patients over 75 years who were frail and presented to ED were admitted between July and December 2018 to 64% in 2021 (430/667).
- Approximately 864 bed days have been avoided.
- Discharges directly home increased by 14% (111) amongst target group exceeding the target of 10% (78). This reflects an increase from 80% pre MFIT (777/972) to 88% with Sláintecare Integration Fund funding (888/1014).
- Discharges to nursing home/long term care/convalescence has reduced by 50% in the same time period. If trends continue, this equates to 148 less people being discharged to nursing homes annually.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Long term care avoidance cont.

Project 382

Frailty Programme
Addressing the needs of older people and their carers in Wexford

Who is delivering this project?	Where?
Wexford General Hospital and South East Community Healthcare Organisation (CHO 5) Frailty programme	Wexford, New Ross, Enniscorthy and Gorey

What is this project about?

This project has established a frailty assessment and intervention team (FIT) with full integration between the acute and community sectors. Inward and outward referral care pathways will be established for frail older persons, and appropriate education around frailty will be provided. The project hub is based in the Day Hospital (DH) in Wexford General Hospital (WGH). The DH also functions as the coordination, information and training hub for services and will support integration between hospital and community-based services. The hub provides acute ambulatory care.

Target Population:

The target group for this project are older adults living in Co Wexford with complex health and social care needs who require input from two or more disciplines.

Project outputs & outcomes:

- New attendances at clinics increased to 2,389 exceeding the target of 1,200. This included the introduction of Virtual Clinics.
- 12% (11) reduction in the percentage of patients applying for Long Term Care from the acute sector. This represents a reduction from 57% to 45%. These 11 patients were referred directly to LTC from the community, avoiding acute admission.
- 14% (1.28 days) reduction in average length of stay in the over 75s cohort exceeding the target of 5% (0.46 days).
- The FIT team assessed and carried out CGA on 1177 patients: this facilitated admission avoidance in 407 patients with new referral pathways to the Age Related Care (ARC) Teams and Community services.
- 1172 inpatient bed days, approximately, were avoided.

This project has been mainstreamed which means it will receive recurring funding annually.

Project 277A

ALONE BConnect; linking healthcare, social care and community care together using technology and services

ALONE's BConnect reducing Emergency Department admissions and delayed discharge through technology and integrated support for older people

Who is delivering this project?	Where?	Operational Period:
ALONE	Dublin North City and County	16 months

What is this project about?

ALONE is a national organisation that supports and empowers older people aged over 60 years to age happily and securely at home. ALONE's BConnect links healthcare, social care and community care together using technology and services. They provide innovative support services that use technology to support older people to better manage their own health and wellbeing, to come home from hospital quicker, and to remain living independently at home. They also work with community and voluntary organisations to help them improve their service through computerisation, training and collaboration. Support services are around housing, social contact, finance and social prescribing.

Target Population:

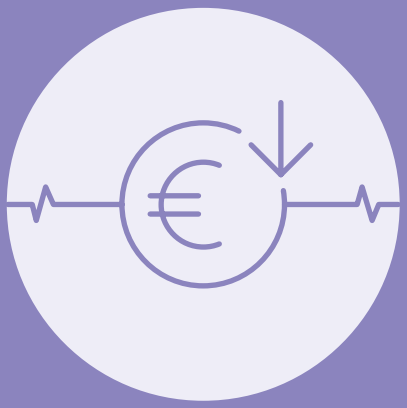
The target group for this project are older people (65+) from three main referral sources: This was a requirement for all referral partners in the project. This was the minimum criteria for which a person could be deemed eligible.

Project outputs & outcomes:

- Technology enabled care solution developed and tested with 48 people against a target of 50.
- Prevented a delay in discharge for 12 people against a target of 5. (In conjunction with Beaumont's FIT programme and Wards, 12 clients had a timely discharge to the ALONE programme).
- Delayed admission to long-term care for 44 people exceeding the target of 10. Only 4 across the full cohort of 48 (8.3%) transferred to a long-term care (LTC) or Palliative Care pathway.
- Prevented an avoidable presentation to the ED for 5 people against a target of 5.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2 cont.



Cost reduction

Project 132

Establishment of Oxygen assessment clinics in Primary Care Donegal

Shifting care to the community increases quality and safety of care

Who is delivering this project?	Where?	Operational Period:
Community Health Organisation Area 1(CHO 1)	Donegal	8 months

What is this project about?

