IMPACT EVALUATION

Interreg VA – Priority Axis 4 Health & Social Care

Final Report

20/07/2022

t33 Srl - www.t33.it
via Calatafimi 1, 60121 Ancona (Italy)
Tel.+39 071 9715460 - Fax +39 0719715461
E-mail: info@t33.it

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ACRONYMS

ACE: Adverse Childhood Experiences

ADHD: Attention-Deficit/Hyperactivity Disorder

CAWT: Cooperation and Working Together

CP: Cooperation Programme

eMS: electronic Monitoring System

EQ: Evaluation Question

ERDF: European Regional Development Fund

EU: European Union

FCU: Financial Control Unit

GDPR: General Data Protection Regulation

GP: General Practitioner

HSE: Health Service Executive

LoO: Letter of Offer

NGO: Non-Governmental Organisation

NHS: National Health Service

NI: Northern Ireland

PA: Priority Axis

RNIB: Royal National Institute of Blind People

RoI: Republic of Ireland

SEUPB: Special EU Programmes Body

SO: Specific Objective

UK: United Kingdom

EXECUTIVE SUMMARY

SUMMARY OF PURPOSE

The objective of the impact evaluation is to assess the intervention logic of Priority Axis 4 'Health and Social Care' of the INTERREG V-A programme covering Northern Ireland, the Border Counties of Ireland and Western Scotland and, in line with the provisions of the evaluation plan, determine the effectiveness of the programme's Priority Axis 4, the efficiency in terms of the relationship between funding disbursed and results achieved and the impact and the programme contribution to the end-objectives of EU Cohesion Policy.

SUMMARY OF METHOD AND APPROACH

The final report regarding the programme's contribution to change in the Health and Social Care priority axis aims to answer eleven evaluation questions, organised in three chapters: Performance of Priority Axis 4, Results and impacts, Sustainability and mainstreaming.

The first chapter aims to provide an overview of project implementation in Priority Axis 4: a) financial progress of the axis and the benchmarking with the performance of the other programme axes, and b) output progress, with a focus on the effectiveness of cross-border frameworks, cross-border accessibility and quality of services, as well as project-level obstacles that hinder implementation.

The second chapter informs on the progress of projects towards results, as a way to measure their contribution to the expected change in the area, i.e. their impact. Results have been analysed at project level, with the assumption that the overall contribution to change is the sum of the project-level contributions. Subsequently, the effectiveness of project partnerships was analysed as well as the impact of cross-border cooperation on delivery under Priority Axis 4. Finally, an analysis of external factors that positively or negatively influence cooperation and the achievement of results, was conducted. This was based on the perception of projects, as emerging from the e-mail questionnaire responses, and on project-specific literature reviews to assess additional external factors affecting projects' contribution to programme impact, taking into account the specificities of critical areas identified by the cooperation programme.

The third chapter explores the efforts, success and setbacks in terms of sustainability and mainstreaming of interventions under the Health and Social Care priority axis.

The evaluation team combined qualitative methods, such as interviews, surveys and case studies, with the quantitative data available, programme monitoring data and survey data. The results of the evaluation are based on the desk analysis of programme and project documentation, and on literature review to assess external factors, and on the analysis of responses to the e-mail questionnaire sent to the ten financed projects. In addition, five case studies were conducted on advanced or finalised projects selected with the programme.

KEY FINDINGS AND RECOMMENDATIONS

PERFORMANCE OF PRIORITY AXIS 4

Output achievement

EQ 1: How have the cross-border interventions affected accessibility in terms of equipment, consultants, service/procedures available?

As to whether the interventions have improved accessibility in terms of equipment, consultants, services and procedures available, all financed projects have replied affirmatively. Three specific dimensions were particularly highlighted: the easier and quicker access to services by project target groups thanks to the delivered interventions/services; the alleviated pressure from hospitals thanks to the new services delivered locally in the communities; the increased accessibility thanks to the newly developed digital services and the equipment provided.

EQ 2: How effective have cross-border frameworks been?

After a late start of the activities due to delays in staff recruitment and procurement, all frameworks were successfully established. The benefits generated by the establishment of these services are discussed in paragraph 2.2 (Project results and impacts).

EQ 3: How have the cross-border interventions affected the quality of service delivered?

The cross-border interventions have positively affected the quality of services delivered. These has occurred in a wide array of aspects of service delivery, namely: the involvement of target groups (patients, targeted vulnerable group etc.) in the delivery of services result in a better understanding and better planning and delivery of services; the creation of services of early interventions supports vulnerable groups through a timelier treatment of their condition; the opportunities for staff training and development ultimately improve the services provided to patients; the shift to digital services, further pushed by the pandemic, has led to opportunities to deliver services through different tools which allow to access a wider pool of patients and to reach people located in remote and isolated areas (rural areas, islands etc.) who can be provided services in the comfort of their own homes. The focus on community health care interventions means services can be accessed closer to home and be more tailored to individual needs.

EQ 4: Are there any obstacles that are hindering project implementation?

The key obstacles identified by projects are: problems with staff recruitment and staff turnover; difficulties with procurement procedures; monitoring, reporting and reimbursement of expenses; GDPR and Data Sharing; delays in the signature of the Letter of Offer (LoO) mainly due to financial and legal complications related to Brexit and the late setting up of eMS.

A vast majority of projects experienced issues and delays with staff recruitment. In some cases, this was due to the difficulties in finding candidates or to lengthy recruitment processes in statutory bodies. Public procurement represents another key obstacle highlighted by most projects which delayed project implementation or added a significant amount of administrative burden to project leaders and partners. Financial reporting requirements and slow reimbursement of expenses were also often reported as hindering project implementation. On the one hand, meeting reporting obligations is considered demanding and time-consuming. On the other hand, the reimbursement of claims is perceived as too slow by some projects. This, in particular, represents a significant issue for smaller third sector organisations which risk struggling with the running costs of the project and the missing cash flow. Significant steps have been taken by the programme to accelerate the reimbursement process.

Finally, the differences not only in structures and legislation among different jurisdictions, but also in the intensity of investment in specific sectors can result in different capacity among partners at cross-border level.

RECOMMENDATIONS

- ➔ To improve project implementation in the next programming period, efforts should be made to provide further support with regard to financial reporting and the use of eMS.
- ➔ Delays in the signature of the LoO should be avoided where possible not to interfere with the timeline for the implementation of project activities set by the partnerships.
- ➔ Where possible, the programme should support projects in procurement procedures to reduce the administrative burden and incurred costs (time, resources) of lengthy processes.
- ➔ The flexibility provided by the SEUPB during the Covid-19 emergencies has been greatly appreciated. Greater flexibility for internal budget shifts and adaptation of project activities in case of emerging new needs should be provided, in compliance with existing EU and national rules and regulations.

RESULTS AND IMPACTS

Programme result indicator

EQ 5: To what extent has the result indicator been achieved?

At the moment of drafting this report, the result indicator target set by the programme for 2023 has almost been achieved (94%) with a number of episodes of health and social care delivered on a cross-border basis amounting to 8,440 per annum. Progress recorded in 2019 was below the baseline, with 3,611 episodes of care per year, only 40% of the 9,000 episodes target set for 2023.

RECOMMENDATIONS

- ➔ By using a comparable definition of ‘episodes of care’ to that used for the calculation of the result indicator, data could, if feasible, be collected and aggregated on the total ‘episodes of care’ delivered at regional or county level in the programme area in RoI and NI. The number of cross-border episodes could then be compared to the total amount so as to provide a relative value, in addition to the absolute one (‘episodes per annum’).

$$\frac{\textit{n. of cross-border episodes of care in year xxxx}}{\textit{total n. of episodes of care in the programme area in year xxxx}}$$

Project results and impacts

EQ 6: What has been the impact of cross-border interventions?

The cross-border interventions have generated tangible impacts in the programme area. These can be categorised according to the challenges that health and social care projects are addressing.

Improving access to care

- **Acute Services** (target group: patients in scheduled and unscheduled care streams): alleviated pressure from hospitals; alleviated pressure from ambulance services, easier access to care in the community and own homes, new pathways to reduce hospital admissions, reduced isolation of patients from rural areas.
- **MACE** (target group: children/families with Multiple Adverse Childhood Experiences): support to practitioners and professionals through thorough list of support interventions to vulnerable children and their families; easier access to services through the autism spectrum disorder (ASD) programme; easier access to therapy for severely traumatised children.

Improving patients' empowerment and self-management

- **iRecovery** (target group: people with lived experience of mental health difficulties): increased self-management of condition by Recovery College participants (service users); increased skills of people with experience of mental health who have become Peer Educators.

Improving lives of people with chronic or long-lasting health conditions

- **Changing Lives** (target group: children with behaviour consistent with ADHD aged 3-7 years old): changed behaviour patterns in children with (suspected) ADHD: reduced frequency, intensity, duration and severity of problems; reduced risk of social exclusion; improved family-child relationships; new informal networks of families facing similar challenges; increased knowledge and skills of professionals (including teachers).
- **CoH-Sync** (target group: people living in border area with long-term conditions and local communities where Hubs established): expertise, skills and experience in health and wellbeing; new networks of cooperation in local communities; increased skills of health trainers; increased skills of community health facilitators increasing their chances for employment.
- **iSIMPATHY** (target group: people living with chronic conditions and comorbidities with multiple medicine prescriptions): develop a whole-system approach to ensure sustainable use of medications; develop a guidance to support patients and clinicians; shared learning across jurisdictions. *(expected impacts)*

Reducing social isolation of users

- **mPower** (target group: 65+ age group at risk of isolation): improved access to care for hard-to-reach groups through digital services (e.g. virtual GP appointments); increased digital confidence and competence; increased connections between target group and their local communities.
- **Need to Talk** (target group: people affected by sight loss): increased mental wellbeing of participants; new confidence; increased sense of independence.
- **ONSIDE** (target group: people with disabilities): increased mental wellbeing of participants; increased IT skills of participants; new sense of independence.

Cross-border partnerships

EQ 7: What new ways of working/partnerships/relationships have been created as a result of activities carried out within the priority axis?

Project partners have shown creativity in setting up effective ways of working. These entail internal organisational solutions (data management, supply chain, project management tools etc) as well as the establishment of new relationships with other territories and sectors (e.g. third sector, schools etc.). Governance models remain an essential element, as already observed in the previous evaluation reports, with all the projects showing considerable capacity to set up fit-for-purpose structures according to their specific missions.

In light of the COVID-19 pandemic, projects turned the loss of in-person events into an opportunity to consolidate online collaboration and jointly face ongoing changes and challenges.

EQ 8: What cooperation impacts have resulted from delivery under this axis?

The strength of cross-border partnership is a success factor in addressing health care issues in the programme area, with partners deeply interested and strongly committed to continue collaboration in the future. The fruitful collaborations have generated dual impacts both for beneficiary organisations but also the community as a whole, which now benefit from (cross-border) services not previously available. At the level of individual organisations, impacts relate to increased capacities of partners to overcome cross-border obstacles, offset clinical competence gaps and enable upskilling and to jointly face severe crisis during the pandemic. Impacts are also visible at community level with extended service delivery areas, the availability of services not previously operating, and the higher quality of the services delivered reported by projects.

External factors

EQ 9: What are the external factors that have affected delivery under priority axis 4? How have projects adapted to these and what has been the overall impact of these factors?

The main barriers identified, as reported by projects and as emerging from recent literature and data, relate to the consequences of the COVID-19 pandemic. The cooperation context for projects profoundly changed since its outbreak which impacted upon nearly every aspect of daily life in the programme area, but particularly the social and economic dimensions. With vulnerable groups becoming harder to reach, social indicators (isolation, poverty, domestic abuse etc.) have sharply increased in the programme area, creating more demand for health and social care. In turn, this creates an increasing demand on health and social care budgets both in the UK and Ireland.

Nevertheless, some positive changes resulted from the pandemic. Projects reported a good capability to adapt to the new circumstances and the opportunity to re-design the way health care is provided to citizens, the importance of community empowerment and the upskilling of clinical competences. Interesting impacts can be observed in relation to community empowerment and the capacity of people to improve the wellbeing of citizens in their own communities.

Brexit, the main negative external factor as perceived by projects until 2020, remains a source of anxiety and concern, but only marginally.

SUSTAINABILITY AND MAINSTREAMING

EQ 10: What level of mainstreaming has occurred for cross-border delivery of health services?

The mainstreaming of health and social care services stemming from the financed projects is still quite limited. In many cases, mainstreaming strategies and activities are yet to be thoroughly decided and implemented. The majority of projects have declared that efforts to mainstream activities are still under discussion by project

partners and depend to a large degree on the outcome of internal project evaluations which will determine and the extent to which project activity could be mainstreamed nationally or locally in the involved jurisdictions. At the same time, mainstreaming of services implemented or tested in the cross-border projects has tended to occur at the level of a single jurisdiction, rather than being mainstreamed at a cross-border level. In other words, the cross-border aspect of the projects has been crucial to design and implement new services but has not always ensured cross-border service delivery after project completion.

EQ 11: What type of support is required for mainstreaming project activities at risk of interruption after the end of the projects?

The availability of Interreg funding for the evaluation of services implemented by projects and to ensure the mainstreaming efforts undertaken by projects is key to support cross-border project activity. Most projects have underlined the importance of devoting resources to the evaluation of the success and impact of newly created services to understand which strands of activities and services are worth mainstreaming. The time gap between the end of project implementation under one programme (i.e. Interreg V-A) and the operational start of the new programme (i.e. Peace Plus) represents a risk for those projects which rely on Interreg funding and which might lose momentum to mainstream or upscale their activities when funding ceases.

RECOMMENDATIONS

- ➔ Dedicated funding towards the end of the programming period (i.e. through specific calls) could be envisaged to allow advanced and finalised projects to receive additional resources to mainstream activities, provided there is enough time and depending on the overall priorities of the programme.
- ➔ Make potential applicants aware that part of the project budget can be devoted to the project evaluation of the effectiveness, results and impacts of delivered interventions to better understand which strands of activities and services are worth mainstreaming, to which extent and in which areas.

SUMMARY OF CONCLUSIONS

In terms of financial and output achievement, the programme is progressing well towards the set targets. Despite initial delays related to Brexit and the disruptions caused by the COVID-19 pandemic, the programme has shown great resilience and ability to adapt to new unforeseen circumstances. The time and budget flexibility provided to projects during the crisis has been particularly praised by projects.

The internal factors hindering implementation are considered by the evaluator as common and inherent to Interreg programmes (e.g. public procurement issues, financial monitoring and reimbursements, project staff recruitment and turnover etc.). Those obstacles that have been exacerbated by Brexit should, however, be closely monitored in the future.

As concerns the programme contribution to change under Priority Axis 4, the cross-border interventions have generated tangible impacts in the programme area in a wide range of health and social care sub-fields, not only in the general improvement of the access to care, but also in e.g. patients' empowerment and self-management and in the reduction of isolation of specific vulnerable groups. A key aspect worth underlining is the increase, extension and improvement of services delivered locally at community level, providing access to care that is more tailormade and much closer to citizens and alleviating pressure from hospitals.

The cross-border dimension has proven to be an 'enabling factor' to face the health and social care challenges in the programme area. Cross-border partnerships have also generated benefits for beneficiary organisations in terms of new knowledge, skills and capacities. Cross-border partners are strongly committed to continue collaborating in the future.

External factors influencing cooperation and the programme contribution to change are, in recent years, overwhelmingly related to the pandemic. In the 2021-2027 programming period, great attention and relevance

will continue to be given to the programme by actors interested in cooperating across borders, also due to the increasing demands of health and social care as a result of increasing social isolation, poverty, unemployment etc.

The programme is largely perceived by beneficiaries as key to ensuring cross-border cooperation and funding in the health and social care sector. The continuation of the health and social care strand under Peace Plus was very positively welcomed and a high interest in the opportunities provided by the new programme should be expected.

In the 2021-2027 programming period, more attention should be paid to guiding projects towards the mainstreaming of their project activities into the national systems. Where possible, the cross-border dimension of mainstreaming should be considered.

INTRODUCTION

The objective of the impact evaluation is to assess the intervention logic of Priority Axis 4 'Health and Social Care' of the INTERREG V-A programme covering Northern Ireland, the Border Counties of Ireland and Western Scotland and, in line with the provisions of the evaluation plan, determine:

1. the effectiveness of the programme Priority Axis 4, i.e. the attainment of the specific objective set and the intended results;
2. the efficiency in terms of the relationship between funding disbursed and results achieved;
3. the impact and the programme contribution to the end-objectives of EU Cohesion Policy.

The impact evaluation explores the contribution of the programme to the movement of the identified result indicator, i.e. "the number of 'episodes of health, community and social care' delivered on a cross-border basis". The result indicator may have moved more or less than anticipated, and the movement may have been due to programme investment or other external factors.

The final evaluation report aims to identify relevant lessons learnt to inform and feed into the new programming period. The following conclusions and lessons learnt can be drawn.

In terms of financial and output achievement, the programme is progressing well towards the set targets. Despite initial delays related to Brexit and the disruptions caused by the COVID-19 pandemic, the programme has shown great resilience and ability to adapt to new unforeseen circumstances. The time and budget flexibility provided to projects during the crisis has been particularly praised by projects.

The internal factors hindering implementation are considered by the evaluator as common and inherent to Interreg programmes (e.g. public procurement issues, financial monitoring and reimbursements, project staff recruitment and turnover etc.). Those obstacles that have been exacerbated by Brexit should, however, be closely monitored in the future.

As concerns the programme contribution to change under Priority Axis 4, the cross-border interventions have generated tangible impacts in the programme area in a wide range of health and social care sub-fields, not only in the general improvement of the access to care, but also in e.g. patients' empowerment and self-management and in the reduction of isolation of specific vulnerable groups. A key aspect worth underlining is the increase, extension and improvement of services delivered locally at community level, providing access to care that is more tailormade and much closer to citizens and alleviating pressure from hospitals.

The cross-border dimension has proven to be an 'enabling factor' to face the health and social care challenges in the programme area. Cross-border partnerships have also generated benefits for beneficiary organisations in terms of new knowledge, skills and capacities. Cross-border partners are strongly committed to continue collaborating in the future.

External factors influencing cooperation and the programme contribution to change are, in recent years, overwhelmingly related to the pandemic. In the 2021-2027 programming period, great attention and relevance will continue to be given to the programme by actors interested in cooperating across borders, also due to the increasing demands of health and social care as a result of increasing social isolation, poverty, unemployment etc.

The programme is largely perceived by beneficiaries as key to ensuring cross-border cooperation and funding in the health and social care sector. The continuation of the health and social care strand under Peace Plus was very positively welcomed and a high interest in the opportunities provided by the new programme should be expected.

In the 2021-2027 programming period, more attention should be paid to guiding projects towards the mainstreaming of their project activities into the national systems. Where possible, the cross-border dimension of mainstreaming should be considered.

METHODOLOGICAL APPROACH

In line with the Terms of Reference and the approach adopted in the Project Initiation Document (PID)[1], the final report regarding the programme's contribution to change in the Health and Social Care priority axis aims to answer the following evaluation questions, organised in three chapters.

Table 1 Organisation of the evaluation questions in the report

Chapter 1 *Performance of Priority Axis 4*	• What new ways of working/partnerships/relationships have been created as a result of activities carried out within the priority axis? • What cooperation impacts have resulted from delivery under this axis? • How have cross-border interventions affected accessibility in terms of equipment, consultants and service/procedures available? • How have cross-border interventions affected the quality of service delivered? • How effective have cross-border frameworks been?
Chapter 2 *Progress towards results*	• To what extent has the result indicator "The number of episodes of care[2] delivered on a cross border basis" been achieved? • What has been the impact of cross-border interventions? • What are the external factors that have affected delivery under priority axis 4? How have projects adapted to these and what has been the overall impact of these factors?
Chapter 3 *Sustainability and mainstreaming*	• What level of mainstreaming has occurred for cross-border delivery of health services? • What type of support is required for mainstreaming project activities at risk of interruption after the end of the projects?