In Donegal, assessment for Long Term Oxygen Therapy (LTOT) was provided in Letterkenny University Hospital (LUH) only. This project now enables patients' oxygen needs (ambulatory and long term) to be assessed and monitored in Primary Care, enabling a full review of their condition and allowing oxygen therapy to be introduced, optimised or discontinued. The provision of this assessment in a Primary Care location can reduce significant travel time (up to 3 hours round trip) for some patients, which may have been a barrier to attendance for LTOT assessment.

Target Population:

The primary target group for this project was adults living with chronic respiratory disease who required initial assessment and/or review of their home oxygen therapy needs. The presenting respiratory conditions included asthma, bronchiectasis, COPD, lung cancer, post Covid pneumonitis, pulmonary fibrosis and pulmonary hypertension. The age range of patients assessed was from 41 to 92 years. 66% of all patients referred for LTOT assessment lived in rural areas of Co. Donegal, including the 2 Island dwelling communities off Donegal.

Project outputs & outcomes:

- 66 newly referred and existing patients accessed to initiate oxygen therapy assessments.
- 57 access Long term Oxygen Therapy assessment when their condition is stable.
- Number of stable respiratory patients attending LUH for Long Term Oxygen Therapy assessment has been reduced by 45 patients.
- Enhanced assessment of patients presenting with acute exacerbations by 9 patients.
- 19 patients referred to the service were assessed and did not require an oxygen therapy prescription. Cost savings from identification of 19 unwarranted referrals to 31st May: €12,834 (estimated).
- 12 patients referred to the service were assessed and were supported to discontinue oxygen therapy to 31st May 2021. Cost savings from discontinuing 12 oxygen therapy prescriptions to 31st May: €8,928 (estimated).
- Total savings to 31st May: €21,762 (estimated).
- 68% (45) of the 66 initial LTOT assessments were conducted in the community setting to 31st May against a target of 25% (17).

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2 cont.

Patient and Professional Satisfaction, through the use of surveys

Two SIF funded projects; specialising in Diabetes Care and Palliative Care; had a primary high-level outcome to increase patient and professional satisfaction. The average operational period of the various services at the time of this report is **18** months. To date **1,815** individuals have participated. Participants have shown increased satisfaction with services and increased self-efficacy.

Project 267

Rehabilitative Palliative Care

Optimising well-being and empowering people to live independently with advancing illness

Who is delivering this project?	Where?	Operational Period:
Mater Misericordiae Hospital & St Francis Hospice	Ireland East Hospital Group	15 months

What is this project about?

Rehabilitative Palliative Care optimises wellbeing and enables people to live as independently as possible despite advancing illness. It empowers people to adapt with dignity by providing a support system to help patients cope with changes associated with deteriorating health. This project provides an innovative model of rehabilitative palliative care spanning hospital and community. It integrates rehabilitation and enablement into the model of Palliative Care and improves hospital flow, supports integrated discharge, and builds capacity for Allied Health Professionals to work in partnership across transitions of care. People with life-limiting conditions are empowered to self-manage their condition, enabling them to live fully and enjoy the best quality of life at home.

Target Population:

The target group are people with life-limiting conditions. These conditions include, but are not limited to, advanced cancer, advanced heart failure or chronic obstructive pulmonary disease and progressive neurological conditions such as Motor Neurone Disease.

Project outputs & outcomes:

- 554 patients have been provided with rehabilitative palliative care. Target was 200.
- 91% (104) of participants felt enough information about their rehabilitation needs was given to them. Target was 70%.
- 95% (117) felt they had enough time to discuss their rehabilitation plan with a member of the hospital staff. Target was 70%.
- 95% (119) were satisfied with the rehabilitative palliative care service experience. Target was 70%.

This project has been mainstreamed which means it will receive recurring funding annually.

Appendix 2: Patient and Professional Satisfaction, through the use of surveys cont.

Project 278

Facilitating Integration of Childhood Obesity Services in Primary Care Through Education

Building capacity in primary care for the management of child and adolescent obesity

Who is delivering this project?	Where?	Operational Period:
Royal College of Surgeons in Ireland	National	21 months

What is this project about?

Child and adolescent obesity can lead to serious health consequences during childhood and into adulthood. In line with the UN Convention on the Rights of the Child, children should have access to treatment for health conditions and providing treatment for obesity and related co-morbidities is a key focus of Irish health policy since 2005.

This project aligns to the four aims of Sláintecare by:

- Improving training of primary care health professionals to improve the experience of service users.
- Improving health professionals' engagement and experience by enhancing their skillset.
- Facilitating timely access to treatment at the right time, with the right person in the right place.
- Reducing the need for visits to paediatric tertiary sites for outpatient appointments.

The project facilitates development of a network of health professionals around the country who are trained in line with the international recommendations and committed to the delivery of evidence-based treatment for child and adolescent obesity. The project employs one and a half full-time staff.

Target Population:

The primary target group for the project are health professionals caring for children with obesity in Ireland.

Project outputs & outcomes:

- Delivered training licenses to 2000 health professionals with 1,044 health professionals enrolled in the course. Target was 78.
- 535 health professionals completed the blended-learning training package on childhood obesity. Target was 78.
- 769 health professionals have joined a community of practice for childhood obesity, exceeding the target of 20.

This project has been extended to facilitate further review in 2022.

Appendix 3
Table of project evaluations

ID	Project Name	Evaluation Type	Evaluation/ Publication Name	Organisation /Reviewer etc.	Key Findings
2	Sustain and Expand Targeted Response with Youth (TRY)	External Evaluation	Targeted Response with Youth (TRY) Evaluation	University of Limerick	Targeted Response with Youth (TRY) worked with people in the Donore Avenue area, in and around St Teresa's Gardens (STG), Dublin 8. TRY's mentor-led IOB model is a promising practice employing a relationship-based, holistic, person-centred approach that is not restricted by presenting issue or geographical boundary. The evaluation found that TRY improves the health outcomes for participants, their households, and their community by 'Promoting the engagement and empowerment of citizens in the care of their own health' epitomising the delivery model of the 'right care in the right place at the right time by the right team'. **https://www.drugsandalcohol.ie/34556/**
15	Dublin 8 Social Prescribing Project	External Evaluation	An Evaluation of Get-Well Connected Social Prescribing pilot project	Partners Training for Trans-formation	The findings from the data showed significant positive changes over the time of engagement with the social prescribing project. Self-reported wellbeing measures improved, and the impact of causes for concern in the lives of participants diminished. Community involvement and knowledge of services in the community also increased over the same time. Recommendations are made in relation to the continuation of the project, and its continued development and growth in the months and years ahead. **https://sdcpartnership.ie/wp-content uploads/2021/02/ Final-SDCP-Social-Prescribing-Evaluation.pdf**
18	Sheds for Life	External Evaluation	Sheds for Life Impact Report	Waterford Institute of Technology/ Carlow Institute of Technology	Sheds for Life demonstrated that the programme has been successful in effectively engaging a Hard-to-Reach group of men and enhancing their health and wellbeing outcomes. It has highlighted the rich potential of the Shed environment for men to engage with health and wellbeing in a meaningful and effective way. SFL has successfully implemented a structured and targeted prevention strategy that responds to the needs of Men's Shed members made possible by the strength of its partnership approach. **https://menssheds.ie/wp-content/uploads/2021/04/SFL-impactreport.pdf**
21	Primetime for Older Adults	Published Journal Article	Multimodal Physical Activity Participation Rates in Middle-Aged and Older Adults	Irish Medical Journal	The article examined the results of 353 adults aged 50-90 years in Laois who completed a survey looking at participation in training, barriers to participation, perceived benefits and physical activity opportunities participants would like to see available. A large majority of participants said physical activity improved their mental health (91.9%,), helped them feel less stressed (90%) and 77% reported that they would like to take part in more physical activity in the future. **https://imj.ie/multimodal-physical-activity-participation-rates-inmiddle-aged-and-older-adults/**

ID	Project Name	Evaluation Type	Evaluation/ Publication Name	Organisation /Reviewer etc.	Key Findings
23	Community Living Mental Health Recovery Co-Ordinator	Internal Evaluation	Evaluation of Community Living Mental Health Recovery Co-Ordinator	HAIL's Peer Support Service	The evaluation found that the coordinator has been able to accelerate the integration of peer volunteers within HAIL, strengthening the voice of lived experience and embedding coproduction in line with the Advancing Recovery in Ireland principles to improve service design and delivery. Slaintecare funding has facilitated the development and introduction of a model which is sustainable, replicable and will continue to be a core aspect of HAILs work to support clients to integrate into their communities, reduce the likelihood of hospital admission and length of hospital stay, provide support around hospital discharge, and reduce the risk of homelessness. ese concerns or early indicators to their clinical teams/supports.
31	Expansion of Social Prescribing service in Waterford and mainstreaming of pilot service in Waterford Metropolitan area	Internal Evaluation	Review of Social Prescribing Service in Rural County Waterford	Sacred Heart Community & Childcare Project CLG	Successfully established county-wide service since commencing post in November 2019, exceeding all Slaintecare's agreed outputs and outcomes. Set up hubs across four locations in Waterford County and engaged in continued promotion across these areas, incorporating mediums including local and national media, social media and professional presentations. Working closely with 5 Primary Care Teams across rural Waterford. Continue to represent service on various Local and National working groups. Collaborative work with Health Management Support for Long Term Health Conditions, ALONE, Local Sports Partnership, Creative Ireland, Waterford Area Partnership, Waterford and Wexford ETB, Get Ireland Walking, Community Based Drugs Worker.
48	The LGBT+ Champions programme	Evaluation	The LGBT+ Champions programme Evaluation	Lane-Spollen and Associates	The LGBT+ Champions programme aims to make health, care, and support services for older people LGBT+ friendly, the report concludes that the programme was both effective in terms of meeting its intended outcomes and was a cost-effective way to address the problem of low visibility of LGBT+ in older people's services. Effectiveness would be increased where there is an overarching policy in place at organisational level within the setting supporting LGBT+ inclusivity and through developing networks amongst Champions within their setting. **https://lgbt.ie/champions-programme/outcomes-of-the-lgbtchampions-training/**