The first chapter aims to provide an overview of project implementation in Priority Axis 4. Starting from programme-level information regarding the financial progress of the axis and the benchmarking with the performance of the other programme axes, the report then moves to analysing output progress, with a focus on the effectiveness of cross-border frameworks, cross-border accessibility and quality of services, as well as project-level obstacles that hinder implementation.

The second chapter informs on the progress of projects towards results, as a way to measure their contribution to the expected change in the area, i.e. their impact. Results have been analysed at project level, with the assumption that the overall contribution to change is the sum of the project-level contributions. For the purpose of this evaluation, a number of programme outputs related to Priority Axis 4 have been treated as closer to project *direct results* that measure the immediate and short-term effects and the direct benefit and outcome of the intervention for the target groups, e.g. 'Beneficiaries supported by new cross-border area initiatives for positive health and wellbeing and the prevention of ill health' and 'Beneficiaries supported by new cross-border area initiatives for disabled people of all ages who are socially isolated'.

Subsequently, the effectiveness of project partnerships was analysed as well as the impact of cross-border cooperation (cross-border added value) on delivery under Priority Axis 4.

Finally, questionnaire and case studies were undertaken to enable an analysis of external factors that positively or negatively influence the achievement of results, as perceived by project beneficiaries. In addition, project-specific literature reviews have been conducted to assess additional external factors affecting projects' contribution to programme impact. An analysis of external factors has taken into account the specificities of

[1] See page 24 of the PID, 'KA3. Assessment of the programme's contribution to change'.
[2] Episodes of care refer to the access to health and social care interventions delivered on a cross-border basis.

critical areas identified by the cooperation programme. The main data sources for the review are databases of clinical and public health literature such as PubMed and CINAHL as well as official national statistics.

The third chapter explores the efforts, success and setbacks in terms of sustainability and mainstreaming of interventions under the Health and Social Care priority axis. Based on the questionnaire and case studies, the chapter focuses on the projects' concrete efforts to ensure the sustainability, transferability and mainstreaming of results into the local and national policy contexts beyond the project duration, as well as obstacles hindering this process and the support needed. The section then moves to an analysis of the programme's contribution to wider EU objectives, such as EU2020.

This impact evaluation report embraces a 'theory-based approach'. We have addressed the overarching question of why and how interventions funded under Priority Axis 4 have worked so far, using a mixed-method evaluation strategy. The choice of combining different research methods is a consequence of the need to consider the following three elements:

1. The perspective of the evaluation. The change of the result indicator of the CP (e.g. cross-border health care use) has a different meaning according to the perspective employed i.e. a) a societal perspective (comprising all costs and benefits associated with a health programme, including the so-called externalities); b) a service providers' perspective (solely budgetary considerations), and c) a service-users perspective. In evaluating the impact of the programme we adopt a wider societal perspective but, at the same time, distinguish whenever possible whether the observed changes affect mostly the end-users (and their families), the service provider (e.g. the NHS) or other stakeholders (employers, companies, NGOs, etc.).
2. Complexity of outcomes in health and social care. The impact of factors such as investments and initiatives in other policy areas, changes in the regional economy and population socio-economic conditions will need to be isolated from the programme performance.
3. Changes in health-related behaviour occur in the mid- and long-term perspective. The evaluation activity is, by necessity, longitudinal and identifies relevant lessons at distinctive points in time that might potentially inform the future programming period and future policy interventions.

Elements 2 and 3 are particularly addressed in the analysis of external factors in Chapter 2.4.

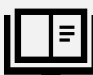
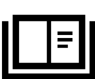
According to this strategy, the evaluation team combined qualitative methods, such as interviews, surveys and case studies, with the quantitative data available, programme monitoring data and survey data (see the table below).

The results of the evaluation are based, in particular, on the desk analysis of programme and project documentation (i.e. application forms, eMS data) and on a literature review for the identification of additional external factors, as well as on the analysis of responses to the e-mail questionnaire sent to the ten financed projects. Project leaders have replied to the questionnaire in the months of January, February and March 2022. In addition, five case studies were conducted on advanced or finalised projects selected with the programme[3].

The triangulation of the data collected using different methodologies allowed causal pathways underpinning the observed changes and trends to be identified.

[3] Acute Services, Changing Lives, Coh-Sync, mPower, ONSIDE.

Table 2. Overall organisation of the report in relation to data sources

Chapter		Data source
Chapter 1 – Performance of Priority Axis 4		Desk analysis of the cooperation programme, application forms, draft Annual Implementation Report 2021, data retrieved from the electronic Monitoring system (eMS).
		E-mail questionnaire: output progress and achievements, obstacles hindering implementation.
		Case studies: output progress and achievements, obstacles hindering implementation
Chapter 2 – Results and impacts		E-mail questionnaire: input on results and impacts, external factors
		Desk analysis of the cooperation programme, application forms, draft Annual Implementation Report 2021, data retrieved from the electronic Monitoring system (eMS). Desk analysis of clinical and public health literature to assess external factors.
		Case studies: project results and impacts, partnership and cooperation impacts, external factors.
Chapter 3 – Sustainability and mainstreaming		E-mail questionnaire: sustainability and mainstreaming of project activities and services.
		Case studies: sustainability and mainstreaming of project activities and services.

CHAPTER	EVALUATION QUESTION	Desk/data analysis	Questionnaire to all projects	Case studies
(Chapter 1) Progress in project implementation	• How have cross-border interventions affected accessibility in terms of equipment, consultants and service/procedures available?	*Output monitoring data*	✓	✓
	• How have cross-border interventions affected the quality of service delivered?	*Output monitoring data*	✓	✓
	• How effective have cross-border frameworks been?	*Output monitoring data*	✓	✓
	• Are there any obstacles that are hindering project implementation?		✓	✓
(Chapter 2) Progress towards results	• To what extent has the result indicator "The number of episodes of care delivered on a cross-border basis" been achieved?	*Result indicator monitoring data*		
	• What has been the impact of cross-border interventions?		✓	✓
	• What new ways of working/partnerships/relationships have been created as a result of activities carried out within the priority axis?		✓	✓
	• What cooperation impacts have resulted from delivery under this axis?		✓	✓
	• What are the external factors that have affected delivery under priority axis 4? How have projects adapted to these and what has been the overall impact of these factors?	*Clinical and public health literature*	✓	✓
(Chapter 3) Contribution to wider policy objectives	• What level of mainstreaming has occurred for cross-border delivery of health services?		✓	✓

1 PERFORMANCE OF PRIORITY AXIS 4

1.1 OVERVIEW

The total budget dedicated to Priority Axis 4 amounts to EUR 62 million (ERDF: EUR 52,7 million) and if compared to other priority axes, its allocation represents 23% of the total programme funding.

When looking at the overall implementation, PA 4 has supported the highest number of projects with the lowest share of financial resources, as illustrated in the table below. Progress in terms of financial implementation and absorption is the most limited of the PAs (53% of certified expenditures) compared to the more advanced PA 1 with 83% of expenditure declared by beneficiaries to date.

Table 3 Overall implementation of the Programme – eligible expenditure declared as a percentage of total funding allocation.

PA	PA name	N. projects	Total eligible expenditure declared	Total funding allocated	% absorption
1	Strengthening research, technological development and innovation	8	€ 59,730,313	€ 71,678,630	83%
2	Preserving and protecting the environment and promoting resource efficiency	9	€ 63,536,326	€ 84,705,883	75%
3	Promoting sustainable transport and removing bottlenecks in key network infrastructures	5	€ 34,409,157	€ 47,058,824	73%
4	Promoting social inclusion, combating poverty and any discrimination	10	€ 33,220,606	€ 62,352,942	53%
Tot		32	€ 190,896,404	€ 265,796,279	72%

Source: SEUPB, 31/12/2021 data

1.2 FINANCIAL PROGRESS

In terms of financial implementation, PA4 (see table 4) has made significant progress compared to 2020 (the year of the second impact evaluation report and the COVID-19 outbreak). Certified expenditure increased significantly to an average 53% across all projects, compared to 17% in 2020.

The Changing Lives initiative has almost certified its entire budget (98%) while CoH-Sync certified 80% of its total expenditure. Conversely, the MACE project, expected to be completed by June 2023, still has considerable remaining budget to absorb (69%).

The largest projects in financial terms, mPower and Acute Services with around EUR 10 million euro allocated to each, have certified 43% and 61% of available budget respectively. Given the expected

project end dates, in July and December 2022 respectively, the Programme should investigate whether the outstanding amount will be spent and certified in time.

More recent projects (iSimpathy and ONSIDE) show considerable progress, with ONSIDE having certified 50% of its budget.

Table 4 Financial progress of each project

Project name	Start date	End date	Total allocation	Certified expenditure	% absorption
MACE	01/01/2017	30/06/2023	€ 5,010,240	€ 1,546,972	31%
Need to talk	01/01/2017	30/06/2022	€ 1,942,365	€ 1,279,929	66%
mPower	01/09/2016	30/07/2022	€ 10,072,778	€ 6,155,566	61%
i-Recovery	01/09/2016	31/08/2022[4]	€ 7,614,750	€ 3,182,137	42%
CHITIN	01/09/2016	30/06/2023	€ 10,601,181	€ 5,876,985	55%
Changing Lives	01/09/2016	30/04/2021	€ 3,023,143	€ 2,955,844	98%
Acute services	01/09/2016	31/12/2022	€ 10,485,220	€ 4,519,106	43%
CoH-Sync	01/09/2016	30/04/2022	€ 5,010,370	€ 4,018,697	80%
ONSIDE	01/07/2018	30/06/2022	€ 5,557,509	€ 2,753,299	50%
iSIMPATHY	30/09/2019	31/03/2023	€ 3,520,671	€ 932,067	26%
Total			**€ 62,838,230**	**€ 33,220,606**	**53%**

Source: SEUPB, 31/12/2021 data

1.3 OUTPUT ACHIEVEMENT

KEY FINDINGS

EQ 1: How have the cross-border interventions affected accessibility in terms of equipment, consultants, service/procedures available?

As to whether the interventions have improved accessibility in terms of equipment, consultants, services and procedures available, all financed projects have replied affirmatively. Three specific dimensions were particularly highlighted: the easier and quicker access to services by project target groups thanks to the delivered interventions/services; the alleviated pressure from hospitals thanks to the new services delivered locally in the communities; the increased accessibility thanks to the newly developed digital services and the equipment provided.

EQ 2: How effective have cross-border frameworks been?

After a late start of the activities due to delays in staff recruitment and procurement, all frameworks were successfully established. The benefits generated by the establishment of these services are discussed in paragraph 2.2 (Project results and impacts).

EQ 3: How have the cross-border interventions affected the quality of service delivered?

The cross-border interventions have positively affected the quality of services delivered. These has occurred in a wide array of aspects of service delivery, namely: the involvement of target groups (patients, targeted vulnerable group etc.) in the delivery of services result in a better understanding and better planning and delivery of services; the creation of services of early interventions supports vulnerable groups through a timelier treatment of their condition; the opportunities for staff training

[4] Request for seven-month extension to 31 March 2023.

and development ultimately improve the services provided to patients; the shift to digital services, further pushed by the pandemic, has led to opportunities to deliver services through different tools which allow to access a wider pool of patients and to reach people located in remote and isolated areas (rural areas, islands etc.) who can be provided services in the comfort of their own homes. The focus on community health care interventions means services can be accessed closer to home and be more tailored to individual needs.

EQ 4: Are there any obstacles that are hindering project implementation?

The key obstacles identified by projects are: problems with staff recruitment and staff turnover; difficulties with procurement procedures; monitoring, reporting and reimbursement of expenses; GDPR and Data Sharing; delays in the signature of the Letter of Offer (LoO) mainly due to financial and legal complications related to Brexit and the late setting up of eMS.

A vast majority of projects experienced issues and delays with staff recruitment. In some cases, this was due to the difficulties in finding candidates or to lengthy recruitment processes in statutory bodies. Public procurement represents another key obstacle highlighted by most projects which delayed project implementation or added a significant amount of administrative burden to project leaders and partners. Financial reporting requirements and slow reimbursement of expenses were also often reported as hindering project implementation. On the one hand, meeting reporting obligations is considered demanding and time-consuming. On the other hand, the reimbursement of claims is perceived as too slow by some projects. This, in particular, represents a significant issue for smaller third sector organisations which risk struggling with the running costs of the project and the missing cash flow. Significant steps have been taken by the programme to accelerate the reimbursement process.

Finally, the differences not only in structures and legislation among different jurisdictions, but also in the intensity of investment in specific sectors can result in different capacity among partners at cross-border level.

RECOMMENDATIONS

- ➔ To improve project implementation in the next programming period, efforts should be made to provide further support with regard to financial reporting and the use of eMS.
- ➔ Delays in the signature of the LoO should be avoided where possible not to interfere with the timeline for the implementation of project activities set by the partnerships.
- ➔ Where possible, the programme should support projects in procurement procedures to reduce the administrative burden and incurred costs (time, resources) of lengthy processes.
- ➔ The flexibility provided by the SEUPB during the Covid-19 emergencies has been greatly appreciated. Bearing in mind that such flexibility for projects in recent years was closely linked to the consequences of the pandemic and cannot be entirely applied in 'non-emergency' situations, greater flexibility for internal budget shifts (e.g. among Work Packages) and adaptation of project activities in case of emerging new needs should be provided, in compliance with existing EU and national rules and regulations and when reasonably justified.

The table below reports achievements against each output indicator until 1 January 2022. It should be noted that these values have been self-reported by projects and are therefore still under verification and validation by the managing authority.

As outlined in the methodology, a selection of the output indicators have been treated as 'direct result' indicators for the purpose of the evaluation and will be presented and commented upon in paragraph 2.2.

Table 5 Level of achievement for each output indicator[5]

Output indicator	Total achievement (2021)	Programme target (2023)	% achieved
4.110 - Number of new interventions to support positive health and wellbeing and the prevention of ill health	11	12	92%
4.112 - New cross-border area community support services to support disabled people who are socially isolated (including the use of web-based information outlining community assets)	3	2	150%
4.114 - New cross-border area community and voluntary sector infrastructure to support clients who have recovered from mental illness (including utilisation of e- health e.g. patient records and support services)	1	1	100%
4.116 - New border area frameworks for early intervention with vulnerable families	3	2	150%
4.118 - Establish cross-border frameworks, for scheduled and unscheduled care streams, to improve utilisation of scarce human, physical and financial resources	3	4	75%
4.122 - Specialist training and development programmes for cross-border area health and social care providers (trained staff)	3,763	3,800	99%
4.123 - Develop infrastructure and deliver cross-border area health care intervention trials for novel but unproven health care interventions to prevent and cure illness	11	10	110%

Source: SEUPB, self-reported achievement values up to 31/12/2021; cooperation programme target values.

A very high level of achievement against the targets set by the Programme for 2023 can be observed in all output indicators, with most having attained close or equal to 100% of the expected target by

[5] As self-reported by projects, 1 January 2022.

the end of 2021. Some indicators (4.112, 4.116 and 4.123) have exceeded the initial programme targets.

1.3.1 Interventions, infrastructure, equipment and services

A majority of financed projects under PA4 have successfully contributed to the delivery of new cross-border interventions, services and equipment as well as the development of infrastructure, therefore increasing their accessibility in the cross-border area.

As concerns output 4.110 'new interventions to support positive health and wellbeing and the prevention of ill health', CoH-Sync contributed with the achievement of the project target of eight new interventions through the creation of eight Health and Well-being Community Hubs. Despite some initial delays, three hubs were established in the Republic of Ireland, three in Northern Ireland and two in Scotland. The Hubs are located in areas of high health and well-being disadvantage. The locally-established hubs delivered services on behalf of the statutory sector, increasing their provision, and the project provided the opportunity to break down barriers between the statutory and community sector. As a result of the establishment of the hubs, local communities have gained experience, skills and expertise and have established networks of cooperation.

The ONSIDE and Need To Talk projects contribute to output indicator 4.112 'New cross-border area community support services to support disabled people who are socially isolated'.

ONSIDE has developed a cross-border community support service for disabled people who are seeking to improve their health and wellbeing through increasing their social networks both in the community and online. It supports participants through a tailored personal development plan, identifying and addressing the barriers to socialisation. The service is provided locally in the communities through dedicated community navigators, digital inclusion training, access to a digital disability community and support from volunteer peer advocates.

Need to Talk has developed two cross-border services for blind and partially-sighted people from the ages of 11 upwards who are socially isolated:

- Emotional support and counselling service; and
- Confidence Building Programmes.

Output indicator 4.114 'New cross-border area community and voluntary sector infrastructure to support clients who have recovered from mental illness' achieved its target thanks to the Innovation Recovery (iRecovery) project, which has developed a cross-border hub and spoke Recovery College infrastructure to deliver community-based mental health recovery education. In particular, the infrastructure is now operating across three geographical regions and 12 counties (Area 1 West: Derry/Londonderry, Letterkenny, Strabane and West Donegal; Area 2 South: Cavan, Monaghan, Sligo, Leitrim and Fermanagh; Area 3 East: Belfast, Armagh, Newry, Louth) and has delivered a diverse range of courses to over 3,000 people including those with lived experience of mental health issues, carers, and health professionals. In mid-2021, the College has gone digital through the creation of an online platform with the aim to bring mental health and wellbeing education to a wider audience of people living within Northern Ireland and the border counties of the Republic of Ireland.

The CHITIN project has achieved and surpassed the programme target of 10 'cross-border area health care intervention trials for novel but unproven health care interventions to prevent and cure illness' (output indicator 4.123) by starting 11 healthcare intervention trials.

According to the project leader, all 11 trials have commenced and have obtained favourable ethical and governance approval. Four trials have completed the recruitment of key personnel on trial delivery teams, with three others expected to follow in 2022, and put in place trial infrastructure. Most trials have commenced their training delivery (with more than 500 distinct health and social care practitioners in receipt of training by March 2022). Over 3000 participants have been recruited to trials.

1.3.2 Cross-border frameworks

Three projects have contributed to the establishment of new cross-border area frameworks[6]: Acute Services, Changing Lives and MACE.

The Changing Lives project contributed to output 4.116 'New border area frameworks for early intervention with vulnerable families' with the establishment of a framework for the assessment and treatment of vulnerable families with a child with social, emotional or behavioural difficulties.

The MACE project established two border area frameworks for early intervention targeting families experiencing Adverse Childhood Experiences (ACEs):

- Cross-border framework 1: Development of an Adversity Matrix for the identification and assessment of children and families most at risk of multiple adverse childhood experiences.
- Cross-border framework 2: Development of Risk Stratification Tool for a risk stratification approach for family and children identified via the Adversity Matrix and identification of appropriate targeted interventions.

The Acute Services project has managed to create three cross-border frameworks for scheduled and unscheduled care streams, to improve utilisation of scarce human, physical and financial resources (indicator 4.118):

- Framework 1 - Reform and modernisation of the management of unscheduled care; Patients will be assessed/treated more effectively at the point of contact, with alternative care pathways established during the pre-hospital phase e.g. community paramedic hubs to see/treat/transport to appropriate medical facilities using a range of paramedic skills, they may also diagnose/discharge or refer suitable minor injury and/or acute illness patients. These 'episodes of care' will improve the availability of alternative options to A&E/ED attendance ensuring that timely/appropriate interventions are taken to facilitate treatment.
- Framework 2 (scheduled care) – Reform and modernisation of outpatient services and supporting diagnostic relocation to outpatient settings for procedures currently preformed in day-theatre settings where appropriate; the framework was rolled out in dermatology, urology and vascular services.
- Framework 3 (scheduled care) – Reform, modernise and deliver minor, intermediate and major operations and procedures across a range of surgical specialisms, utilising day-case/ endoscopy/main theatre facilities to maximum efficiency; by using robotics, patients receive minimally invasive surgical techniques, resulting in significantly less traumatic surgery in their 'episode of care'.

[6] According to the Interreg V-A indicator guidance, a framework is 'a set of policies, aims or a defined approach. A cross-border framework should be developed, agreed on and adhered to by a range of relevant service providers on both sides of the Border'.

A fourth framework initially foreseen in the scheduled care stream was replaced by specialist training to health and social care providers. For this reason, the programme target of 4 established cross-border frameworks under indicator 4.118 will not be achieved.

After a late start to activities due to delays in staff recruitment and procurement, all frameworks were successfully established. The benefits generated by the establishment of these services are discussed in paragraph 2.2.

1.3.3 Training

As an output indicator chosen by the majority of projects, the 'Specialist training and development programmes for cross-border area health and social care providers' (output 4.122), counted as the number of trained staff, deserves a separate analysis.

Training in the framework of project activities has often been described as crucial as well as one of the main benefits for target groups. The development of specific skills to treat patients in their communities has alleviated pressure from hospitals, while the inclusion of vulnerable groups in specific accredited trainings has allowed them to acquire new skills which can lead to employment. In addition, the cross-border dimension of projects has enabled to expand and share learning on a wider geographical scale allowing a broader exchange of knowledge and development of skills.

It should be noted that the shift to online training due to COVID-19 has often been reported as an unexpected but positive development which allowed to reach a much wider audience beyond the initially planned geographical scope of training events. The shift also proved effective in terms of savings on organisational costs and staff time.

The following table provides programme achievements in relation to trained staff (output achievement) and an overview of the perception of projects regarding specialist training.

Table 6 Programme achievements in relation to trained staff

Project name	Trained staff (as of 1/01/2022)	Highlights on specialist training
Acute Services	760	Highly trained Community Paramedics ambulance staff have undergone further specialised training accredited by Glasgow Caledonian University which enabled them to see and treat patients in their communities and their own homes, significantly reducing the quantity of people that would have been transported to busy hospital emergency departments, and, in some instances, admitted to hospital. The learning aspect of the project was also pivotal for knowledge sharing and the building of relationships among professionals. As part of the dermatology strand, Scottish dermatology nurses have been collaborating with counterparts in NI and the RoI to devise appropriate training and education through a cross-border electronic system that will be

Project name	Trained staff (as of 1/01/2022)	Highlights on specialist training
		applied in all three regions.
CHITIN	455	*No information provided*
CoH-Sync	60	The skills of health trainers have been improved through their participation in accredited training programmes. The project enables many local women with no formal qualifications to receive accredited training and gain a formal qualification to work as a community health facilitator. This can be used to contribute further to the community, through next-door health and wellbeing promotion or through their potential employment in the broader healthcare sector.
iRecovery	644	The accredited and evidence-based training programmes have enabled health professionals to upskill themselves and deliver additional training in the partner organisations to colleagues. The cascading of mental health programmes has become even more important during the pandemic.
iSIMPATHY	3	The key result of the project is to ensure the best and most sustainable use of medicines for patients by training pharmacists and other medical professionals to deliver medicine reviews and embedding a shared approach to managing multiple medicines ('Evidence-Based Polypharmacy Reviews and the 7-Step Process').
MACE	247	*No information provided*
mPower	1265	*No information provided*
Need to Talk	329	*No information provided*

1.3.4 Improved accessibility

As to whether the interventions have improved accessibility in terms of equipment, consultants, services and procedures available, all financed projects have replied affirmatively. Three specific dimensions were particularly highlighted:

- the easier and quicker access to services by project target groups thanks to the delivered interventions/services (e.g. Changing Lives, MACE);
- the alleviated pressure from hospitals thanks to the new services delivered locally in the communities (e.g. Acute Services);

- the increased accessibility thanks to the newly developed digital services and the equipment provided (e.g. tablets in the mPower project).

Insights from projects

CHANGING LIVES

The provided service has improved access to ADHD interventions. Many of the families who benefitted from the project would have had to wait several years to access traditional ADHD services. Many were too young to be considered for formal diagnosis of ADHD, while the Changing Lives intervention can be delivered pre-diagnosis, and there are long waiting lists in specific areas (e.g. in the Belfast Trust, families wait over 3 years to access services).

ACUTE SERVICES

The project has allowed a number of new patient pathways to be explored and implemented to reduce hospital admissions, when appropriate, and to treat patients either at home or in the community.

iRecovery

The Virtual Recovery College provides an online platform that is accessible to individuals across 12 counties and also more widely. The modules focus on mental health and well-being and can be accessed for free 24/7. The training content has been co-produced by health professionals and peer educators to support individuals to self-manage their mental health and well-being on their journey of recovery.

MACE

The reports from practitioners working closely with vulnerable children have mentioned improved accessibility thanks to the MACE project including:

- *Easier access to services through the autism spectrum disorder (ASD) programme for families with a child demonstrating ASD or behaviour relating to other disabilities, where there is usually a year-long waiting list for assessment and formal diagnosis;*
- *Easier access to therapy through the MACE project for severely traumatised children which are part of an 'emergency foster care placement' and urgently need therapy to deal with the trauma experienced.*

mPOWER

The adoption of Attend Anywhere in HSE represents a significant improvement in the access to services, and the connections to local communities has also been greatly enhanced through the project. The establishment of Community Digital Hubs *across almost all the partners is a lasting resource. The Community Digital Hubs have improved access to digital services.*

1.3.5 Quality of services

All financed projects reported that cross-border interventions have positively affected the quality of services delivered.

These has occurred in a wide array of aspects of service delivery, namely:

- the involvement of target groups (patients, targeted vulnerable group etc.) in the delivery of services resulting in a better understanding, planning and delivery of services;
- the creation of early intervention services supports vulnerable groups through a timelier treatment of their condition;
- the opportunities for staff training and development ultimately improve the services provided to patients;
- the shift to digital services, enhanced by the pandemic, has led to opportunities to deliver services through different tools which allow access a wider pool of patients and reach people located in remote and isolated areas (rural areas, islands etc.) who are treated / trained in the comfort of their own homes;
- the focus on community health care intervention means services can be accessed closer to home and are more tailored to individual and local needs.

Insights from projects

Acute

The shared learning, both at inter-organizational and cross-border levels, between Project Board members and clinical professionals has provided opportunities for staff development and training which will ultimately improve the services provided to patients.

CoH-Sync

Through the Community Health Hubs, the project has created a successful model of how a better health and well-being behaviour can be achieved and measured. The model can be adapted and adopted at community level, with the adequate statutory/departmental support and adoption into future policy and practice.

iRecovery

Peer Educators with lived experience of mental health have helped increase the quality of co-productive sessions with health professionals in developing training materials which has led to a better understanding of service-user engagement in planning and delivering services. Individuals have been supported on their journey of recovery by peer educators who have first-hand experience of mental health conditions.

iSIMPATHY

The polypharmacy reviews have provided improved patient access and reduced patient harm at a time of considerable pressure across the healthcare system. In the Republic of Ireland the project delivers a new model of care, pharmacist-led comprehensive medicines reviews delivered in primary care, the first time outside of a research setting. Benefits to the service to date in Northern Ireland include improved patient education and signposting as well as health literacy support.

MACE

By providing access to a wide and diverse range of support interventions to vulnerable families, practitioners are able to provide timely interventions to help vulnerable children before their situation worsens.

1.3.6 Internal obstacles hindering project implementation

The e-mail consultation and case studies gathered information about internal obstacles which have hindered project implementation. It should be noted that these internal factors, i.e. relating to project and programme procedures and to the nature of partners and partnerships, are sometimes closely linked to external factors such as Brexit or, more predominantly, the COVID-19 pandemic. These external factors are analysed separately in Chapter 3 of the report.

The key obstacles identified by projects are:

- Problems with staff recruitment and staff turnover;
- Difficulties with procurement procedures;
- Monitoring, reporting and reimbursement of expenses;
- GDPR and Data Sharing;
- Delays in the signature of the Letter of Offer (LoO).

A vast majority of projects experienced issues and delays with staff recruitment. In some cases, this was due to the difficulties of finding candidates (limited number of applications, difficulty in attracting specialists) or to lengthy recruitment processes in bigger organisations (e.g. statutory bodies). Regarding the latter, the different pace of staff recruitment across the three jurisdictions was detrimental to the alignment of project implementation across the programme area, as reported by the mPower project. In all cases, delays in staff recruitment entailed delays in project implementation as certain activities could not be performed without adequate human resources. This was exacerbated, in the experience of CoH-Sync and iRecovery, by the high staff turnover in management positions.

Public procurement represents another key obstacle highlighted by most projects which delayed project implementation or added a significant amount of administrative burden to project leaders and partners. Problems occurred, for instance, because of the "failure of the OJEU advertised procurements to find providers for community and voluntary sector delivery" (CoH-Sync, iRecovery) which resulted in significant delays in getting delivery models operational in some areas. mPower highlighted how projects under Interreg V-A, at least under PA4, are compelled to use national/government procurement frameworks as they are faster to navigate. However, Interreg V-A rules that require evidence of the establishment of such procurement frameworks are difficult to comply with: framework owners tend to not be keen to release such evidence as it is too time-consuming and of no benefit to them. At the same time, the 25% correction applied by Interreg where evidence cannot be provided is considered too high for partners.

Acute Services also mentioned the difficulty in obtaining an agreement between the NI Health Services Procurement Department and the SEUPB as to what procurement documentation could be shared for verification and audit purposes, which delayed the purchase of equipment in NI. This issue overlaps with complications due to the need for data sharing agreements (see below).

Financial reporting requirements and slow reimbursement of expenses were also often reported as hindering project implementation. On the one hand, meeting reporting obligations is considered demanding and time-consuming for project partners and additional training e.g. on financial reporting and on the correct use of the eMS platform would be welcome prior to the project start. On the other hand, the effort to keep up with requirements and deadlines is often perceived as not 'rewarded' with the reimbursement of claims being perceived as too slow. This, in particular, represents a significant issue and a cause of stress for smaller third sector organisations (e.g. NGOs, charities, voluntary organisations) such as the ones implementing the Changing Lives and ONSIDE projects,

which risk struggling with the running costs of the project and the missing cash flow. These delays in reimbursement made certain partners rather reluctant to apply for Interreg funding in the future.

It should be noted, however, that significant efforts have been made by the programme to accelerate the reimbursement process in recent years. According to the 2019 AIR "There is a significant time pressure on processing claims leading to delays in payment. There is a variety of reasons for this. Historically, there have been frequent delays in the provision of adequate supporting documentation from project partners and the policy to direct project partners to submit all retrospective claims has, and will, continue to contribute to delays. Also, competing priorities, such as the requirement for Financial Control Unit (FCU) staff to carry out further value for money assessments on applications for funding and modification requests, as well as internal resourcing issues, have contributed to the problem."

The table below summarises the measures taken by the SEUPB to address this issue.

Table 7 Measures taken by the SEUPB to accelerate the reimbursement of claims

Year	Measures taken
2018	- Processing times and any resulting delays or backlogs monitored monthly by the Financial Controller and Managing Authority Director, actions identified, and remedial action implemented (general action or action specific to an individual projects or group of projects). - Recruitment of additional staff by the FCU to share the expenditure verification workload.
2019	Measures: - Continued monthly monitoring by FCU Finance Manager and Managing Authority Director of processing times and any resulting delays, actions identified, and remedial action implemented. - Facilitation and development, by FCU team, of projects' capacity to ensure adequate supporting documentation is in place. - Recruitment of additional temporary staff to undertake expenditure verification workload.
2020	The restrictions put in place to mitigate COVID-19 have challenged projects' ability to access offices etc. to secure supporting documentation. There has been an increased pressure on the FCU staff such as the requirement for these same staff to carry out value for money assessments on applications for funding and modification requests which have arisen from the issues projects have dealt with as a result of the COVID-19 emergency. In 2020, the programme was falling short of its internal target that 80% of claims be certified within 42 days of receipt of adequate supporting documentation. In response, the SEUPB put in place a number of measures including: - development of projects' capacity and - recruitment of additional temporary staff.
2021	As of December 2021, the 80% target was being met. To ensure that the SEUPB continue to improve the throughput of claims, the following measures have been taken: - Continuation of 1-to-1 support and training to projects by Programme Officers. - Escalation of problem claims/issues to Director level. - Engagement with projects to ensure mutually agreed timescales for claims verification.

Source: SEUPB, based on 2019, 2020 and 2021 AIRs

As well as the above, SEUPB has prioritised claims of organisations who have raised concerns regarding cash-flow. In addition, the SEUPB set up two advance payment mechanism to mitigate the effects of any delays on the cash flow of smaller organisations: (1) an ordinary advance which was normally

issued at the start of a project (2) a special covid advance where advance payments were made against submitted claims. The Covid payment system was ended in the first half of 2022.

GDPR requirements and data sharing agreements between SEUPB and contracted companies also complicate and delay project activity, taking a substantial amount of time and effort. These were further complicated by Brexit and changing legislative contexts, highlighting the different processes existing across countries with regard to data protection and sharing.

Finally, the delays in the signature of the Letter of Offer were reported by approximately half of the projects, with this issue being perceived as of greatest importance to most of the CAWT-led projects (Acute Services, CoH-Sync, iRecovery). The delay in the start of project activities often meant that partners needed to adjust and re-prioritise certain activities. According to CAWT, to overcome this initial barrier it was "*crucial that the Project Board had a shared understanding of the project priorities and actively supported their achievement*".

Further to these cross-cutting obstacles, some project-specific obstacles and considerations are worth mentioning, especially with regard to the differences not only in structures and legislation among different jurisdictions, but also in the intensity of investment in specific sectors which can result in different capacity among partners at cross-border level.

Insights from projects

CoH-Sync

A considerable delay had occurred with the implementation of the CoH-Sync Data Collection and Reporting System (DCRS). This significant delay meant the DCRS did not become operational until 2019 and therefore retrospective work was scheduled and undertaken to upload client data from a variety of Health and Well-being Plans prior to DCRS. This involved considerable additional resources and time to complete which had not been initially factored in. Both the retrospective client data and directly uploaded DCRS held client data are separate data sets and will make the data analysis more challenging.

[…] Right from the outset and during the planning, it was clear that the community and voluntary sectors across the three jurisdictions had experienced different levels of investment and strategic positioning which had resulted in substantial differences in capacity. While the community sector in the UK tends to be vibrant, following years of work on community development and health as well as significant infrastructure, the Republic of Ireland is characterised by more fragmented infrastructure, that is smaller in scale, and a scarcity of community-led programmes.

Acute Services

For how beneficial the cross-border aspect can be, it also leads to delays or obstacles. In fact, the two countries jurisdictions have different structures and legislation in their health systems, which hampered project activities.

The table below summarises the experiences of projects regarding the key obstacles to implementation.

Table 8 Obstacles hindering project implementation according to consultation and case studies

Project	Staff recruitment and turnover	Procurement process	Monitoring, reporting and reimbursments	Data sharing rules (GDPR)	Delayed start (LoO signature)
Acute Services	The project experiences some difficulties attracting clinical/professional staff for specialist services, further exacerbated by the pandemic because staff had to be redeployed for periods of time to respond to COVID-19 pressures, e.g. the hired Respiratory Consultant.	Most significant procurement delay around difficulty obtaining agreement between the Procurement and Logistics Service (the NI Health Services Procurement Department) and SEUPB as to what procurement documentation could be shared for verification and audit purposes. The CAWT Programme Manager liaised with both parties and a Data Sharing Agreement was signed off to allow purchase of equipment from existing NI frameworks.	From a managerial point of view, meeting the range of demanding requirements, particularly in relation to setting up project financial and monitoring systems which meet both health services and EU funders requirements at the same time was particularly challenging.	GDPR data sharing agreements between SEUPB and contracted companies took a substantial amount of time and effort.	Time delay from Project Application approval stage to LoO stage and also delays in approval of Requests for Change due to changes in project service needs and demand.
Changing Lives			High level of reporting requirements and slow turnaround of payments from the project funder. This was a source of stress for some partners and might be due to differing national First Level Controller procedures.		
CHITIN			The scale and complexity of CHITIN represents significant challenges in respect of programme delivery, performance management, financial management and subsequent associated reporting		

Project	Staff recruitment and turnover	Procurement process	Monitoring, reporting and reimbursments	Data sharing rules (GDPR)	Delayed start (LoO signature)
			obligations. The Interreg V-A programme rules have been the most challenging aspect for CHITIN partners.		
CoH-Sync	Recruitment of some project staff took longer than anticipated. CAWT HR Manager and HR Strategy Group provide support to HR and recruitment issues. High staff turnover in the staff delivery model in Scotland was particularly challenging and motivated the project to include Third Sector Organisations for the remaining months of delivery.	The procurement notice advertised in the Official Journal of the EU (OJEU) advertised procurement did not bring forward the necessary providers for three of the eight hubs. This meant that there were longer delays in getting a delivery model operational in some areas.			The project did not receive its final Letter of Offer until July 2017.
iRecovery	Recruitment of some project staff took longer than anticipated. CAWT HR Manager and HR Strategy Group provide support to HR and recruitment issues. High staff turnover in management positions (Project Manager and Recovery College Coordinators) was particularly challenging and resulted in delays in project implementation.	The procurement notice advertised in the OJEU made did not bring forward providers for community and voluntary sector delivery and an online recovery college, which resulted in significant delays in getting delivery models operational in the 3 hub areas. Additional procurement processes in NI linked to Brexit caused significant delays in the second half of 2021 and early 2022.		Additional processes for data protection, GDPR and cyber-security caused significant delays in the second half of 2021 and early 2022.	The project did not receive the final LoO until June 2017. It was crucial that the Project Board had a shared understanding of the project priorities and actively supported their achievement.
MACE	Delays in the job evaluation process for 4 new admin	Time required to engage with Project Partner service leads			

Project	Staff recruitment and turnover	Procurement process	Monitoring, reporting and reimbursments	Data sharing rules (GDPR)	Delayed start (LoO signature)
	staff, started in August 2021 and completed only in February 2022. Much urgent work has been delayed in the last six months due to the lack of staff resources. This is partly due to Covid-19.	to inform on procurement specifications development was not adequately factored into project timeline prescribed in LoO.			
mPower	Differences in pace of recruitment process at project start (e.g. 3 months in Scotland, 6 months in RoI).	Health projects prefer to use national/government procurement frameworks as they are faster to navigate. Interreg rules on providing evidence of establishment of framework are an issue: organisations will not release evidence as too time-consuming and of no benefit to framework owner. 25% correction applied where evidence not provided often too burdensome.		EU GDPR rules slowed and complicated project activities. Brexit highlighted the existing and increasingly different processes across countries. Despite the fact that the ambition is to carry on same activities across the programme area, partners have concluded that this is not possible, even more so when these must comply with varying rules.	
ONSIDE			Release of payments was a cause of stress to small size organisations such as most project partners (NGOs, voluntary organisations, charities etc.) which struggled with the running costs of the project and with meeting deadlines for reporting and verification. These made certain partners particularly reluctant to apply		

Project	Staff recruitment and turnover	Procurement process	Monitoring, reporting and reimbursments	Data sharing rules (GDPR)	Delayed start (LoO signature)
			to Interreg projects in the future.		

Conclusions

In terms of financial and output achievement, the programme is progressing well towards the set targets. Despite initial delays related to Brexit and the disruptions caused by the COVID-19 pandemic, the programme has shown great resilience and ability to adapt to new unforeseen circumstances. The time and budget flexibility provided to projects during the crisis has been particularly praised by projects. The internal factors hindering implementation are considered by the evaluator as common and inherent to Interreg programmes (e.g. public procurement issues, financial monitoring and reimbursements, project staff recruitment and turnover etc.). Those obstacles that have been exacerbated by Brexit should, however, be closely monitored in the future.

2 RESULTS AND IMPACTS

2.1 PROGRAMME RESULT INDICATOR

KEY FINDINGS

EQ 5: To what extent has the result indicator been achieved?

At the moment of drafting this report, the result indicator target set by the programme for 2023 has almost been achieved (94%) with a number of episodes of health and social care delivered on a cross-border basis amounting to 8,440 per annum. Progress recorded in 2019 was below the baseline, with 3,611 episodes of care per year, only 40% of the 9,000 episodes target set for 2023.