Appendix 3 cont.

ID	Project Name	Evaluation Type	Evaluation/ Publication Name	Organisation /Reviewer etc.	Key Findings
121	My Slainte Community Lifestyle Programme	Participant Survey	Croí MySláinte programme End of Programme Evaluation	Croi	Evaluations were completed by participants as an End of Programme assessment. Overall, the Croí MySláinte programme was very positively evaluated, with 95% of evaluation respondents rating the programme as Very Good. In comparison to other similar programmes the participants had experienced, 47% rated the Croí MySláinte programme as "Much Better" and 37% rated is as "Better" than previous projects. **https://croi.ie/wp-content/uploads/2022/01/MySla%CC%81inte-Report_e-copy.pdf**
134	Jigsaw Online	Internal Evaluation	Jigsaw Online Services: Evaluation Report	Jigsaw	Jigsaw Online was launched in June 2020 comprised of an individual live chat service, a group chat service and email-based support for young people aged 12-25 living in the Republic of Ireland. The live chat service provided free, anonymous, real-time, text-based mental health support; group chats are clinician moderated online peer spaces where young people can discuss topics of interests (e.g., self-harm, stress, anxiety etc) and email-based support provide young people with detailed, individualised responses. Satisfaction with Jigsaw Live Chat was high, indicating that the service met young people's immediate need.
135	Promoting Physical Activity Programmes for People with Neurological Conditions in The Community	External Evaluation	Looking Beyond COVID-19: Embracing Digital Solutions to Neurological Car Promoting physical activity programmes for people with neurological conditions in the community	Neurological Alliance of Ireland	**https://www.nai.ie/assets/2/3E0C2446-80E4-4825-9CE95636F81C30B8_document/Online_Report_FINAL.pdf**

ID	Project Name	Evaluation Type	Evaluation/ Publication Name	Organisation /Reviewer etc.	Key Findings
137	S.M.I.L.E Supporting Multi Morbidity Self-Care	External Evaluation	Evaluation of SMILE Supporting multi-morbidity self-care through Integration, Learning and eHealth	Dundalk Institute of Technology (NetwellCASALA) and Trinity College Dublin	SMILE is a new, innovative service to enable Irish citizens to proactively self-manage their health and well-being from home supported by a digital platform and nurse-led remote assessment and triage. Participants with two or more conditions including diabetes, COPD, chronic heart failure, and heart disease utilised a selection of healthcare devices based on their needs to monitor their health and wellbeing. Using the 'ProACT' digital health platform, developed by researchers in NetwellCASALA at Dundalk IT and the TCPHI at Trinity College Dublin, participants effectively were able to monitor their data (captured by their devices) and receive education about their conditions through their ProACT app. **https://ijic.org/articles/abstract/10.5334/ijic.ICIC20393/**
140	WellComm Active Well Communities Connect Project 2	Evaluation	Active Communities are Well Communities Evaluation Report	Cork Local Sports Partnership (CLSP), supported by Cork Kerry Community Healthcare (CKCH)	In response to an ageing population, growing waiting lists, and the need for rethinking the delivery of health services, Cork Local Sports Partnership (CLSP), supported by Cork Kerry Community Healthcare (CKCH), announced the launch of a new initiative: WellComm Active - Active Communities are Well Communities. The initiative, which places a greater emphasis on increased physical activity, self-care, and illness prevention, was found to have had a positive impact on participants and promoted the development of integrated Referral Pathways for evidencebased, community-based, peer-led, non-clinical programme interventions.
171	My Home MHCIS	External Evaluation	My Home Project	National University of Ireland, Galway	The primary aim of My Home Project was to provide a comprehensive assessment of the housing and support needs of residents in mental health congregated settings in Galway/Roscommon Mental Health Services (MHS), to enable some of the residents to transition into accommodation which is suited to their needs and is of their choosing, and to deliver a new housing-led community integrated recovery focused model. The evaluation found that the My Home Project has proven its' efficacy and importance in the lives of HSE service users who have transitioned from congregated settings to their independent homes and the service provided should be continued. The report concludes with the recommendation that consideration should be given at management level to the expansion of the My Home Project across the entire CHO2 area. **https://galwaysimon.ie/wp-content/uploads/My-Home-Research-Report_Dr-Ann-OKelly_April-2021.pdf**