RECOMMENDATIONS

➔ By using a comparable definition of 'episodes of care' to that used for the calculation of the result indicator, data could, if feasible, be collected and aggregated on the total 'episodes of care' delivered at regional or county level in the programme area in RoI and NI. The number of cross-border episodes could then be compared to the total amount so as to provide a relative value, in addition to the absolute one ('episodes per annum').

$$\frac{\textit{n. of cross-border episodes of care in year xxxx}}{\textit{total n. of episodes of care in the programme area in year xxxx}}$$

The result the programme seeks to achieve is the increase in the number of episodes of health, community and social care delivered on a cross-border basis. The rationale behind the choice of this result indicator is the inequality in the provision of health care services in the Republic of Ireland – Northern Ireland – Scotland border areas, as a result of the existence of the border. Through projects financed through the health and social care priority axis, the programme aims to increase the level of access to and the quality of health care for communities in the region. It should be noted that, in line with the 2014-2020 approach and definition, result indicators are not supposed to measure the direct impacts of the programme but changes in the characteristics of a given area due to programme interventions and / or other factors (i.e. external to the Interreg V-A programme).

The cooperation programme started from a baseline of 4,700 episodes per annum in 2015 to a target of 9,000 per annum at the end of the programme. This data is collected by Cooperation And Working Together (CAWT), a partnership between the Health and Social Care Services in Northern Ireland and Republic of Ireland, which facilitates cross border collaborative working in health and social care.

By 2019, the programme reported the achievement of 3,611 episodes of cross-border care delivered which was less than half of the total target for 2023 (9,000 episodes per annum) and also below the baseline value of 2014. Although the baseline is 4,700, this value should not be viewed as a starting point from which the programme progresses. The baseline was sourced from the previous INTERREG IV-A Programme using the pro-rata number of beneficiaries from 2009 to 2014. The measurement of the result indicator directly relies on outputs from projects in the current Interreg V-A programme, thus the 2019 value of 3,611 built up from a starting point of 0.

Table 9 Progress of PA4 result indicator

Result indicator	Baseline	Programme target (2023)	2019	2020	2021
The number of episodes of health, community and social care delivered on a cross-border basis (episodes per annum)	4,700	9,000	3,611	7,265	8,440

2.2 PROJECT RESULTS AND IMPACTS

KEY FINDINGS

EQ 6: What has been the impact of cross-border interventions?

The impacts of cross-border interventions can be categorised according to the challenges that health and social care projects are addressing.

Improving access to care

- **Acute Services** (target group: patients in scheduled and unscheduled care streams): alleviated pressure from hospitals; alleviated pressure from ambulance services, easier access to care in the community and own homes, new pathways to reduce hospital admissions, reduced isolation of patients from rural areas.
- **MACE** (target group: children/families with Multiple Adverse Childhood Experiences): support to practitioners and professionals through thorough list of support interventions to vulnerable children and their families; easier access to services through the autism spectrum disorder (ASD) programme; easier access to therapy for severely traumatised children.

Improving patients' empowerment and self-management

- **iRecovery** (target group: people with lived experience of mental health difficulties): increased self-management of condition by Recovery College participants (service users); increased skills of people with experience of mental health who have become Peer Educators.

Improving lives of people with chronic or long-lasting health conditions

- **Changing Lives** (target group: children with behaviour consistent with ADHD aged 3-7 years old): changed behaviour patterns in children with (suspected) ADHD: reduced frequency, intensity, duration and severity of problems; reduced risk of social exclusion; improved family-child relationships; new informal networks of families facing similar challenges; increased knowledge and skills of professionals (including teachers).
- **CoH-Sync** (target group: people living in border area with long-term conditions and local communities where Hubs established): expertise, skills and experience in health and wellbeing; new networks of cooperation in local communities; increased skills of health trainers; increased skills of community health facilitators increasing their chances for employment.
- **iSIMPATHY** (target group: people living with chronic conditions and comorbidities with multiple medicine prescriptions): develop a whole-system approach to ensure sustainable use of medications; develop a guidance to support patients and clinicians; shared learning across jurisdictions. *(expected impacts)*

Reducing social isolation of users

- **mPower** (target group: 65+ age group at risk of isolation): improved access to care for hard-to-reach groups through digital services (e.g. virtual GP appointments); increased digital confidence and competence; increased connections between target group and their local communities.
- **Need to Talk** (target group: people affected by sight loss): increased mental wellbeing of participants; new confidence; increased sense of independence.
- **ONSIDE** (target group: people with disabilities): increased mental wellbeing of participants; increased IT skills of participants; new sense of independence.

The analysis of programme and project documents has led to the selection of a number of current outputs in the health priority axis which could be considered as direct results (see Methodology). The programme has the merit of having included, already in 2014, a number of programme-specific output indicators which are close to the definition of direct result indicators proposed for the next programming period, in particular:

- 4.111 Beneficiaries supported by new cross-border area initiatives for positive health and wellbeing and the prevention of ill health (linked to the development of interventions under output 4.110) ;
- 4.113 Beneficiaries supported by new cross-border area initiatives for disabled people of all ages who are socially isolated (linked to the development of cross-border area community support services under output 4.112);
- 4.115 Cross-border area clients in receipt of mental illness recovery services (linked to the establishment of cross-border area community and voluntary sector infrastructure under output 4.114);
- 4.117 Vulnerable families in receipt of an intervention (linked to the creation of new border area frameworks under output 4.116);
- 4.119 Patients benefitting from scheduled and unscheduled care streams (linked to the creation of cross-border frameworks for scheduled and unscheduled care streams under output 4.118);
- 4.120 Patients availing of e-health interventions to support independent living in caring communities.
- 4.121 Patients availing of a shared cross-border framework and service for the identification, assessment and referral of patients identified as "at risk".

The table below shows the current (aggregate) progress against programme targets, based on data provided by the Managing Authority on the ten financed projects. It should be noted that the values are self-reported by projects and are subject to verification.

Table 10. Progress against direct result indicators[7]

***Direct result* indicator**	**Total achievement (2021)**	**Programme target (2023)**	**% progress**
4.111 Beneficiaries supported by new cross-border area initiatives for positive health and wellbeing and the prevention of ill health	12,863	15,000	86%
4.113 Beneficiaries supported by new cross-border area initiatives for disabled people of all ages who are socially isolated	4,163	4,000	104%
4.115 Cross-border area clients in receipt of mental illness recovery services	5,036	8,000	63%
4.117 Vulnerable families in receipt of an intervention	4,323	5,000	86%

[7] As self-reported by projects, 31 December 2021.

Direct result indicator	Total achievement (2021)	Programme target (2023)	% progress
4.119 Patients benefitting from scheduled and unscheduled care streams	16,631	15,000	111%
4.120 Patients availing of e-health interventions to support independent living in caring communities	5,101	4,500	113%
4.121 Patients availing of a shared cross-border framework and service for the identification, assessment and referral of patients identified as "at risk"	2,525	2,500	101%

Source: SEUPB, self-reported achievement values up to 31/12/2021, Cooperation programme target values

In line with the output indicator achievement observed in paragraph 1.3, a very high level of achievement against the targets set by the programme for 2023 can be observed in all 'direct result' indicators, with most having attained close or equal to 100% of the expected target by the end of 2021. Some indicators (4.113, 4.119 and 4.120) have exceeded the initial programme targets. Only indicator 4.115 'Cross-border area clients in receipt of mental illness recovery services' reports a lower rate of achievement, i.e. about two thirds of the programme target.

The number of **beneficiaries supported by new cross-border area initiatives for positive health and wellbeing and the prevention of ill health** (**4.111**), linked to the achievement of output 4.110 'Number of new interventions to support positive health and wellbeing and the prevention of ill health', has achieved 86% of the target.

The CoH-Sync project and the iSIMPATHY project have contributed to this indicator.

CoH-Sync has supported a total of 10,052 (against a project target of 10,000) beneficiaries after the establishment of the 8 Community health and wellbeing hubs across all thematic areas of the project (Nutrition, Mental Health, Smoking, Physical Activity, Mental Health) and the cross-cutting theme of Health Literacy. The project planned to achieve the following results: healthier population, reduction in health inequalities, improved health literacy, increased support from primary care (general practitioners, community pharmacy, members of Primary Care teams etc.), strengthened and empowered community infrastructure, and addressing imbalances in the community and voluntary sector across the three jurisdictions.

According to the project leader, CoH-Sync has achieved all the intended results. The eight **Community health and wellbeing hubs** as interventions supporting positive health and wellbeing have proven **beneficial to the local communities** where they have been established, not only in terms of the increased **experience, skills and expertise** in health and health literacy but also of the **new networks of cooperation** created. Unexpected benefits have been reported mostly due to the shift to digital pushed by the Covid-19 pandemic and related restrictions. In particular, the project managed to:

- **Support local communities during Covid**: Many of the beneficiaries who engaged with the CoH-Sync project were experiencing anxiety and isolation due to Covid restrictions and lockdowns. All eight hubs developed innovative ways to enable social inclusion and promote the physical, mental and emotional health and wellbeing of people during a very challenging

time. Many of the Hubs collaborated with statutory and community support developed to assist people during the pandemic and were able to recruit and engage with clients as a result of the unplanned collaborative working.

- Provide **online interventions**: the growth and popularity of online support and interventions was not planned but proved to be very popular. It also enabled certain groups to participate that might not have been able to attend physical classes or interventions, e.g. single parents and carers.
- **Increase participation in specialised training**: whilst the Project provided accredited training in Community Health Facilitation, further specialised training was developed to support the provision of a wider variety of online interventions in all three jurisdictions. For example, two additional training courses were delivered to CoH-Sync Community Health Facilitators to broaden the range of quality interventions (either for online and/or face-to-face) to beneficiaries. The training has provided facilitators with an accredited qualification, thus increasing their skillset, motivation, job satisfaction and morale during this pandemic.

Insights from projects - Impact of CoH-Sync

Local communities have gained experience, skills and expertise and have established networks of cooperation. The skills of health trainers have been improved through their participation in accredited training programmes. The project has also enabled many local women with no formal qualifications to receive accredited training and gain a formal qualification to work as a community health facilitator. This can be used to contribute further to the community, through next door health and wellbeing promotion or through their potential employment in the broader healthcare sector.

iSIMPATHY has started its implementation in late 2020 and is still at an early stage compared to the other PA4 projects. Up to the end of 2021, the project had supported a total of 2,811 beneficiaries (against a project target of 15,000) after the establishment of the three polypharmacy review models in RoI, NI and Scotland.

The key result of the project is to ensure the **best and most sustainable use of medicines for patients' multiple long-term or chronic diseases** by training pharmacists and other medical professionals to deliver medicine reviews and embedding a shared approach to managing multiple medicines.

Considerable progress has been made to achieve its results through, among others:

- A comprehensive training programme on 'Evidence-Based Polypharmacy Reviews and the 7-Step Process' available to all Health Care professionals;
- A valuable inter-jurisdiction collaborative network;
- A generalisable robust data collection, evaluation, monitoring and quality assurance system.
- A new website which constitutes a valuable resource hub (www.isimpathy.eu).

The intention is to achieve this through training, a new model of polypharmacy reviews and their delivery (i.e. the 15,000 targeted beneficiaries).

The long-term impacts expected from the project are:

- To develop a whole-systems approach across health care that ensures the optimal and sustainable use of medications for those with multiple morbidity to enable them to lead healthy and active lives.

- To embed a **whole-systems approach towards medicine** reviews that is scalable in the three project jurisdictions.
- To **share learning across the three jurisdictions** to facilitate understanding and implementation of effective medicine reviews throughout the project's lifespan.

Insights from projects - unexpected results of iSIMPATHY

COVID-19 resulted in a large number of patients having reduced access to health services, for instance reduced access to primary care General Practitioner (GP) appointments. This has meant that patients involved in the project have welcomed the opportunity to discuss their medicines but also other matters of concern that would normally have been dealt with by a GP.

Regarding **direct result 4.113** '**Beneficiaries supported by new cross-border area initiatives for disabled people of all ages who are socially isolated**', linked to output 4.112 'New cross-border area community support services to support disabled people who are socially isolated', the target has been achieved and surpassed (4,163 beneficiaries, 104%). The ONSIDE and Need to Talk projects have contribute to its achievement.

ONSIDE has managed to reach 3,358 beneficiaries so far (over their 2,410 project target) thanks to the creation of a programme for people with disabilities providing tailored support and training to improve their independence as well as choice and control over their social connections.

The majority of the **ONSIDE programme participants** report high levels of satisfaction and state that the support and skills they have gained has given them a **new sense of independence**. The project helped people who are usually isolated to feel more included, less isolated and to engage with people who might not go through the same exact disability, but who share similar feelings. People with very low digital uptake have also **increased their IT skills** and feel more confident in their capabilities. They have learnt how to use several tools and online services such as e-banking, online shopping, online healthcare services to improve their day-to-day experience. Overall, the project had a positive impact on the target group's **mental wellbeing**, with some of the recipients even feeling empowered enough to themselves become peer volunteers: 20 disabled people have become action researchers, 50 peer volunteers, and 55 have been involved in co-production activity.

The **Need to Talk** project reached 805 out of the original target of 1,928 beneficiaries and has experienced some delays due to Covid-19 and the inability to conduct certain activities online. Need to Talk also contributes to **direct result indicator 4.120 'Patients availing of e-health interventions to support independent living in caring communities'**, having reached 24 patients so far (out of the 152 target).

Need to Talk provides a cross-border counselling service and confidence building programme for people affected by sight loss throughout the programme area. It addresses social isolation and emotional distress, which is often experienced by people with sight loss, which is exacerbated in rural isolated areas where people are reliant on very limited public transport services to access support. The courses focus on a range of themes including mobility and daily living, emotional support and well-being, assistive technology, eye health, peer support and leisure time. Family and friends are also encouraged to attend the course.

The developed counselling service has been reported as giving **new confidence to participants** and increasing their **independence**.

As an unexpected benefit, closer working relationships between the partners have been created enabling them to share expertise beyond the purpose of the project and to explore other funding opportunities for the partnership.

Direct result indicator **4.115 Cross-border area clients in receipt of mental illness recovery services,** linked to output indicator 4.114 - New cross-border area community and voluntary sector infrastructure to support clients who have recovered from mental illness, has achieved 64% of its target (5,036 out of 8,000 clients) so far. The innovation Recovery (iRecovery) project is the only project contributing to this indicator.

The project aims to empower and enable people to take greater control over their own mental and emotional wellbeing by providing education as a route to recovery through the production of a diverse range of educational programmes in response to the needs of people who are experiencing mental health challenges. These programmes are being delivered by three Recovery Colleges established in three areas (Derry, Letterkenny, Strabane and West Donegal; Cavan, Monaghan, Sligo, Leitrim and Fermanagh; Belfast, Armagh, Newry, Dundalk). Such colleges have also recently become digitally accessible through a dedicated website.

The project adopts a collaborative approach to working with people suffering from mental illness, i.e. they become partners in their own **recovery process**, representing a shift from the medical model of treatment for people who have experienced mental health issues to a more **social model**. E-health solutions are used in the delivery of the project to enable promotion and continuation of the mental health recovery process. The design of e-health solutions is informed by the views of service users, carers and mental health staff, e.g. Recovery College **Peer Educators supporting the design, facilitation and delivery of training courses**.

As for the CoH-Sync project, the unexpected results of iRecovery are closely linked to the changes brought by the Covid-19 pandemic.

Insights from projects - unexpected results of iRecovery

- Support to local communities during Covid: many of the beneficiaries were experiencing poor mental health due to Covid-19 restrictions and lockdowns and, for some, pre-existing conditions were adversely affected. All three Recovery College Hubs developed innovative ways to enable people to reach out and connect with each other. A clear focus was placed on building knowledge and developing skills to help strengthen the mental health and emotional wellbeing of people during a very challenging time. Peer Educators who had previous experience of long stays in mental health hospitals used their experience to write courses that would support people through long lockdown periods
- Online interventions: The growth and popularity of online support enabled certain groups to participate that might not have been able to attend physical classes and interventions e.g. staff from community and voluntary sector organisations who were working from home and supporting their own staff virtually. People with caring responsibilities could also access courses more easily. To improve access during COVID-19 lockdown restrictions the project developed an online training programme of 45 courses.
- Specialised training: although many health care professionals were redeployed during Covid, non- frontline health professionals benefited from accredited and evidence-based training programmes online. This training has enabled the health professionals to upskill themselves and deliver additional training in the partner organisations to colleagues.

Achievement against direct result indicator **4.117 'Vulnerable families in receipt of an intervention',** linked to output indicator 4.116 'New border area frameworks for early intervention with vulnerable families', is at 86% of its target, thanks to the Changing Lives and MACE projects.

The **Changing Lives Initiative** is a cross-border community-based project addressing the issue of ADHD, a behavioural disorder that emerges in early childhood which, if left untreated, can have a big impact on adult life as well, leading to mental health issues, unemployment, involvement in crime and incarceration. The project focuses on prevention with children aged 3-7 and on providing an early intervention programme for families with kids experiencing behaviours consistent with ADHD. The project entails different levels of intervention starting from Information and Awareness Sessions, through a Screening Programme to the last step which includes an intensive intervention in the form of an evidence-based ADHD-focused 'Incredible Years' parent-training programme.

Changing Lives, which ended in April 2021, has reached 2,004 vulnerable families (against an initial target of 2,000). The impact on target families and children is considered tangible and is corroborated by the project outcomes evaluation in which the project involved all participant families (both children and parents or guardians). They reported **changed behaviour patterns** in children in terms of **reduced frequency, intensity, duration and severity of problems**, impacting on daily family dynamics as well as social and emotional well-being, **reducing the risk of their exclusion** from school. Even parents whose children experienced limited change in ADHD symptoms reported good levels of satisfaction with the initiative as they highlighted the **positive benefit of establishing support networks with families in similar situations**. Parents have tended to feel less overwhelmed, more in control and generally more optimistic about their child's future. Finally, **improved relationships** between parents and children were reported as well as improved family relationships with parents and siblings.

Regarding Information and Awareness sessions for professionals, the goal was to tackle the deficit in terms of preparedness around ADHD, which turned out to be greater than expected. These training sessions were organised to provide **knowledge and the skills to enable professionals to better identify the disorder from its early symptoms** and therefore be able to provide more timely and effective care. The workshops led to a change in the mindset of these professionals too, as they are now more aware that it is not a wilful behaviour and have enhanced their tools to support children in the classroom setting.

The **MACE** project has reached 2,319 vulnerable families so far. The project intends to deliver a range of trauma-informed supports and interventions to at least 3,125 vulnerable families by June 2023, as well as develop a user-friendly toolkit for practitioners across a range of professions. The objective is to help them carry out assessments in a more 'trauma-informed' manner and to train 300 staff on how to use the MACE assessment toolkit effectively in their role and 200 staff to deliver interventions to families; and finally, create an electronic menu of a wide range of trauma-informed support/interventions accessible to practitioners working with vulnerable children and their families.

Regarding the latter, the MACE project leader has reported some unexpected results not initially planned. Whilst it was intended that a **range of supports would be delivered to vulnerable families**, it was never anticipated that an accessible user-friendly list or 'menu' of support interventions would be developed. A list of the range of interventions available through MACE has been widely circulated to professionals working with vulnerable children and their families across the border corridor and it allows practitioners and professionals working with vulnerable families to browse through the list where the descriptions highlight suitable audiences and expected outcomes. This information enables them to make a professional judgement on which of the interventions is most suitable to meet the needs of the individual child or family.

The **Acute Services** project contributes to direct result indicator **4.119 Patients benefitting from scheduled and unscheduled care streams,** linked to output indicator 4.118 'Establish cross-border frameworks, for scheduled and unscheduled care streams, to improve utilisation of scarce human, physical and financial resources'. The project has benefitted 16,631 patients, surpassing the programme target of 15,000 patients.

The Acute Services project idea emerged from recognition of the fact that the three jurisdictions face the same difficulties and challenges in terms of health care: lack of resources, long waiting lists, low service provision in the context of an ageing population, rising obesity rates, and the impact of smoking, alcohol misuse and physical inactivity upon health profiles in socially deprived areas. These led to **increasing demand for pre-hospital/acute services** which, alongside staff and skill shortages, put a strain on acute hospitals, many of which lack the skills and infrastructure to cope with increasing patient numbers. It is even more difficult for people living in **rural border areas**, who need to travel long distances or to another jurisdiction to access services. The project aims to assess and treat higher volumes of patients more effectively at local level before they go to an acute hospital, both in scheduled and unscheduled care pathways through improved and reformed service delivery models on a cross-border basis. Scheduled care services include dermatology, urology, general surgery and vascular specialties, while unscheduled care services are cardiac and geriatric. Moreover, five different areas within unscheduled care have been explored: Community Paramedics, Community Cardiac Investigations, Reform of A&E/ED, Direct Access Unit/Clinical Decision Unit and Community Respiratory services. The Community Paramedic service was established incorporating the Northern Ireland Ambulance Service, Scottish Ambulance Service and Ireland's National Ambulance Service.

The project had an impact on acute service delivery with clear positive feedback from individuals who participated. The paramedic service, in particular, exceeded project expectations and **helped lift**

pressure from the emergency services departments thanks to its complementary activity. Community Paramedics are highly trained Ambulance staff who have undergone further specialised training accredited by Glasgow Caledonian University which enabled them to see and **treat patients in their communities and their own homes**, thus significantly reducing the quantity of people that would have been transported to busy hospital emergency departments, and, in some instances, admitted to hospital. This approach is also helping to **alleviate pressure from the front-line ambulances** in the programme area.

The Clinical Decision Unit[8] (CDU) was beneficial as it allowed several new patient pathways to be explored and implemented to **reduce hospital admissions**, when appropriate, and to treat patients at home or in the community. This has alleviated some of the distress that was prevalent during the COVID-19 surges with people less keen on going to the hospital and **more reliant on health services delivered locally**.

The **mPower** project contributes to both direct result indicator **4.120 Patients availing of e-health interventions to support independent living in caring communities,** where it has reached 5,077 patients surpassing the 4,500 target, and **4.121 Patients availing of a shared cross-border framework and service for the identification, assessment and referral of patients identified as "at risk"**, reaching 2,500 patients.

The mPower project was developed around preventive medicine, through a shared approach regarding the correlation between health and wellbeing. It aims to transform services offered to older people in Ireland, Northern Ireland and Scotland, assisting people to **improve their health conditions** and live well, safely and independently in their own homes, **self-managing their health in the community**. The project mainly targets citizens from the '**65+ older people at risk'** age group and category. The project delivers social prescribing and eHealth interventions through Community Navigators (CNs). Following referrals from primary care staff or other sectors, CNs undertake home visits and guided conversations and co-produce personalised Wellbeing Plans, using a **person-centred approach**, focusing on prevention and connection to activities in the community and to technology to enhance support for health and wellbeing.

According to the project leader, the adoption of Attend Anywhere as a **national video consultation platform for the Health service in Ireland** is a key success. This activity showcased the value of cross-border working as it benefitted greatly from the openness of shared learning and insight between HSE and NHS Scotland. Additionally, the project was able to echo and align to national initiatives which were unknown at the beginning of the project but were critical to achieving shared outcomes. These activities included support for Covid-19 responses including significant support for digital connectivity and **digital access** in care homes: in cooperation with Connecting Scotland, around 60,000 tablets were provided to people supporting digital connectivity in care homes, including training on how to use the tablets.

The mPower team have achieved considerable success in the area of **digital intervention**, increasing digital **confidence** and **competence** in the targeted audience. Through technological services, people learnt to better manage their health and social wellbeing, and in many cases were able to stay connected to family, friends and health and social care professionals. Partners from the different jurisdictions succeeded in exchanging practices and expertise. For instance, HSE was more experienced in terms of **social prescribing** and helped the NHS to improve this service, as well as better use of digital applications in health services.

[8] The CDU is a short stay unit (open 24 hours a day) within the emergency department for people who need more clinical care, but do not need to be admitted to hospital.

Thanks to mPower, HSE in the Republic of Ireland started using "Attend Anywhere", a video-enabled care system for virtual appointments. This tool was already being used in Scotland, providing around 330 virtual appointments per week, but with COVID-19 virtual appointments in Ireland increased from 50 to 17,000 per week. The benefits of this tool are numerous and include reduced risk of COVID-19 infection, additional choice of engagement for the patient/client with their service provider, **improved access for hard-to-reach groups such as people living on islands or with no access to private transport**, thus providing an alternative to travel to a clinic - saving time, money and potentially the need for a family member to take time off work to accompany a relative to an appointment.

Moreover, **connections to and among local communities** have also been greatly enhanced.

The table below summarises the impacts of PA4 projects, divided according to the primary and specific challenge addressed by each project.

Table 11 Impacts of PA4 projects according to the primary and specific challenge addressed by each project

Primary Challenge	Project	Challenge addressed by the project	Main impacts generated by the project results
Improving access to care	**Acute Services**	Difficulties responding to the rising demand for scheduled and unscheduled care in the cross-border area.	• Alleviated pressure on hospitals • Alleviated pressure on ambulance services • Easier access to care in the community and own home • New pathways to reduce hospital admissions • Reduced isolation of patients in rural areas
	MACE	Children/families with Multiple Adverse Childhood Experiences (MACE) are a group receiving low preventive support and are at risk of severe adverse outcomes.	• Support to practitioners and professionals through thorough list of support interventions to vulnerable children and their families • Easier access to services through the autism spectrum disorder (ASD) programme • Easier access to therapy for severely traumatised children
	CHITIN	Inequality of access to opportunity for involvement in health intervention research in a setting most appropriate to need.	*(Impacts to be expected in late 2022 - early 2023)* *Project heavily impacted by the crisis due to the increased costs associated with trial delivery. Some of the planned trials were forced to cease participant recruitment activities as a result of the increased pressure on primary and secondary care and general practice.*
Improving patients' empowerment and self-management	**iRecovery**	People with lived experience of mental health difficulties rely heavily on statutory health services for medical/clinical support and often struggle to effectively self-manage their condition.	• Increased self-management of conditions by Recovery College participants (service users) • Increased skills of people with experience of mental health who have become Peer Educators
Improving lives of people with chronic/long-lasting health conditions	**Changing lives**	Vulnerability of ADHD children and their families in the project areas	• Changed behaviour patterns in children with ADHD: reduced frequency, intensity, duration and severity of problems • Reduced risk of social exclusion • Improved family-child relationships • New informal networks of families facing similar challenges • Increased knowledge and skills of professionals (including teachers)

Primary Challenge	Project	Challenge addressed by the project	Main impacts generated by the project results
	CoH-Sync	People living in border areas of the INTERREG V-A eligible area are affected to a greater degree by known risk factors for long-term conditions (chronic disease).	• Beneficial to participants and local communities where Hubs established: expertise, skills and experience in health and wellbeing. • New networks of cooperation in local communities • Increased skills of health trainers • Increased skills of community health facilitators increasing their chances of employment
	iSIMPATHY	People living with chronic conditions and comorbidities with multiple medicine prescriptions.	(Expected impacts) • Develop a whole-system approach to ensure sustainable use of medications. • Develop guidance to support patients and clinicians • Shared learning across jurisdictions
Reducing social isolation of users	**mPower**	Isolation of older population from local communities.	• Improved access to care for hard-to-reach groups through digital services (e.g. virtual GP appointments) • Increased digital confidence and competence • Increased connections of at-risk population of 65+ with their local communities
	Need to talk	Social isolation of people affected by sight loss.	• Increased mental wellbeing of participants • New confidence • Increased sense of independence
	ONSIDE	Social isolation of people with disabilities.	• Increased mental wellbeing of participants • Increased IT skills of participants • New sense of independence

2.3 CROSS-BORDER PARTNERSHIPS

KEY FINDINGS

EQ 7: What new ways of working/partnerships/relationships have been created as a result of activities carried out within the priority axis?

Project partners have shown creativity in setting up effective ways of working. These entail internal organisational solutions (data management, supply chain, project management tools etc) as well as the establishment of new relationships with other territories and sectors (e.g. third sector, schools etc.). Governance models remain an essential element, as already observed in the previous evaluation reports, with all the projects showing considerable capacity to set up fit-for-purpose structures according to their specific missions.

In light of the COVID-19 pandemic, projects turned the loss of in-person events into an opportunity to consolidate online collaboration and jointly face ongoing changes and challenges.

EQ 8: What cooperation impacts have resulted from delivery under this axis?

The strength of cross-border partnership is a success factor in addressing health care issues in the programme area, with partners deeply interested and strongly committed to continue collaboration in the future. The fruitful collaborations have generated dual impacts both for beneficiary organisations but also the community as a whole, which now benefit from (cross-border) services not previously available. At the level of individual organisations, impacts relate to increased capacities of partners to overcome cross-border obstacles, offset clinical competence gaps and enable upskilling and to jointly face severe crisis during the pandemic. Impacts are also visible at community level with extended service delivery areas, the availability of services not previously operating, and the higher quality of the services delivered reported by projects.

Consultation with project partners in 2022 evidenced strong interest in continuing and building upon the established project relationships, including planning activities being undertaken by some organisations to apply for Interreg PEACE PLUS 2021-2027 funding.

The table below reports novelties in terms of working approaches as well as their impacts for cross-border relations reported by the projects involved in the 2022 evaluation.
New ways of working enhanced thanks to cross-border partnership working relate to:

- The sharing of values and visions supported by operational tools such as shared protocols for delivery and preventative approaches to anticipate problems and solutions.
- The introduction of new project management tools (such as Prince2) by some projects (e.g. CoH-Sync and iRecovery) to improve project organisation, management, timing and budget.
- New data management systems to ensure the proper counting of health service beneficiaries according to EU funding rules (MACE project).
- New relationships with different territories (such as Scotland for the CAWT partnerships) and with the third sector (mPower, iRecovery and Need to Talk).
- The governance model. As already observed in the previous evaluations, a well-defined structure, with a clear identification of roles and responsibilities, allows for an efficient exchange of information among the various parts and for a smooth decision-making process. The CAWT experience represents the strongest example, but in general all the projects put in place the due structures (boards, periodic assemblies etc..) to enhance effective and constructive collaboration.

The shift to digital as result of the pandemic has led toa reduction of in-person events but also new collaborative modalities and opportunities to share learning and problem solve creatively. All of the partners considered that COVID-19 had provided an opportunity to consolidate collaboration in the design and delivery of health services and jointly face the ongoing challenges

Insights from projects: mPower

The move to virtual collaboration has been embraced and provided continued opportunities to share learning and problem solve creatively.

A singular example would be HSE's implementation of their 'Video Enabled Care' product Attend Anywhere. This was rolled out nationally at the start of the pandemic. 50% of the national eHealth team were mPower staff. The fast-tracked delivery was directly supported by Digital Health and Care colleagues in Scotland who were a few years ahead with this product.

There have been 16 project assemblies all focused on shared learning and shared problem solving. There's been a further 9 learning sessions on the ECHO platform which aligned the project to Northern Ireland's mandated collaboration platform.

When looking at the **impacts of these new ways of working**, they are dual, embracing both the beneficiary organisations, as well as the community as a whole which can now benefit from cross-border services not previously available.

Projects partners reported experiencing the following positive impacts:

- Sharing of knowledge expertise and resources allowing progress in certain health care topics (for instance the trauma informed practices) and increase in the clinical competence of practitioners.
- Better capacity to overcome cross-border obstacles (specifically resulting from the different legal and organisational frameworks of the different jurisdictions).
- Increased resilience of the relationships, particularly at a time of severe crisis such as the pandemic that put many core services of health facilities under significant additional pressure.
- Increased financial accountability thanks to the fixed costs of interventions which paved the way for organisations to expand their way of working and provide practitioners and managers with a clear and cost transparent view of health care initiatives.
- Increased sense of identity and understanding of cross-border work resulting in a willingness for future collaboration.

Insights from projects: *MACE*

From a Value for Money perspective and a financial accountability perspective, whilst MACE is only a small intervention budget compared to the annual multi million pound budgets that CAWT partners and Tusla spend on interventions, I think the fixed cost menu of interventions offers organisations a vehicle to progress and expand on this way of working to give a really clear and cost-transparent view to practitioners and managers alike, each time a vulnerable family is referred for a particular support (or range of supports).

The role of partnership was utmost to addressing health care challenges of the programme area and overcoming any related obstacles. Project partners reported in particular that communities can now:

- Avail of specific services in another jurisdiction rather than travelling longer distances.
- Count on a number of services in areas typically under-represented in public services (rural and peripheral areas).

- Rely on better clinical competence due to economies of scale resulting from combining population on a cross- border basis and achieving a critical mass.
- Receive higher quality services thanks to the increased awareness on specific health conditions and the available services.
- Demand health care in extended services areas and with the same level of support between countries.

Insights from projects: Need to Talk

Need to Talk project

With the partnership with Fighting Blindness in the Republic of Ireland with RNIB this has implemented delivery of services in the Republic of Ireland which was not there before and has impacted positively on people's lives. This has gone beyond the delivery of NTT outcomes. Beneficiaries living in cross-border areas are now receiving the same level of support both in the Republic of Ireland and Northern Ireland.

Table 12 New ways of working experienced by projects and related impacts

	New ways of working/partnerships/relationships reported	Cooperation impacts reported
Acute Services	• The establishment of the project's bodies (Project Board) allowed members to work collaboratively. • Working with Scotland is a new dimension for the CAWT partnership.	• Partnership as a decisive element to overcome obstacles • Keen interest to develop partnership further (in the framework of Peace Plus funding) based on the lessons jointly learned and shared learning • Patients can avail of specific services in another jurisdiction rather than travelling longer distances • Clinicians and doctors are providing services to a larger geographical area thus supporting the retention of services in more rural and peripheral areas • Retention of scarce clinical skills
Changing Lives	• The project formed positive working relationships with local agencies, service providers and stakeholders. • Harmonisation of protocols and practices between jurisdictions.	• The partnership has strengthened and will continue beyond the project. • Knowledge, expertise and resources sharing.
CHITIN		• Knowledge transfer on specific relevant topics (e.g. the Anticipatory care planning trial)
CoH-Sync	• Project management tool (Prince2) contributed to the maintenance of a productive and cohesive relationship among the Project Board members and to a shared responsibility for ensuring all challenges are resolved. • Working with Scotland is a new dimension for the CAWT partnership.	• Partnership as a decisive element to overcome obstacles. • The collaboration among partners delivered a successful project, which meets its outputs and beneficiary targets and has enhanced the health and well-being of citizens and communities. • Training, resources and expertise shared leading to upskilling. • Shared sense of identity and increased understanding of cross-border work. • Service delivery on cross-border basis as a new venture for providers.
iRecovery	• Project management tools (Prince2) contributed to the maintenance of a productive and cohesive relationship and to a shared responsibility for ensuring all challenges are resolved. • New collaboration with General Practitioners federations, schools and colleges.	• Partnership as a decisive element to overcome obstacles. • Strong commitment in collaborating even in severe crisis (critical points during the pandemic with the core services of health facilities being in crisis). • Shared sense of identity and increased understanding among those engaged in cross-border work.

	New ways of working/partnerships/relationships reported	Cooperation impacts reported
		• Enhanced mental health education/well-being services.
MACE	• Different pathway for accessing support services for families to ensure that beneficiaries were counted as per EU funding rules. • New data management approaches. • New system with suppliers to deal with the no attendance risk of vulnerable people to therapy sessions. • Shared learning from the MACE Trauma Informed assessment toolkit which was developed jointly by NI and RoI engagement in the process. • The Project Board meetings four times a year as a safe place for senior managers to explore issues.	• Sharing of local experiences and knowledge leading to fertilisation of ideas between the two jurisdictions. • Increased financial accountability thanks to the fixed cost menu of interventions. • Cross-border partnership as a decisive element to resolve issues (often the advice required to resolve an issue in one jurisdiction/organisation come from the other side of the border or another organisation). • Progress in the awareness of ACEs and the importance of trauma informed practice.
mPower	• Virtual collaboration allowed for shared learning and creative problem solving. • Cooperation with project partners from the Voluntary sector. • Project assemblies to share progress and develop ideas collaboratively.	• The effective collaboration allowed for technology transfer for health service delivery (i.e. Attend Anywhere, a secure NHS video call service for people with pre-arranged appointments only).
Need To Talk	• New partnership established engaging communities and the third sector, also with the support of famous testimonials to better reach out audience.	• The partnership allowed to extend the delivery area of services for blind people, ensuring they receive the same level of support both in NI and RoI.
iSimpathy	• Fertilisation of knowledge between pharmacists within primary and secondary care.	• Knowledge gaps filled.

2.4 EXTERNAL FACTORS

KEY FINDINGS

EQ 9: What are the external factors that have affected delivery under priority axis 4? How have projects adapted to these and what has been the overall impact of these factors?

The main barriers identified, as reported by projects and as emerging from recent literature and data, relate to the consequences of the COVID-19 pandemic. The cooperation context for projects profoundly changed since its outbreak which impacted upon nearly every aspect of daily life in the programme area, but particularly the social and economic dimensions. With vulnerable groups becoming harder to reach, social indicators (isolation, poverty, domestic abuse etc.) have sharply increased in the programme area, creating more demand for health and social care. In turn, this creates an increasing demand on health and social care budgets both in the UK and Ireland.

Nevertheless, some positive changes resulted from the pandemic. Projects reported a good capability to adapt to the new circumstances and the opportunity to re-design the way health care is provided to citizens, the importance of community empowerment and the upskilling of clinical competences. Interesting impacts can be observed in relation to community empowerment and the capacity of people to improve the wellbeing of citizens in their own communities.

Brexit, the main negative external factor as perceived by projects until 2020, remains a source of anxiety and concern, but only marginally.

2.4.1 External factors reported by projects

If until 2020 the main barriers reported by the projects had been those related to the Brexit process and the concerns about the future availability of funding, the outbreak of the COVID-19 pandemic became the key external factor affecting the socio-economic context of the programme area as whole in the subsequent period.

More specifically in relation to the intervention framework of PA 4, the pandemic has significantly affected healthcare services provision as well as the individual freedom of movement of people and goods (this at least in the very first phases of lockdowns and restrictions), creating new challenges in the delivery of such services. In fact, the evaluation undertaken in 2020 focusing on the impact of COVID-19 on PA4 projects, shed light on the main difficulties faced by projects: reaching target groups when physical meetings were no longer feasible due to health and safety concerns.
Nevertheless, partners began innovating and adapting their models of working from the very early stages of the pandemic to secure continued social care and health services across territories and proved remarkably adaptive and resilient in reacting to the emergency.
Lead partners in 2022 considered the pandemic as the main external factor influencing project implementation and delivery in this period. Consequences related to the overall socio-economic context of the programme territory (see table below) are both positive and negative. For instance, the pandemic exacerbated social exclusion, especially in remote and rural areas, but it also created new job opportunities resulting from the need to face the higher demand for health care services. In this sense, impacts on employment are controversial and require further longer-term investigation.

External factors have been analysed according to the following categories:

Social factors. COVID-19 has been reported to have increased the incidence of social isolation in communities (particularly in rural areas). Vulnerable groups, already more difficult to reach, have been the most adversely impacted , further increasing the demand for support. Social isolation directly affected

dimensions such as poverty, deprivation and unemployment. Another negative impact relates to an increase in domestic abuse.

However, the pandemic also provided an occasion to reform healthcare models and improve service provision benefitting communities. In this sense, projects firmly recognise the value of the financing opportunities offered by the programme to boost this positive change. Another positive aspect regards the increase in the use of online recruitment procedures and the new job opportunities resulting from the increase in demand for health-related services.

Social consequences of the pandemic

MACE project

'Covid 19 has been reported to have increased the incidence of domestic abuse in our communities which in turn is leading to an increase in the numbers of children and families being adversely impacted by Adverse Childhood Experiences (ACEs). Demand for therapeutic interventions greatly outweighs supply'.