Appendix 3 cont.

ID	Project Name	Evaluation Type	Evaluation/ Publication Name	Organisation /Reviewer etc.	Key Findings
180	Turn2me 360 Online Stepped Care Mental Health Pilot for Young People and Their Families	External Evaluation	turn2me: Youth & Families Peer Support Pilot Independent Assessment	Niall Morahan & Karen Hand PhD	Turn2me launched a peer-moderated support pilot which used a 24/7 on-line platform, facilitated by a community of volunteers with oversight and trained peer moderators with clinical oversight. The evaluation found that the interactive process of building data and insight into online behaviour can help tailor and adapt mental health services and resources to individual users. Digital mental health services can be part of a full societal approach to positive mental health for young people in Ireland. It is important to maintain clinical governance, safe-guard user privacy and positively harness data on participant engagement and outcomes into all youth mental health support services going forward.
202	Supporting Pregnant Women to Quit and Stay Quit - A Co-design Community Based Integrated Approach	Participant Survey (Your Voice Matters)	Sláintecare/ Southeast Community Healthcare Exploring the Experiences of Participants attending Supporting Pregnant Women to Quit and Stay Quit Service	Sláintecare/ Southeast Community Healthcare Service	Southeast Community Healthcare (SECH) received Sláintecare integration funding to deliver Supporting Pregnant Women to Quit and Stay Quit across the Southeast. This service was offered free to all pregnant women, women who have had babies or women who are planning to become pregnant, their partner/spouse and others in the household who want to quit smoking. 142 participants completed Your Voice Matters survey tool. 52 of the 142 participants who entered the Quit and Stay Quit service up to 31st December 2020 went on to set a quit date, with 49 of these respondents reporting that they no longer smoked at the time of survey completion. The survey found that attending the Quit and Stay Quit service was an extremely positive, supportive experience. **https://www.hse.ie/eng/services/news/media/pressrel/quittingto-stay-quit-in-the-south-east.html**
233	The Exercise Effect - Integrating Exercise Practitioners into the Irish Mental Health Service	External Evaluation	Evaluation of 'The Exercise Effect': A pilot project integrating an exercise practitioner into outpatient mental health services in Ireland	Waterford Institute of Technology	The Exercise Effect evaluation looked at the development and implementation of a model for the integration of an Integrated Exercise Practitioner for mental health. The practitioner would actively support physical activity interventions as part of multidisciplinary treatment within Irish mental healthcare, including referral pathways, interventions, and discharge protocols. The evaluation found that the programmes developed and implemented by the IEP were successful in meeting the needs of service users that were referred to and engaged in the intervention. Mixed method inquiry found that interventions delivered to service user participants were beneficial for service users and holistic service delivery, with findings that reflect the best available international literature. The evidence obtained through the research evaluation show that the project has scope to continue and further warrants scale-up to other mental health services. **https://repository.wit.ie/3524**

ID	Project Name	Evaluation Type	Evaluation/ Publication Name	Organisation /Reviewer etc.	Key Findings
252	HealthEIR: A Journey to Improving Health and Wellbeing Through Community-Based Social Self-Care	Evaluation	HealthEir – Supporting and enhancing the delivery of brief interventions in primary care	Royal College of Surgeons Ireland & University College Dublin	HealthEir is a blended service that combines digital and face to face elements in a manner that efficiently utilises healthcare worker time and is engaging for patients. The evaluation found that HealthEir is fundamentally scalable and adaptable. It can rapidly be introduced to new pharmacy and GP settings with minimal equipment and training outlay. Although designed for the pharmacy and GP context, HealthEir is readily adapted for use by a broad range of HCWs and in a broad range of healthcare settings. These can include primary care centres, dental care settings, allied healthcare services and outpatient hospital clinics, as well as social care contexts such as social prescribing coordination and self-management support services. Potential also exists to integrate HealthEir with existing social prescribing and healthcare software including elemental and universal healthcare records in the future.
352	StrokeLINK Innovating Stroke Support	StrokeLINK Innovating Stroke Support	Is the StrokeLINK approach an effective mechanism for improving patient empowerment and integrating care, and for spread and scale locally and nationally?	School of Nursing, Midwifery and Health Systems, University College Dublin	It is clear from this review that the StrokeLINK model has achieved improved integration of care between the hospital and community settings and the empowerment of patients/carers to be partners in their own health care. Our review of the baseline data indicates that the StrokeLINK service is reducing reliance on the acute hospital sector by preventing avoidable re-admissions, and is preventing medical crises arising, requiring urgent medical attention. The estimated operational cost of the StrokeLINK service (€110,938 per annum) is relatively modest when compared to the potentially greater costs to the State of having to provide care across the acute and community settings to such patients and, in some cases, social welfare payments, such as disability benefit/assistance and carer's allowance, when patients or their carers have to cease remunerated employment as a direct result of stroke-related morbidity.
253	Cork Kerry Health & Wellbeing Community Referral	External Evaluation	Understanding the Social Prescribing Approach: Insights from the Health and Well-Being Community Referral Service in Cork	University College Cork	The evaluation looked at the Understanding the Social Prescribing Approach: Insights from the Health and Well-Being Community Referral Service in Cork and found that services using a social prescribing approach have potential to support population health and wellbeing and to reduce the pressure on the healthcare system in Ireland. Looking to the future, the report recommends that these services need adequate and sustainable funding to succeed. It is hence important that clear national guidelines are developed to ensure a level of consistency between services that will allow them to be accurately evaluated and to develop the bank of evidence supporting the efficacy of this approach for population health and well-being. **https://www.ucc.ie/en/media/research/carl/DermotOCallaghanCARLresearchreport2020.pdf**

Appendix 3 cont.

ID	Project Name	Evaluation Type	Evaluation/ Publication Name	Organisation /Reviewer etc.	Key Findings
267	Palliative Care Rehabilitation	Evaluation	Palliative Care Rehabilitation – Evaluation Report	Prof. Karen Ryan, Consultant in Palliative Medicine, UCD Clinical Professor and Consultant in Palliative Medicine, Mater Hospital and St Francis Hospice Dublin. Dr. Bridget Johnston, Research Assistant Professor, Public Health & Primary Care, Trinity College Dublin.	The report examined the potential of Palliative Care Rehabilitation in maintaining physical function and independence for patients living with advanced illness enabling them to maintain their autonomy, control, and dignity. The evaluation report concludes that it is imperative that palliative care services adapt to meet the needs of an older population living and dying with chronic illnesses which are often characterised by long periods of frailty, disability, and dependence. Palliative rehabilitation offers a meaningful response to those challenges and to critically appraise fitness to respond to the significant demographic shifts that lie ahead and to be dynamic in responding to those challenges.
277 B	Service Co-ordination for Older People	External Evaluation	B-Connect the Alone Pilot Project an Evaluation	Rodd Bond Service Innovation	The ALONE SIF project was conceived as a pilot initiative to test the evolving B-CONNECT model, implemented as a service improvement programme to explore how ALONE could strengthen and enrich its attachment and inter-connectivity with the on-going Integrated Care programme and pathways developing in North Dublin. While the project's success in delivering positive outcomes for participants and the health service are important, a key outcome is the extent to which project learning can be translated into the future development of ALONE's model, so that it is economically sustainable and operationally efficient.
278	Facilitating Integration of Childhood Obesity Services in Primary Care through Education	Online Training Tool	Childhood Obesity Education for Health Professionals – eLearning Tool	Led by RCSI Obesity Research and Care Group	The Sláintecare Childhood Obesity team launched an online training course for health professionals. The project team consisted of health professionals from medicine, nursing, dietetics, physiotherapy, and psychology in addition to health researchers, educators, and eLearning specialists. The course was developed in collaboration with the W82GO Child and Adolescent Weight Management Service in Children's Health Ireland at Temple Street, LearnUpon, the Association for the Study of Obesity on the Island of Ireland, the Department of Health in New South Wales and the Children's Hospital at Westmead, Sydney and will support primary care health professionals in continuing education in the field of childhood obesity. **https://childhoodobesity.ie/about/**