Need to Talk project

'In hard-to-reach communities, counselling still has a stigma. Some parts of Scotland are still not connected via the internet, and this has made it harder to connect and offer services. This was particularly true of the Covid-19 pandemic when it was even harder to run an online group'.

Political factors. Specific health-related needs became particularly relevant in the past years, increasing political pressure to take action to face the new demand. This is particularly true for mental health and older people related needs.

Positive political factor

mPower project

'The politics across the partnerships moved to support the project's aims. Strategies published during the project's lifetime promoted older people's self-management and the notion of integrated care within a community setting and infrastructure'

Some concerns remain regarding the uncertainty and anxiety among population related to Brexit.

Economic factors. Demand and supply of healthcare are experiencing an expansion due to the pandemic, thus creating new economic conditions for the sector in general. Many projects reported that the change in delivery models and the use of new technologies required upskilling and levelling up of the competences. Interesting effects can be observed in relation to community empowerment and the capacity of people to improve the wellbeing of citizens in their own communities.

Beside the budget constraints for funding interventions, negative economic consequences are not strictly related to the pandemic. One project reported that changes in public services contracts led to time delays and an increase in the costs of service provision.

Negative economic external factors

MACE project

'Changes in contractual requirements for public service contracts such as the GDPR liability insurance, new mandatory risk impact assessment protocols for Cyber-attacks and Data protection impact assessments (NI only) prior to award of contracts are all adding additional time delays and in turn costs for implementing the MACE services.'

'The capped hourly rates mandated by public service salary rates have meant that many specialist therapists have not been attracted to provide services for MACE.'

Health related factors. As already mentioned under social factors, the pandemic provided the catalyst for a change in the design and delivery of health and social care services. Health related indicators are, however, of concern due to the incidence of certain diseases (obesity, smoking, alcohol, mental health etc…).

The table below summarises the external factors as perceived by project partners.

Table 13 External factors as perceived by projects

	Positive	Negative
Social factors	**Related to the pandemic:** • Opportunity to reform how healthcare is delivered to their citizens *(Acute, CoH-Sync, iRecovery)* • Increased community support with additional services *(Acute, CoH-Sync, iRecovery)* • Increase recruitment activities and employment opportunities thanks to online procedures *(CoH-Sync)*	**Related to the pandemic:** • Difficulties in establishing contact with vulnerable people and to grasp their needs *(mPower, Need to talk)* • Poverty / deprivation / unemployment *(Acute, CoH-Sync, iRecovery)* • Social isolation in rural areas distant from economic centres *(Acute, CoH-Sync, iRecovery, MACE)* • Dependence upon public transport / lack of affordable transport *(Acute, CoH-Sync, iRecovery)* • Increase in the domestic abuse *(MACE)*
Political factors	**Not pandemic-related** • Increased political commitment towards specific topics (self-management for older people, mental health etc…) *(Changing life, mPower)*	**Not pandemic-related** • Continued uncertainty and anxiety among population related to Brexit *(Acute, CoH-Sync, mPower)*
Economic factors	**Pandemic-related:** • Upskilling *(iRecovery, CoH-Sync, Acute)* • Creation of additional employment *(Need to talk, Acute)* • Increase in services available locally *(Acute, CoH-Sync)* • Community empowerment *(CoH-Sync)*	**Pandemic-related:** • Limited budget to fund interventions *(Changing lives)* • Difficulties in recruiting staff (seasonal staff and capped hourly rate for public service salary) *MACE)* **Not pandemic-related** • Changes in contractual requirements for public services *(MACE)*

	Positive	Negative
Health-related factors	**Pandemic-related:** • Rebuilding health and social care services in the aftermath of Covid-19 *(Acute, CoH-Sync, iRecovery)* • Ever increasing demand of Health/Social care budgets *(Acute)*	**Pandemic-related:** • Ageing population – increases in chronic disease / long term conditions and more demand for services *(Acute)* • Rising obesity rates *(Acute)* • Impact of smoking, alcohol misuse and physical inactivity in socially deprived areas. *(Acute)* • Pressure on mental health services. *(iRecovery)*

2.4.2 Identification of additional external factors

Identification of additional external factors, as emerging from the intervention logic analysis and the literature review

In February 2019, as part of the Impact Evaluation, the Evaluation Team performed an analysis of the projects' characteristics and structure in order to identify which external factors unrelated to Brexit might create additional barriers to their implementation.

The analysis started from the (re-) development of problem trees[9] by the Evaluation team, describing the project logic (problem addressed, objectives and activities) which were sent for validation to the eight project managers. The creation of trees was instrumental to formalise each project-specific intervention logic especially in terms of primary challenges addressed. In this respect, we found that, despite using slightly different formulations, the eight projects could be grouped in subgroups, according to the primary challenges, which are: 1) Improving access to care; 2) Improving patients' empowerment/self-management; 3) Improving lives of people with chronic/long-lasting health conditions; 4) Reducing social isolation of users.

Following this step, a literature review was performed to identify the most comprehensive and widely accepted theoretical models describing the determinants and explanatory variables of each of the four primary challenges identified. The four chosen models are described below.

1. *Access to care.* The conceptual framework proposed by Aday & Andersen[10] supports the identification of external factors which can affect access to care. According to this model the utilization of health care is influenced by factors such as: "*health policy*", "*characteristics of the population at risk*", "*characteristics of the delivery system*", and "*consumer satisfaction*".

2. *Empowerment and self-management of patients. T*he conceptual framework proposed by Bravo et al. (2015)[11] was identified. Empowerment and self-management of patients are affected by the following key elements: the "*patient level characteristics*", those of the "*health care provider*" and of the "*health care system overall*". Whilst the level of patient empowerment can be improved by specific health care intervention, this improvement is moderated by several other variables such as the health care provider's personal characteristics, the patient's context, personal characteristics, values, social support as well as the circumstances of their disease (e.g. duration, severity) and, of course, the political context (for example the UK withdrawal from the EU).

3. *Quality of life of people with chronic/long-lasting conditions. T*he conceptual framework created by the World Health Organization and the McColl Institute for Health care Innovation[12] was identified, which provides a comprehensive overview of the factors affecting lives of people with chronic/long-lasting conditions. In addition to genetics, interacting risk factors identified by the model are the "*policy environment*", "*community*", "*health care organization*".

4. *Social inequalities and isolation. T*he conceptual framework theorised by Berkman et al.[13] shows that individuals health is influenced by: "*psychosocial mechanisms*" (micro level, i.e. social support, social influence, social engagement, person-to-person contact and access to resources and material goods), "*social networks*" (mezzo level, i.e. social network structure and characteristics of network ties) and "*social-*

[9] Problem trees are project-level logic models. The Problem Tree method was used to distinguish the causes and effects of the challenges addressed by each project.
[10] Aday, L. A., & Andersen, R. (1974). A framework for the study of access to medical care. *Health services research*, *9*(3), 208.
[11] Bravo, P. et al. (2015). Conceptualising patient empowerment: a mixed methods study. *BMC Health Services Research*, 15:252.
[12] Epping-Jordan JA (2002). Innovative care for chronic conditions: Building Block for actions: Global report. *WHO Library Cataloguing-in-Publication Data*
[13] Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. E. (2000). From social integration to health: Durkheim in the new millennium☆. *Social science & medicine*, *51*(6), 843-857.

structural conditions" (macro level, i.e. culture, socioeconomic factors, politics and social change). All these factors affect micro-psychosocial and behavioural processes, which in turn have a strong effect on pathways closely linked to health status including (1) health damaging (e.g. smoking, alcohol consumption) or promoting (e.g. healthy diet, exercise) behaviours, (2) mental wellbeing (e.g. self-esteem, depression), (3) physiologic agents (exposure to infectious disease agents such as HIV, or tuberculosis).

The table below summarises the results of this activity. By using the four models mentioned above we were able to define a shortlist of relevant external factors to be considered while monitoring project execution (for more details on this activity, please see the Impact Evaluation Report released in February 2019) and for each factor we tried to retrieve specific indicators from official sources.

Table 14. Challenges addressed by projects (Table readapted from the first Impact Evaluation Report, 2019).

Project	Challenge addressed by the project	Primary Challenge	Explanatory model used for identification of external factors	External factors of interest
Acute Services	"Difficulties to cope with the rising demand for scheduled and unscheduled cross-border care in the programme areas"	1. Improving access to care	Aday & Andersen (1974)[14]	External factors related to the general trends in the following domains: - health and social care policy; - characteristics of the health delivery system - characteristics of the population at risk - consumer satisfaction
MACE	"Children/families with multiple Adverse Childhood Experiences (MACE) are a group receiving low preventive support and are at risk of severe adverse outcomes"			
CHITIN	"Inequality of access to opportunity for involvement in health intervention research in a setting most appropriate to need"			
iRecovery	"People with lived experience of mental health difficulties rely heavily on statutory health services for medical/clinical support and often struggle to effectively self-manage their condition"	2. Improving patients' empowerment/self-management	Bravo et al. (2015)[15]	External factors related to the general trends in the following domains: - Patient context, personal values and characteristics - Healthcare provider characteristics - Healthcare system characteristics
Changing lives	"Vulnerability of ADHD children and their families in the project areas"	3. Improving lives of people with chronic/long-lasting health conditions	Epping-Jordan JA (2002). [16]	External factors related to the general trends in the following domains: - Policy environment - Community - Healthcare
CoH-Sync	"People living in border areas of the INTERREG VA eligible area are affected to a greater degree by known risk factors			

[14] Aday, L. A., & Andersen, R. (1974). A framework for the study of access to medical care. *Health services research*, *9*(3), 208.
[15] Bravo, P. et al. (2015). Conceptualising patient empowerment: a mixed methods study. *BMC Health Services Research*, 15:252.
[16] Epping-Jordan JA (2002). Innovative care for chronic conditions: Building Block for actions: Global report. WHO Library Cataloguing-in-Publication Data

Project	Challenge addressed by the project	Primary Challenge	Explanatory model used for identification of external factors	External factors of interest
	for some long-term conditions (chronic disease)"			organization
mPower	"Isolation of older population from their local communities"	4. Reducing social isolation of users	Berkman et al (2000)[17]	External factors related to the general trends in the following domains: - Social structural conditions - Social networks - Psychosocial mechanisms
Need to talk	"Social isolation of people affected by sight loss"			

The analysis incorporated official comparable statistics from Eurostat but also integrated data coming from the most recent literature in order to grasp the most up-to-date trends connected with the Covid crisis. Details for each specific indicator or available sources are included in Annex 2.

Interestingly, whilst a consistency in the trends of some indicators already identified three years ago was observed (e.g. availability of healthcare facilities, staff, GDP growth, social care expenditures), the Covid-19 outbreak and the related countermeasures (e.g. quarantines, limitation of freedom to move, closure of sports clubs, etc.) seemed to have impacted significantly in some domains. The analysis of the trends revealed two relevant issues:

- an inversion in previously positive trends related to 'people at risk of poverty', which was once decreasing in the programme areas but started to increase again in 2020; and
- an acceleration of the negative ongoing trends related to unhealthy lifestyles, such as smoking and alcohol consumption.

These trends are indeed relevant to understand the sustainability of project results in the future but can also support the interpretation of current results.

= official statistics indicating an increase of the indicator (which is associated to a positive impact for society	= lack of official statistics, but availability of preliminary research data indicating a negative trend of the indicator.
= official statistics indicating a decrease of the indicator (which is associated to a negative impact for society)	= Trend related to the Republic of Ireland
= official statistics indicating an increase of the indicator (which is associated to a negative impact for society)	= Trend related to the UK
= stability of the indicator	

[17] Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. E. (2000). From social integration to health: Durkheim in the new millennium☆. Social science & medicine, 51(6), 843-857.

Table 15. Potential external factors and related indicators.

Primary Challenge	**1. Access/use of health care**				**2. Empowerment/Self-management**		
Projects	**Acute Care, MACE, CHITIN**				**iRecovery**		
Components of the Conceptual Framework(s) / Indicators retrieved from Eurostat	*Healthcare policy*	*Characteristics of the health delivery system*	*Characteristics of population at risk*	*Consumer satisfaction*	*Patient context, personal values, characteristics*	*Healthcare provider characteristics*	*Healthcare system characteristics*
BMI			IE ↑ UK ↑		IE ↑ UK ↑		
DRINKING			⚠		⚠		
SMOKING			(=)		(=)		
DAILY CONSUMPTION OF FRUIT AND VEGETABLES			(=)		(=)		
PHYSICAL ACTIVITY			⚠		⚠		
SELF PERCEIVED HEALTH			IE ↑ UK ↓		IE ↑ UK ↓		
GDP	IE ↑ UK ↓						IE ↑ UK ↓
HEALTHCARE EXPENDITURE	IE ↑ UK ↓						IE ↑ UK ↓
EXPENDITURE ON SOCIAL PROTECTION	IE ↑ UK ↓						IE ↑ UK ↓
HEALTH PERSONNEL		↑				↑	
HOSPITAL BEDS		IE ↑ UK ↓				IE ↑ UK ↓	
LONG TERM CARE BEDS		IE ↑ UK ↓				IE ↑ UK ↓	
LIFE EXPECTANCY			↑		↑		
HEALTHY LIFE YEARS			IE ↑ UK ↓		IE ↑ UK ↓		
RISK OF POVERTY AND SOCIAL EXCLUSION			⚠		⚠		
LONG TERM ILLNESS			IE ↓ UK ↑		IE ↓ UK ↑		
UNMET HEALTHCARE NEEDS			↑		↑		
POPULATION 65+			↑		↑		

Primary Challenge	**3. Chronic/long-lasting conditions**			**4. Social isolation**		
Projects	**Changing lives; CoH-Sync**			**mPower; Need to talk**		
Components of the Conceptual Framework(s) / Indicators retrieved from Eurostat	*Policy environment*	*Community*	*Healthcare organization*	*Social structural conditions*	*Social networks*	*Psychosocial mechanisms*
BMI						
DRINKING						
SMOKING						
DAILY CONSUMPTION OF FRUIT AND VEGETABLES						
PHYSICAL ACTIVITY						
SELF PERCEIVED HEALTH						
GDP						
HEALTHCARE EXPENDITURE						
EXPENDITURE ON SOCIAL PROTECTION						
HEALTH PERSONNEL						
HOSPITAL BEDS						
LONG TERM CARE BEDS						
RISK OF POVERTY AND SOCIAL EXCLUSION						
LONG TERM ILLNESS						
UNMET HEALTHCARE NEEDS						
POPULATION 65+						

Conclusions

- ➔ The cross-border interventions have generated tangible impacts in the programme area in a wide range of health and social care sub-fields, not only in the general improvement of the access to care, but also in e.g. patients' empowerment and self-management and in the reduction of isolation of specific vulnerable groups. A key aspect worth underlining is the increase, extension and improvement of services delivered locally at community level, providing access to care that is more tailormade and much closer to citizens and alleviating pressure from hospitals.
- ➔ The programme is largely perceived by beneficiaries as key to ensure the success of cross-border interventions in the health and social care sector. The continuation of the health and social care strand under Peace Plus is very positively welcomed and a high interest in the opportunities provided by the new programme should be expected.
- ➔ Cross-border partnerships have been considered an enabling factor to face the health and social care challenges in the programme area. The evaluations undertaken in the past years have collected evidence confirming their capacity to enhance historical collaborative relationships as well as to address the new needs resulting from the pandemic. Despite the challenging circumstances, project partners were not only able to secure their outputs but also to respond to the emergency and increase social solidarity and community efforts.
- ➔ External factors influencing cooperation and the programme contribution to change are, in recent years, overwhelmingly related to the pandemic. It has significantly affected healthcare service provision as well as the individual freedom of movement of people and goods creating new challenges in the delivery of such services.
- ➔ The increasing demands of health and social care, a result of e.g. increasing social isolation, poverty, unemployment etc. related to the pandemic, entail great attention and relevance will continue to be given to the programme by actors interested in cooperating across borders also in the 2021-2027 programming period.

3 SUSTAINABILITY AND MAINSTREAMING

KEY FINDINGS

EQ 10: What level of mainstreaming has occurred for cross-border delivery of health services?

The mainstreaming of health and social care services stemming from the financed projects is still quite limited. In many cases, mainstreaming strategies and activities are yet to be thoroughly decided and implemented. The majority of projects have declared that efforts to mainstream activities are still under discussion by project partners and depend to a large degree on the outcome of internal project evaluations which will determine and the extent to which project activity could be mainstreamed nationally or locally in the involved jurisdictions. At the same time, mainstreaming of services implemented or tested in the cross-border projects has tended to occur at the level of a single jurisdiction, rather than being mainstreamed at a cross-border level. In other words, the cross-border aspect of the projects has been crucial to design and implement new services but has not always ensured cross-border service delivery after project completion.

EQ 11: What type of support is required for mainstreaming project activities at risk of interruption after the end of the projects?

The availability of Interreg funding for the evaluation of services implemented by projects and to ensure the mainstreaming efforts undertaken by projects is key to support cross-border project activity. Most projects have underlined the importance of devoting resources to the evaluation of the success and impact of newly created services to understand which strands of activities and services are worth mainstreaming. The time gap between the end of project implementation under one programme (i.e. Interreg V-A) and the operational start of the new programme (i.e. Peace Plus) represents a risk for those projects which rely on Interreg funding and which might lose momentum to mainstream or upscale their activities when funding ceases.

RECOMMENDATIONS

- ➔ Dedicated funding towards the end of the programming period (i.e. through specific calls) could be envisaged to allow advanced and finalised projects to receive additional resources to mainstream activities, provided there is enough time and depending on the overall priorities of the programme.
- ➔ Make potential applicants aware that part of the project budget can be devoted to the project evaluation of the effectiveness, results and impacts of delivered interventions to better understand which strands of activities and services are worth mainstreaming, to which extent and in which areas.

The contribution to change of the programme's cross-border health and social care interventions have been assessed against the concrete actions taken by the financed projects to sustain and mainstream the achieved results beyond the projects' duration. Furthermore, potential drivers and obstacles to sustainability and mainstreaming have been investigated.

Although most projects are at an advanced stage in project implementation, the added value of activities undertaken and the ability of each project to mainstream the cross-border frameworks and services created are still difficult to evaluate. In many cases, mainstreaming strategies and activities are yet to be thoroughly decided and implemented. Nonetheless, through the inclusion of a specific set of questions in the e-mail questionnaires and in case study interviews it was possible to gather first-hand experiences and practices of projects with regard to sustainability and mainstreaming actions as well as their respective drivers and obstacles.

3.1 SUSTAINABILITY

Several projects aim to ensure the sustainability of their interventions through building knowledge and skills (i.e. undertaking training activities) among health care providers' staff and the community and by developing tools (e.g. e-portals, apps) which can allow access to continued support beyond the project duration. Moreover, as several project leaders have reported, sustainability as well as mainstreaming strictly depend on the capacity of the project to provide robust evidence on its positive impact on the lives of people, i.e. through tailormade project evaluations.

Cross-cutting factors which risk hampering project sustainability are the uncertainty related to the availability of funding at department or government level in times of budget cuts in the health and social care sector. Furthermore, the Changing Lives projects cites the "inability to retain scarce clinical skills, particular in the border region" as an obstacle.

New technologies may provide opportunities to deliver services beyond the projects' duration. Alternative service delivery methods have been explored as a result of COVID-19 and the fast shift to digital delivery of certain services, enabling projects to test methods not initially foreseen and having the potential of reducing costs and ensuring sustainability in the long term.

The table below provides a summary of the project responses regarding sustainability, based on the e-mail questionnaire replies.