ID	Project Name	Evaluation Type	Evaluation/ Publication Name	Organisation /Reviewer etc.	Key Findings
320	Promoting cultural sensitivity in community mental health services in Ireland	External Evaluation	Independent Evaluation of a Cultural Competency Education Programme (CCEP) for Community Mental Health Service Staff	Anthony Wilkes, MA, FIfL, InstLM. United Kingdom Investor in Equality and Diversity (UKIED)	Building on the guidelines published in 2016, the project will adapt and pilot a cultural competency education programme for HSE Community Mental Health services and staff. The successful applicant will independently evaluate both the process and outcomes of the piloting of this cultural competency programme. Findings will inform the development of a toolkit for the implementation of cultural competency education for all HSE Community Mental Health services staff.
324	The Establishment of Novel Clinical Pathways for Orthopaedic Outpatient Referrals, integration of local community services and multidisciplinary triage	Excellence Award	Innovation in Service Delivery	Health Service Excellence Awards 2021	The UHW Fast-Track Knee Pathway aims to create a more efficient channel into Orthopaedics for patients who are most in need of surgical intervention. This integrated pathway includes dedicated community-based physiotherapy and dietetics funded through the Slaintecare Integration Fund and access to a Rapid Access Clinic in UHW. **https://www.hse.ie/eng/about/our-health-service/excellence-awards/health-service-excellence-awards-booklet-2021.pdf**
352	StrokeLINK Innovating Stroke Support	External Evaluation	Is the StrokeLINK approach an effective mechanism for improving patient empowerment and integrating care, and for spread and scale locally and nationally?	School of Nursing, Midwifery and Health Systems, University College Dublin & School of Population Health, University of New South Wales	The evaluation of the StrokeLINK model finds that the project has achieved improved integration of care between the hospital and community settings and the empowerment of patients/carers to be partners in their own health care. The design approach has been effective in achieving these objectives. The model has the potential to be adapted and adopted for other acute and chronic medical conditions, such as coronary artery disease, heart failure, chronic kidney disease, diabetes mellitus, chronic obstructive pulmonary disease etc. Some elements of StrokekLINK have already been successfully incorporated into the MMUH lung transplant service.

Appendix 3 cont.

ID	Project Name	Evaluation Type	Evaluation/ Publication Name	Organisation /Reviewer etc.	Key Findings
366	Keeping People with Severe Epilepsy Independent	Published Journal Article	Improving access to epilepsy care for homeless patients in the Dublin Inner City: a collaborative quality improvement project joining hospital and community care	British Medical Journal - Open Quality	The article describes the journey undertaken by a group of healthcare professionals in the quest to improve care for a vulnerable population of citizens. The development of the pathway was conceived and conducted as a coproduced quality improvement project over 4 years and has resulted in an elegant process for interacting with, delivering specialist advice on and improving care for homeless patients with epilepsy. Initial process measures are encouraging, and there is widespread support across the stakeholders for the pathways. Engagement with the patient group for pathway refinement will be important as will prospective measurement of outcome variables, and these will form the basis of a further report. **https://pubmed.ncbi.nlm.nih.gov/33926992/**
370	The LAMP Project – Social Prescribing Integration in the Acute Care Sector	International Conference Paper	Challenges of implementing a social prescription service in the clinic: Social prescribing in the LAMP project	IEEE International Symposium on Technology and Society (ISTAS)	The Local Asset Mapping Project (LAMP) aims to develop new models of tertiary healthcare delivery by integrating patient care into a hospital's surrounding community. To date, LAMP has created a database of almost 3,400 'assets' from part of the ambulance catchment of the largest acute hospital in Ireland an area representing approximately 120,000 citizens. A clinical software called 'Community Health Compass' is presented in this paper which uses this database and could potentially produce 'social prescriptions' to patients coming to the hospital. This prescription would direct them to the assets and services in their community, near their postal address, and tailored to their condition and preferences, which could help to improve their health and wellbeing. **https://ieeexplore.ieee.org/document/7439434**
392	Beaumont Hospital/ National Ambulance Alternative Care Pathways Project	International Conference Paper	Pathfinder Overview Paper	International Federation for Emergency Medicine Online Conference Paper, 2021	Pathfinder is a Slaintecare funded project which is a joint initiative between Beaumont Hospital and the National Ambulance Service. The paper presented described the approach of The Pathfinder team, which is to respond to low acuity 999 calls of a certain category for patients over 65 years and where appropriate, care for them in the home or arrange an alternative care pathway other than the Emergency Department. **http://imj.ie/pathfinder-alternative-care-pathways-for-older-adults-who-dial-999-112/**

ID	Project Name	Evaluation Type	Evaluation/ Publication Name	Organisation /Reviewer etc.	Key Findings
407	Smart Triage of Kidney Transplant Patients using Remote Monitoring	Excellence Award	Innovation in Digital Excellence	Health Service Excellence Awards 2021	The project developed a remote monitoring system for transplant recipients. This system continuously tracks symptoms, blood pressure, weight, and laboratory results in the patients' home, reducing the need for hospital attendance by 70% or just 4 visits on average. Patients were also able to monitor their own data via a bespoke app. **https://www.hse.ie/eng/about/our-health-service/excellence-awards/health-service-excellence-awards-booklet-2021.pdf**

Appendix 4
Sláintecare Integration Fund Health & Wellbeing projects

Specialist Category	Project ID	Project Name
Physical Activity - Health and Wellbeing Programme with input from Sláintecare Division, HSE and Sport Ireland Estimates Bid 2022		
Chronic Disease Self-Management	140	WellComm Active Well Communities Connect Project 2
Diabetes Care	220	Implement a structured exercise programme for people with Diabetes
Mental Health	233	The Exercise Effect - Integrating Exercise Practitioners into the Irish Mental Health Service
Health & Wellbeing Older Persons	21	Primetime for Older Adults
Arthritis Rehabilitation	56	Arthritis Rehabilitation through the Management of Exercise and Diet (ARMED)
Neurological Conditions Activity	135	Promoting physical activity programmes for people with neurological conditions in the community
National Sexual Health Strategy Business Case - Health and Wellbeing Programme		
STI Services and Online Testing	40	Student Sexual Health Service (Athlone Institute of Technology)
STI Self-Management eHealth	57	Integrating online STI testing with public STI services: A pilot to assess feasibility and impact
STI Self-Management	84	North Dublin Integrated Community STI Service
Sláintecare Healthy Communities Estimates Bid 2022		
Making Every Contact Count	252	HealthEIR: A Journey to Improving Health and Wellbeing Through Community-Based Social Self-Care
Living Well	38	Consolidating the Implementation of the Stanford Chronic Disease Self-Management Programme in CHO Dublin North City & County
	78	Delivery of the Stanford Chronic Disease Self-Management across SECH
	185	Extension of Stanford Chronic Disease self-mgt to all of CHO 1
	219	Stanford Chronic Disease Self-Management Programme in CHO 2
	413	Stanford Chronic Disease Self-Management Programme in Community Healthcare East
	418	The roll out Chronic Disease Self-Management Programme

Specialist Category	Project ID	Project Name
Sláintecare Healthy Communities Estimates Bid 2022 cont.		
Social Prescribing	15	Dublin 8 Social Prescribing Project
	31	Expansion of Social Prescribing service in Waterford and mainstreaming of pilot service in Waterford Metropolitan area
	162	Adult Social Prescribing for Individual Resilience and Empowerment
	253	Cork Kerry Health & Wellbeing Community Referral
	284	Social Prescribing for improved Health and Wellbeing
	370	The LAMP Project - Social Prescribing Integration in the Acute Care Sector
Men's Sheds	18	Sheds for Life
Smoking Cessation	202	Supporting Pregnant Women to Quit and Stay Quit - A Co-design Community Based Integrated Approach
Child and Adolescent Obesity	278	Facilitating Integration of Childhood Obesity Services in Primary Care Through Education
Community Mothers Programme	338	Prevention is better than cure - Community Mothers Programme

References

- **Sláintecare webinars recordings and information:**
  https://www.gov.ie/en/publication/d19f8-slaintecare-right-care-right-place-right-time-webinars/
- **Sláintecare Learning Network events 2019 and 2020:**
  https://www.gov.ie/en/publication/ca8a1d-slaintecare-in-action/#january-march-2020
- **Sláintecare Integration Fund projects descriptors publication:**
  https://www.gov.ie/en/publication/0d2d60-slaintecare-publications/#slaintecareintegration-fund-projects
- **Department of Health, 2019. Minister for Health announces €20 million funding for 122 Sláintecare projects.**
  https://www.gov.ie/en/press-release/a98320-minister-for-health-announces-20-millionfunding-for-122-slaintecare/
- **Health Service Capacity Review 2018 executive Report.**
  5bb5ff12463345bbac465aaf02a2333d.pdf (assets.gov.ie)
- **TILDA Report to Inform Demographics for Over 50's in Ireland for COVID-19 Crisis.**
  https://tilda.tcd.ie/publications/reports/pdf/Report_DemographicsOver50s.pdf

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gov.ie/Sláintecare