Table 16 Sustainability actions and hindering/facilitating factors

	Actions planned or implemented to ensure sustainability of project initiatives	Hindering or facilitating factors for sustainability
Acute Services	Project partners to determine what aspects of the project can be continued and where funding can be sourced to facilitate this. The CAWT development centre works extensively to secure EU funding, individual partners explore alternative funding opportunities. Partners are now looking into securing funding with the respective Departments of Health to expand some strands of activity. Partners will seek to integrate project learning and experiences into health and well-being planning and delivery.	Inability to retain the scarce clinical skills in the Border area. Availability of funding.
Changing Lives	Funding was sought and secured to continue the partnership to push towards sustainability and mainstreaming of intervention.	Key facilitating factor is the continuation of the partnership to push progress towards sustainability / mainstreaming.
CoH-Sync	Project partners to determine what aspect of the project can be continued and where funding can be sourced to facilitate sustainability. Partners will seek to integrate project learning and experiences into health and well-being planning and delivery.	Availability of funding.

	Actions planned or implemented to ensure sustainability of project initiatives	Hindering or facilitating factors for sustainability
iRecovery	Key decision-makers are being regularly engaged to support the project´s sustainability efforts. Next steps are currently under discussion at Project Board level and within individual project partner organisations.	
iSIMPATHY	Planned review process to ensure activities can be delivered in all healthcare settings.	Ensure the process can be undertaken in a cost-effective way.
MACE	Some limited evaluation activities and feedback from a range of stakeholders.	Often decisions on mainstreaming depend on the outcomes of objective and independent evaluations, but this will not be possible until near the end of the project when it will be too late to source the core funds required, should evaluation indicate that it is recommended.
mPower	The Community Navigator role will be adopted, to a degree, by some partners. The establishment of Community Digital Hubs across almost all the partners is a lasting resource.	Time. Some of the benefits of the project will not be realised until significantly later than the end of the project.
Need to Talk	Legacy issues are under discussion. The e-programmes developed by the project will be sustainable beyond 2021.	Lack of support from local area referral pathways
ONSIDE	Looking into “bridge funding” opportunities to sustain project activities and not lose momentum while waiting for new Peace Plus opportunities.	Interruption of funding.

3.2 MAINSTREAMING

According to the analysis of e-mail questionnaire and case study responses, the mainstreaming of health and social care services stemming from the financed projects has occurred for some projects but is still at an early stage of planning for most others. The majority of projects have declared that efforts to mainstream activities are still under discussion by project partners and significantly depend on the outcome of internal project evaluations which will determine if and which of the project strands of activities have had an impact and could be mainstreamed nationally or locally in the involved jurisdictions. At the same time, mainstreaming has mostly occurred individually in jurisdictions based on services implemented or tested in the cross-border projects, rather than being mainstreamed on a cross-border level. In other words, the cross-border dimension of the projects has been crucial to design and implement the new services, but it did not ensure their cross-border delivery after project completion.

The existence of a project evaluation plan and dedicated resources has often been cited as an essential element to assess if and which project strands of intervention have been successful and can be mainstreamed.

Insights from case studies

Changing Lives

The three types of evaluation which were included as a project activity in the business plan from the outset provided the evidence needed to support the scaling up of the project. The end goal is to turn the initiative into an ongoing intervention, with more families receiving early support and intervention, not only in the current project locations but extend it to all families that require it across the Republic of Ireland, Northern Ireland and Scotland.

Coh-Sync

The project was not designed with mainstreaming in mind, but thanks to the data collected via the Data Collection and Reporting System and the analysis based on that, it will be possible to understand what can be mainstreamed and which activities from CoH Sync can be incorporated into ongoing project and plans. The process of mainstreaming the project is however complicated by the lack of an internal evaluation. An internal evaluation was included during the final stages of the project, but partners believe that it is not enough for an effective analysis.

The strong engagement of key stakeholders (e.g. local health care providers, community) and the harmonisation of processes across the programme area are also mentioned as key factors to ensure the mainstreaming of cross-border interventions i.e. to transform project activities into core services delivered across the programme area on a cross-border basis.

In addition, communication activities (conferences, awareness raising events, social media etc.) are usually cited as a means of keeping stakeholders updated on the projects' progress and to increase the potential for transferability/mainstreaming. All CAWT partnerships, for example, have their own communication strategy according to which each project systematically updates and presents the progress made to government representatives and health and social care commissioners.

The box below presents some relevant examples of mainstreaming as reported by projects.

Insights from case studies

Acute Services

The main project achievement that has already been mainstreamed is the Community Paramedic Service. It was designed to reduce the number of people who need to visit Accident & Emergency (A&E) Departments and provide specialist training to ambulance staff and paramedics based in Northern Ireland, Ireland and Western Scotland to become Community Paramedics. This specialised training has been developed in partnership with Glasgow Caledonian University. The cardiac service has been mainstreamed as well and there are discussions around the dermatology strand, while urology and vascular services will likely be mainstreamed in Letterkenny Hospital (RoI). The Clinical Division Unit was also mainstreamed and upscaled and new pathways were formally adopted.

mPower

The Community Navigator role is being adopted to differing degrees and according to local needs in Scotland and RoI. Equally some partners have established national and regional digital leads to identify and support the adoption of digital approaches for citizens. The Digital Community Hub will be a key legacy of the project and will be further explored. The use of the Attend Anywhere platform was introduced to the HSE throughout the Irish Health Service via the mPower Project. The service is now widely accessed across HSE for health and care appointments: offering a secure web-based platform that supports health care providers to offer video call access to their clients as part of their 'business as usual', day-to-day operations.

Need to Talk

In the Republic of Ireland our partner has now mainstreamed the counselling and Living Well With Sight Loss courses which means everyone with a sight loss condition living in RoI can receive support. The project leader RNIB has used the learning from the project to adapt their counselling and Living Well with Sight Loss Courses.

Obstacles to mainstreaming mostly stem from three different causes:

1) The lack of financial resources within the project;
2) The absence of a thorough project evaluation;
3) The different models of services delivery existing in the three jurisdictions which entail different approaches to mainstreaming and differing prioritisation of services according to the broader health and social care policies in place.

Insights from case studies

Acute Services

Challenges and difficulties to sustainability and mainstreaming are linked to the pilots within each respective organisation and the process to secure funding to sustain these elements beyond project duration. Interreg funding is crucial to continue and upscale any strand of this project on a cross-border basis and the new opportunity provided by Peace Plus will be key.

The table below summarises the actions and hindering or facilitating factors for mainstreaming according to the replies to the e-mail questionnaire.

Table 17 Mainstreaming actions and hindering/facilitating factors

	Actions planned or implemented to ensure mainstreaming of project initiatives	Hindering or facilitating factors for mainstreaming
Acute Services	The evaluation will support decision-making relating to continuation of project strands (in part or in full) and mainstream decision-making. Communication on the project learnings and experience to key stakeholders, policymakers and funders.	Evaluation of activities as a facilitating factor.
Changing Lives	Three large scale evaluations were built into the project plan and successfully delivered.	It was important for the project to gather evidence to support mainstreaming of interventions.
CoH-Sync	Detailed data analysis to support decision-making relating to continuation of project (in part or in full) and mainstreaming. To communicate the project learning and experience to key stakeholders and funders.	Evaluation/detailed data analysis as a facilitating factor. End of Project event.
iRecovery	Communication activities through traditional and new media. Next steps are currently under discussion at Project Board level and within individual project partner organisations.	Lack of resources to fund an in-depth project evaluation to assess the impact.
iSIMPATHY	Tools have been shared. Plan for board members to share through wider networks the work that is being done as well as through the iSIMPATHY website.	Tools have been made available and other regions will have access to these and training which is accredited by professionals bodies which will encourage it.
MACE	Some limited evaluation activities and feedback from a range of stakeholders.	Outcomes of evaluation activities will influence level of transferability.
Need to Talk	Engagement of local organisations for embedding the project model of intervention into the existing care pathways. The process of harmonization of the process is meant to support future mainstreaming.	Slow development of referral practices in some rural areas.
ONSIDE	Intellectual resources will remain available post-project and open to the public.	

The availability of Interreg funding for the evaluation of services implemented by projects and to ensure the mainstreaming efforts undertaken by projects is considered key to support cross-border projects activities. Most projects have underlined the importance of also devoting resources to the evaluation of the success and impact of newly created services to understand which strands of activities and services are worth mainstreaming. In addition, dedicated funding towards the end of the programming period (i.e. through specific calls) could be envisaged to allow advanced and finalised projects to receive additional resources for mainstreaming activities.

The time gap between the end of project implementation under one programme (i.e. Interreg V-A) and the operational start of the new programme (i.e. Peace Plus) was flagged as a risk for those projects which rely on Interreg funding and which might lose momentum to mainstream or upscale their activities when funding ceases.

Looking to potential future funding opportunities, all projects have expressed their interest in applying to the new Peace Plus programme 2021-2027 to continue or upscale at least part of the activities launched with Interreg V-A funding. For some projects, Interreg funding is considered essential in terms of resources and the creation of a cross-border framework for partnerships and activities.

Insights from case studies

mPower

In terms of resources needed, additional funding is welcome, especially now with the healthcare sector coming out exhausted both from a resource and mental point of view after the COVID-19 crisis. Partners are seeking funding opportunities within PEACE PLUS in the next programming period, but also from national funding (e.g. Connecting Scotland).

CAWT-led projects

In general, mobilising other types of funds is not possible for CAWT, due to its legal status as cross-border partnership, but each partner such as HSE Republic of Ireland, Southern Trust and the Public Health Agency can take the learning and see how they can mainstream project activities within their own jurisdiction, by pursuing other fundings.

Regarding the opportunities provided by Peace Plus, numerous project ideas are already being developed and through these projects they will be able to tackle the already critical situation in the healthcare services, which was exacerbated by COVID-19.

A strategic direction of Peace Plus projects to be presented by CAWT will aim towards integrated care and community services, as well as early intervention and prevention to alleviate pressure from hospitals. The aim is also to establish different pathways to access healthcare in the border region.

Changing Lives

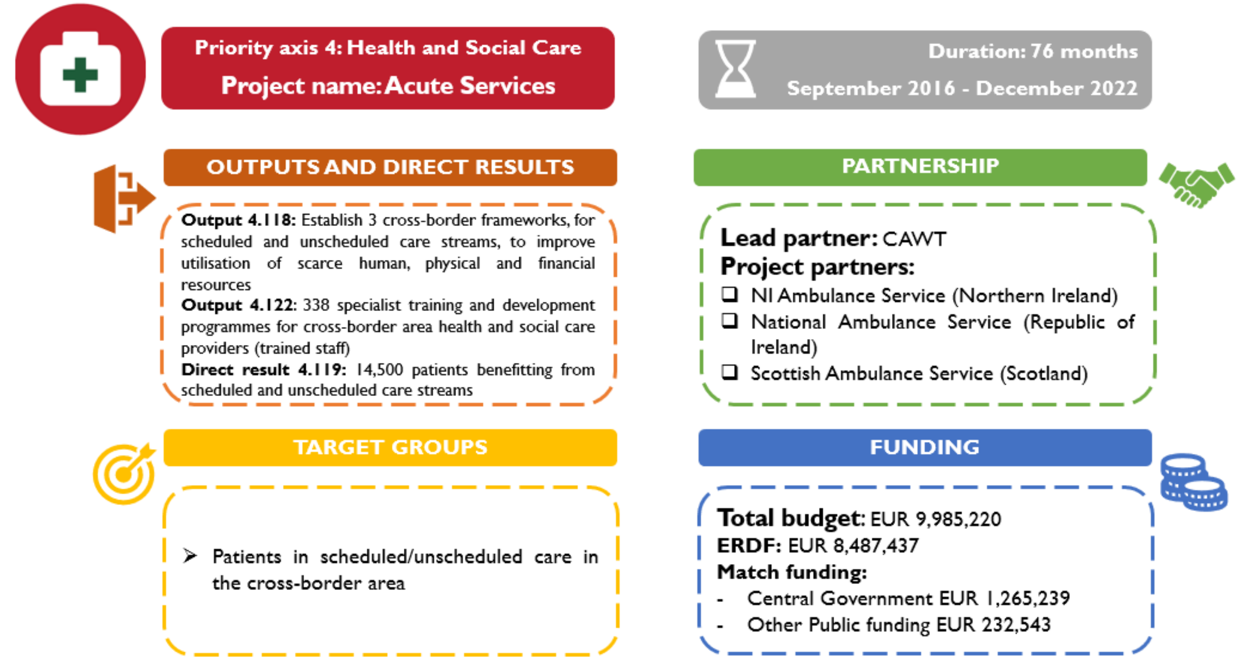
Financial requirements are tight, especially for community voluntary organisations which find it difficult to access the funds if they do not have accounts in order. Allowing for more flexibility for this type of partners would be helpful, given the advantages they have from working on the ground.

Conclusions

- ➔ Several projects aim to ensure the sustainability of their interventions through building knowledge and skills (i.e. training) among health care providers' staff and the community and by developing tools which can allow access to continued support beyond the project duration. Cross-cutting factors which risk hampering project sustainability are the uncertainty related to the availability of funding at department or government level in times of budget cuts in the health and social care sector.
- ➔ Although most projects are at an advanced stage in project implementation, the added value of activities undertaken and the ability of each project to mainstream the cross-border frameworks and services created are still difficult to evaluate. In many cases, mainstreaming strategies and activities are yet to be thoroughly decided and implemented. The existence of a project evaluation plan and dedicated resources have often been cited as essential elements to assess if and which project strands of intervention have been successful and can be mainstreamed.
- ➔ Mainstreaming has mostly occurred individually in jurisdictions based on services implemented or tested in the cross-border projects, rather than being mainstreamed on a cross-border level. In other words, the cross-border dimension of the projects has been crucial to design and implement the new services, but it did not ensure their cross-border delivery after project completion.
- ➔ Obstacles to mainstreaming mostly stem from three different causes: lack of financial resources, absence of a thorough project evaluation, and different models of service delivery existing in the three jurisdictions which entail different approaches to mainstreaming.

Annex I – Case study reports

ACUTE SERVICES



Project description

The Acute Services project idea emerged from recognition of the fact that the three jurisdictions face the same difficulties and challenges in terms of health care: resources, waiting lists, service provision in the context of an ageing population, rising obesity rates, and the impact of smoking, alcohol misuse and physical inactivity in socially deprived areas. These all lead to increasing demand for pre-hospital/acute services which alongside staff and skill shortages put a strain on acute hospitals, many of which lack the skills and infrastructure to cope with increasing patient numbers. It is even more difficult for people living in rural border areas, who need to travel long distances or to another jurisdiction to access services. The project aims to assess and treat higher volumes of patients more effectively at local level before they go to an acute hospital, both in scheduled and unscheduled care pathways through improved / reformed service delivery models on a cross-border basis. Scheduled care services include dermatology, urology, general surgery and vascular specialties, while unscheduled ones are cardiac and geriatric. Moreover, 5 different areas within unscheduled care have been explored: Community Paramedics, Community Cardiac Investigations, Reform of A&E/ED, Direct Access Unit/Clinical Decision Unit and Community Respiratory services. The Community Paramedic service was established incorporating the Northern Ireland Ambulance Service, Scottish Ambulance Service and Ireland's National Ambulance Service.

Project implementation

The project intended to address two programme specific outputs, namely:
4.118 - Establish 4 cross-border frameworks, for scheduled and unscheduled care streams, to improve utilisation of scarce human, physical and financial resources
4.119 - 15,000 Patients benefitting from scheduled and unscheduled care streams (including utilisation of e-health e.g., patient records and support services)

4.122 - 338 specialist training and development programmes for cross-border area health and social care providers (Staff Trained).
The project outputs achieved so far are the following:

Output	4.119 target (n. of patients)	Achieved
Framework 1 - Reform and modernisation of the management of unscheduled care - achieved.	8,000	**10,442**
Framework 2 – Reform and modernise outpatient services and supporting diagnostic relocation to outpatient settings for procedures currently preformed in day theatre settings where appropriate. – achieved.	5,000	**4,339**
Framework 3 – Reform, modernise and deliver minor/ intermediate/ major operations and procedures across a range of surgical specialisms, utilising day-case/endoscopy/main theatre facilities to maximum efficiency. – achieved.	2,000	**1,766**
Health and social care providers receiving specialised training and development.	338	**719**

The project has been granted an extension and will finish in December 2022. In particular, some areas such as vascular and urology required an extension due to a delayed start, with the project only receiving its final Letter of Offer in July 2017. After these delays, other issues further slowed project implementation. For example, procurement was particularly cumbersome in terms of agreements and documentation needed for verification and audit, but the CAWT Programme Manager enabled an agreement allowing for the purchase of equipment from existing NI frameworks. Procurement was further affected by COVID-19 as resources had to be diverted to other areas to face the crisis. Moreover, GDPR data sharing agreements between SEUPB and contracted companies took a substantial amount of time and effort to establish.

The project also experienced some difficulties in the recruitment or redeployment of clinical/professional staff (the latter as a result of the pandemic e.g. the hired Respiratory Consultant). The CAWT Development Centre and Project Manager monitored the impact of COVID-19 on the project and subsequently submitted a request to extend or change those strands of the project that had been impacted.

Moreover, project activities were further hampered by the three jurisdictions different structures and legislation in terms of healthcare. Demonstrating compliance with the range of requirements, to simultaneously meet both national health services and EU funders requirements was particularly challenging. The guidance and expertise of the CAWT Development Centre team proved fundamental in navigating the numerous requirements (e.g. Project Management, Procurement and Contract management, HR, Finance and Communications) demanded by the EU funders and the range of partner organisations involved.

Taking everything into consideration, all these challenges did not substantially change the project planning. The partnership did not experience any significant difficulties, partners have worked collaboratively to ensure that any obstacles can be overcome and ensure a positive outcome for project delivery. The Project Board members have significant cross-border experience and a keen interest to develop their partnership further through lessons learned and shared learning.

Results and impact

The project had an impact on acute service delivery with clear positive feedback from individuals who participated. The paramedic service, in particular, exceeded project expectations and helped lift pressure from the emergency services departments thanks to its complementary activity. Community Paramedics are highly trained Ambulance staff who have undergone further specialised training accredited by Glasgow Caledonian University which enabled them to see and treat patients in their communities and their own homes, thus significantly reducing the quantity of people that would have been transported to busy hospital emergency departments, and, in some instances, admitted to hospital. This approach is also helping to alleviate pressure on the front-line ambulances in the programme area.

The Clinical Decision Unit (CDU) was beneficial as it allowed several new patient pathways to be explored and implemented to reduce hospital admissions, when appropriate, and to treat patients at home or in the

community. This has alleviated some of the distress that was prevalent during the COVID-19 surges with people less keen on going to the hospital and more reliant on health services delivered locally.

The learning aspect of the project was also pivotal for knowledge sharing and the building of relationships among professionals. As part of the dermatology strand, Scottish dermatology nurses have been collaborating with dermatology nurses in Northern Ireland and the Republic of Ireland to devise appropriate training and education through a cross-border electronic system that will be applied in all 3 regions.

External factors

COVID-19

Although health care services were directly affected by the emergency, the project was able to deliver throughout the pandemic, despite delays due to periods when they could not procure or deliver the expected services (i.e. lockdowns) and when the staff which was temporarily redirected to frontline services. In fact, compared to other fields, specialists and practitioners in the health sector were allowed to carry out activities despite some changes in modalities and the use of Personal Protective Equipment (PPE). The impact on the project was therefore considered manageable due to the nature of the project and the extension granted.

Nevertheless, unlike other projects, Acute Services could not entirely shift to an online delivery due to staff redeployments and the inability to deliver some training events online due to the nature of specialty. On the positive side however, unscheduled care elements were enhanced during the COVID 19 pandemic. During this time the services provided by, for example, the Community Paramedic strand and the Clinical Decision Unit (CDU)/ Direct Access Unit (DAU) strand allowed patients to be treated using new pathways and preventing admission to hospital while also alleviating pressures on A&E and GP services.

Brexit

Brexit did not really have an impact on the project itself, but more on project partners' mindset given the uncertainty regarding recruitment and the securing of funding. Individuals applying for the role of specialists were concerned about the actual continuity of their job. Some other issues were related to GDPR and data sharing regulations. As the CAWT partnership has been cooperating at a cross-border level for 30 years with all the key players engaged and health and social care activity is driven by the needs of the region and its health priorities the work continued and issues emerging in this context were resolved.

Cross-border added value

The benefits resulting from cross-border cooperation are several. Health services are national legal entities which would be unlikely to work together without Interreg funding, especially in this same volume and numbers. However, thanks to cross-border funding opportunities, the eligible area was able to carry out changes in delivery of healthcare services, enhancing services to enable people living within the border regions to avail of specific services in another jurisdiction rather than travelling longer distances.

Another added value is that clinicians and doctors are providing services to a larger geographical area, thus supporting the retention of services in rural and peripheral areas or even the establishment of some types of services which would otherwise unlikely be on offer in rural areas. It would ordinarily also be much more difficult to divert resources to pilot some of the elements which were piloted through Acute Services.

Sustainability and mainstreaming

The main project achievement that has already been mainstreamed is the Community Paramedic Service. It was designed to reduce the number of people who need to visit Accident & Emergency (A&E) Departments and provided specialist training to ambulance staff and paramedics based in Northern Ireland, Ireland and Western Scotland to become Community Paramedics. This specialised training has been developed in partnership with Glasgow Caledonian University.

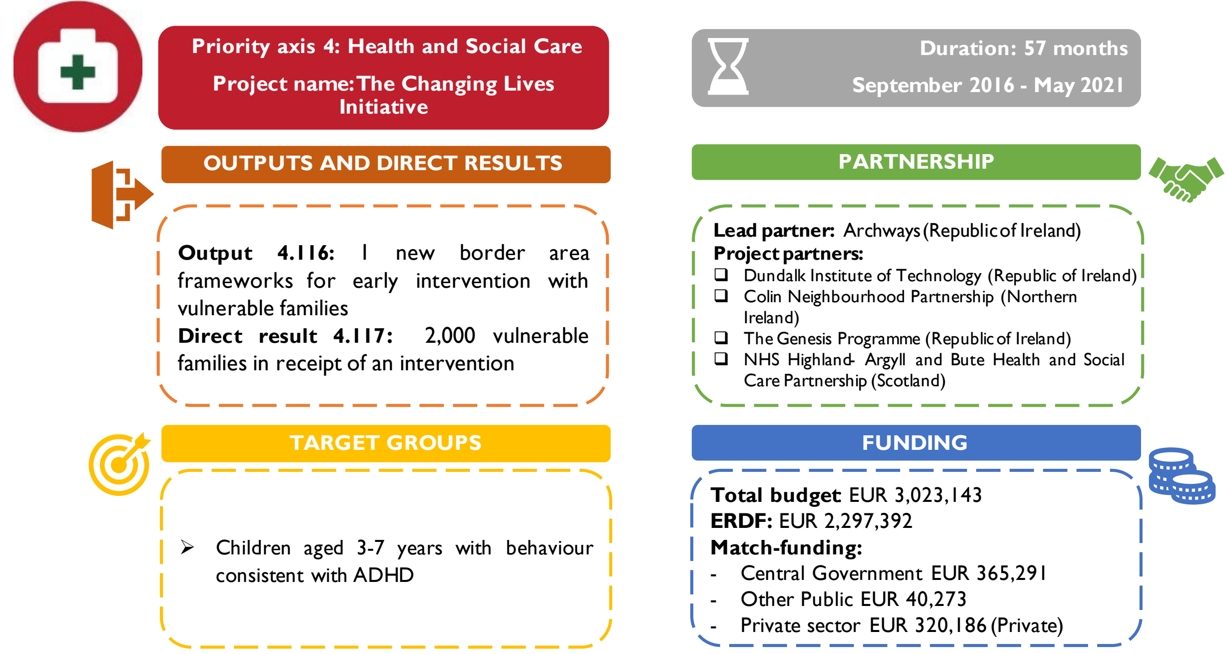
The cardiac service has been mainstreamed as well and there are discussions around the dermatology service, while urology and vascular services will likely be mainstreamed in Letterkenny Hospital (RoI). The CDU was also mainstreamed and upscaled and new pathways were formally adopted.

Challenges and difficulties in relation to sustainability and mainstreaming are linked to the pilots within each respective organisation and the process to secure funding to sustain these elements beyond project duration. Interreg funding is crucial to continue and upscale any strand of this project on a cross-border basis and the new opportunities provided by Peace Plus will be key.

The CAWT development centre works extensively to secure EU funding, but individual partners explore alternative funding opportunities at national, regional and local level. In terms of expanding some of the Acute Services strands of activities, partners are now looking into securing funding with their respective Departments of Health.

Looking to the future, the partners have a strong interest in continuing and building upon the relationships established, as they undertake planning for the next round of EU funding. A strategic direction of Peace Plus projects to be presented by CAWT will aim towards integrated care and community services, as well as early intervention and prevention to alleviate pressure from hospitals, especially in view of rebuilding health and social care services in the aftermath of COVID-19. The aim is also to establish different pathways to access healthcare in the border region. An evaluation will support decision-making relating to continuation of project strands (in part or in full) and mainstream decision making.

THE CHANGING LIVES INITIATIVE



Project description

The Changing Lives Initiative is a cross-border community-based project addressing the issue of ADHD, a behavioural disorder that emerges in early childhood which, if left untreated, can have a big impact on adult life as well, leading to mental health issues, unemployment, involvement in crime and incarceration. The number of children diagnosed with ADHD is increasing, especially in disadvantaged areas within the three jurisdictions, where a timely intervention is not always available. Therefore, the project focuses on prevention with children aged 3-7 and on providing an early intervention programme for families with kids experiencing behaviours consistent with ADHD. Potential families who could benefit have been identified via schools, preschools, GPs, family support hubs and paediatric health services. The project entails different levels of intervention starting from Information and Awareness Sessions, through a Screening Programme to the last step which includes an intensive intervention in the form of an evidence-based ADHD-focused Incredible Years Parent Training Programme. Moreover, the project includes workshops for all those working with children to support them to create a more inclusive environment for children with these behaviours.

Project implementation

The project included a three-layered intervention for families:

- Information and Awareness sessions
- Screening Programme
- Incredible Years (IY) Parent Training Programme. The Incredible Years Basic Parenting Programme is a group-based intervention which targets children aged 0-12 years with behaviour consistent with ADHD. Guidelines from WHO and leading international bodies suggest that first intervention through parenting programmes is key in treating the disorder.

The project intended to address two programme-specific outputs, namely:

4.116 - Develop and implement a new border area framework for early intervention with vulnerable families;

4.117 – 2,000 vulnerable families in receipt of an intervention.

Indicator 4.116 includes 10 project-specific outputs:

Output 1	Protocols developed and provided to parents and communities
Output 2	500 professionals trained to increase their understanding of emotional and behavioural difficulties and ADHD
Output 3	A new cross border framework for early intervention for vulnerable families
Output 4	Two major conferences: one at mid-project, focusing on progress and one at the end as a dissemination event open to a wider expert audience
Output 5	3 evaluations: a process evaluation, a programme evaluation, and a cost effectiveness evaluation
Output 6	Data collection and monitoring on CAMH waiting lists to track the reduction in those lists that should occur due to the impact of the new service on referrals. A reduction in the waiting of 15% is anticipated over the life of the project.
Output 7	An app to support parents in using the skills they have developed as part of the programme
Output 8	Increased knowledge transfer and skills transfer opportunities between locations though joint initiatives
Output 9	New access routes to services based on proximity rather than jurisdiction
Output 10	Information and training support provided to new locations adjacent to the partner locations to introduce the service in their localities.

Regarding output 2, workshops and training modules/ events were delivered to professionals such as healthcare workers, teachers, and early years educators. As the demand was considerable, the target was significantly exceeded, with more than 1,700 professionals taking part in the workshops. This highlighted the need for increased knowledge about ADHD and effective treatment approaches among a wide range of practitioners. When delivered online, these sessions became even more popular as there were no geographical limitations.

Output 5 was successfully achieved as well, with the three evaluations carried out successfully.

Regarding output 7, the App was launched in March 2020 to disseminate information to parents while also increasing the reach and sustainability of the project. It has been used by more than 600 parents and professionals to date (when are these figures for??) but remains available for downloading from the project website.

Indicator 4.117 includes the following project-specific output:

Output 1	Engagement with 3,000 parents – approximately 1,175 families supported

The Initiative achieved the the main expected output with 2,004 families from the cross-border framework receiving an intervention, including the delivery of more than 50 ADHD-focused Incredible Years Parent Training Programme sessions. Participating families came from different backgrounds: mainly low income with poor educational attainment, single parents and ethnic minority families as well as families with a more stable financial situation. This demonstrated that the initiative is applicable across different communities and socio-economic situations.

Some internal issues were linked to differences in software requirements for using video web platforms when moving to remote delivery during COVID-19 and slow and lengthy systems for reimbursement of programme costs to the project partners. While these did not represent a barrier to implementation, it was a source of stress for some partners, and could reflect differing First Level Control procedures across the various jurisdictions. FLC trainings on financial procedures and documentation would have been very useful prior to the start of the project.

Results and impact

The initiative officially ended in April 2021, and the impact on target families and children is tangible. They reported changed behaviour patterns in children in terms of reduced frequency, intensity, duration and severity of problems, impacting on daily family dynamics as well as social and emotional well-being, reducing the risk of their exclusion from school. Even parents whose children experienced limited change in ADHD symptoms reported good levels of satisfaction with the initiative as they highlighted the positive benefit of establishing support networks with families in similar situations. Parents have tended to feel less overwhelmed, more in control and generally more optimistic about their children's future. Finally, improved relationships between parents and children were reported as well as improved family relationships with parents and siblings.

Regarding Information and Awareness sessions for professionals, the goal was to tackle the deficit in terms of preparedness around ADHD, which turned out to be greater than expected. These training sessions were organised to provide knowledge and the skills to enable professional to better identify the disorder from its early symptoms and therefore be able to provide more timely and effective care. The workshops led to a change in the mindset of these professionals too as they are now more aware that it is not a willful behaviour and have enhanced their tools to support children in the classroom setting.

Participants in the ADHD IY Parenting Programme reported high levels of satisfaction with a mean score of 15.36/16. This was particularly high due to the incorporation of additional sessions into the main IY which provided additional time for parents to practice the skills and for educators to focus on the most pressing needs to be addressed.

From the project evaluations, it is evident that the project would have not been possible without a strong partnership, which relied on well-established existing relationships that involved joint planning, design, and delivery.

External factors

COVID-19

With the COVID-19 pandemic outbreak, the Changing Lives Initiative had to adapt to the changing circumstances and restrictions put in place by national authorities. It was important that the project continue its work to support families, who had already lost support structures and routines. Although the project and the wider Incredible Years were initially conceived of and planned for face-to-face interaction, they were adapted quickly to complete some of the project activities through remote delivery methods. From August 2020, Information and Awareness workshops for both professionals and parents/caregivers were delivered online but also extended, with more emphasis on effective strategies to support children's behaviour, while the Screening Programme was also adapted to remote delivery via telephone. However, the ADHD IY Parenting Programme sessions were reduced in terms of duration with materials sent by mail or by email. Despite some initials concerns, participants nevertheless reported high levels of satisfaction around remote delivery and the platform used (Zoom). The online delivery of the training enabled people who did not have their own means of transport to maintain high rates of participation in the programme and additional family members such as co-parents, grandparents or siblings to join the sessions as well. This positive outcome has provided partners with a viable option for the long-term scaling up of the project. Remote delivery was never envisaged in the planning, but COVID-19 proved that it is possible to do so in an effective way, therefore, showing the transferability of the project to remote modality.

Other external factors were easily overcome thanks to the well-established nature of the partnership and the quality and the strength of the project team, who facilitated coordination of activities. In addition to these, the nature of the organisations itself allowed for additional flexibility and facilitated quick adaptations and change, when needed, which would have been more problematic potentially if a wider range of statutory organisations had been involved.

Cross-border added value

The advantages stemming from the cross-border aspect are related to the use of the same models of treatment, practice and protocols across the three jurisdictions. Cross border cooperation also facilitated the development of common strategies to deal with critical issues such as delivering services in rural areas and exploring ICT possibilities for remote delivery. Additionally, in the process of developing and implementing the intervention, partners benefited from cross-border joint training for staff, knowledge sharing and sharing of expertise with the project manager and psychologists working across the different jurisdictions, resulting in cost efficiencies and savings and strengthened the implementation of the project activity. Moreover, on the island of Ireland it also facilitated cross border mobility of parents, who could access services based on geographical proximity rather than jurisdiction, thus increasing the accessibility and uptake of services for vulnerable families.

The project has been a way to test the flexibility and strength of the intervention by:

- Testing the interventions across different settings, such as urban but demographically mixed settings, involving for example, disadvantaged population in Belfast, and rural and dispersed population in Scotland.
- Testing the service delivery both with national Health Services and with community voluntary organisations.

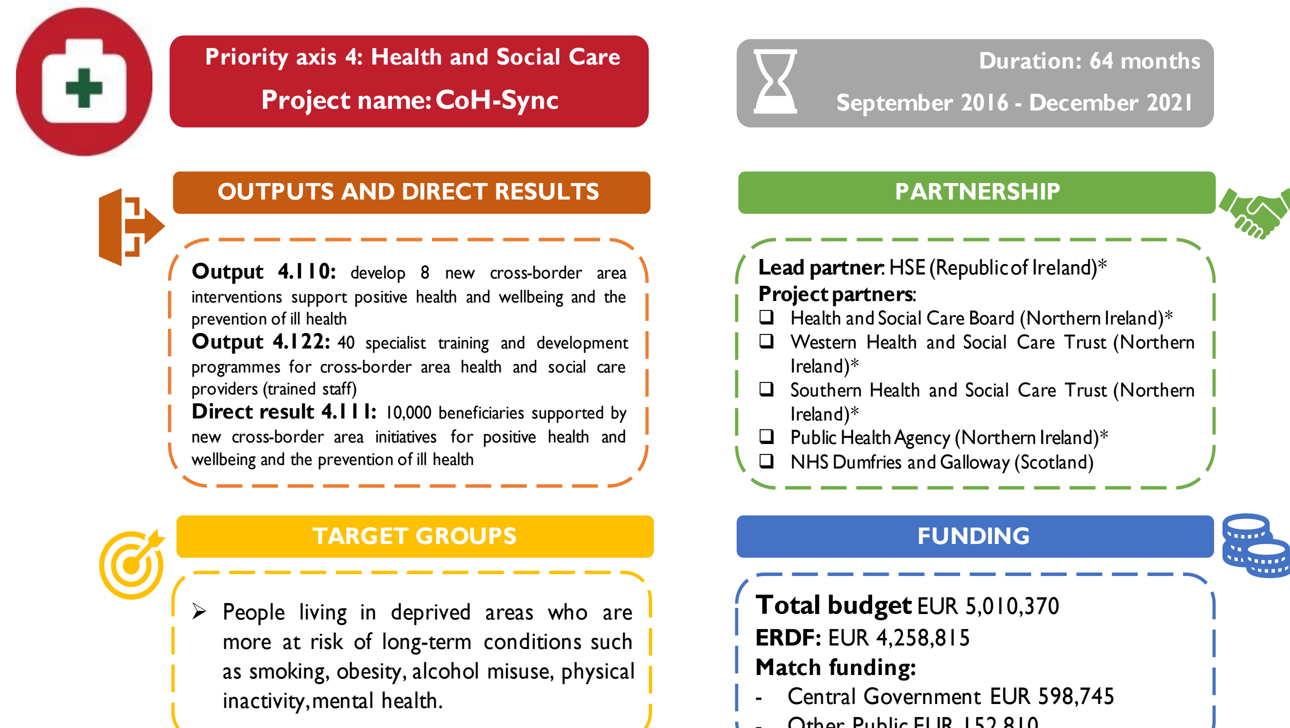
In general, cross-border cooperation has provided for the creation of new opportunities for social development across the three jurisdictions through the creation of a new service infrastructure for vulnerable families. The scale of the cross-border approach and offer enabled a significant sample for data collection on the effectiveness of the approach in comparison with the current service delivery offer.

Sustainability and mainstreaming

The Changing Lives Initiative approach is perfectly in line with current health and broader government policy across the three jurisdictions, in terms of both early intervention and parent support. The three types of evaluations which were included as a project activity in the business plan right from the outset, provided the evidence needed to support the scaling up of the project. The end goal is to turn the initiative into an ongoing intervention, with more families receiving early support and intervention, not only in the current project locations but extend it to all families that require it across the Republic of Ireland, Northern Ireland and Scotland.

This aspect was planned to be addressed during the latter half phase of the project, when COVID-19 hit and slowed down the process. The partnership has managed to secure some external funding necessary for the scale up, but more will be needed. Current planning is at an advanced stage of development in relation to an initial regional, two-county pilot programme. So far, the Changing Lives Initiative has accessed Interreg V-A funds alongside government funds under the WHATWORKS framework from the Department of Children and Equality, the latter being used for additional dissemination work and for further training of professionals. More funds were secured from the All-Island fund, cross-border funding provided by the Community Foundation for Ireland and the Community Foundation for Northern Ireland, particularly to foster cooperation among community and voluntary organisations. The possibility to receive funding from PEACE PLUS and from varying health services is being explored as well. Financial requirements are tight, especially for community and voluntary organisations which find it difficult to access the funds. Allowing for more flexibility for this type of partners would be helpful, given the advantage they have of working on the ground. Flexibility had been possible in the early stages of the pandemic, and SEUPB quickly provided 80% upfront payments, almost all (still?) unverified.

CoH-SYNC



* The HSE and the HSC form the **Co-operation and Working Together (CAWT)**

Project description

The Community Health Sync (CoH-Sync) project focuses on "improving the health and wellbeing of people living in the cross-border region between the Republic of Ireland, Northern Ireland and Scotland by enabling them to access quality health and social care services in the most appropriate setting to their needs".

Starting from mapping of risk factors across the three jurisdictions and drawing from national statistics, the project aimed to establish 8 cross-border hubs led by local communities to promote healthier lifestyles through targeting risk factors linked to long terms conditions. The project seeks to empower and support local communities through their involvement in planning activities to be developed and implemented. Communities are more aware of the needs of their own areas in terms of deprivation and health and are best placed to identify and implement activities to target those who need it the most. With personal linkages and trust, communities are also more influential when trying to persuade people to change their behaviour and lifestyle.

The pandemic has worsened the already existing inequalities in health care provision across the three jurisdictions. Such inequalities are most acutely felt in cross-border areas and the correlation between poverty and poor health status is observed in several reports on health and inequalities. It was important therefore to target these interventions in the communities that needed it the most. The rurality of the project areas usually makes it more difficult to provide services and choosing an area big enough to achieve the target but not too broad and dispersed was, as a result, a significant challenge.

The project's objective is to 'synchronise' the efforts of the community, voluntary and statutory health sectors to improve the health and well-being of individuals and communities. This is done through the implementation of a wide range of sustainable health and wellbeing initiatives to community residents which will improve their health behaviours and habits through Personal Health Plans and the support of Health facilitators. Moreover, the project seeks to improve the health literacy of the population, especially addressing those living in deprived

areas who are more at risk of long-term conditions such as smoking, obesity, alcohol misuse, physical inactivity, mental health. The goal is to encourage people to adopt a healthy lifestyle, focusing on prevention and early intervention.

Project implementation

The project intended to address three programme specific outputs, namely**:**

4.110 - 8 new cross-border area interventions developed to support positive health and wellbeing and the prevention of ill health

4.111 - 10,000 beneficiaries supported by new cross-border area initiatives for positive health and wellbeing and the prevention of ill health

4.122 - training for 40 participants.
These are to be reached through the following project outputs:

1	Completion of an overarching Gap / Needs Analysis Report which details current activity and identifies activities/initiatives required to address health inequalities and social exclusion
2	Utilisation of an on-line repository containing information on current community assets
3	15,000 beneficiaries will be reached through the implementation of the project and associated programmes
4	A competitive tendering/public procurement exercise will be undertaken to contract with 8 Health and Well-being hubs to deliver the activities
5	A cross border community-based network of 8 Health and Well-being hubs will be established with representation from the local community and from minority groups
6	Those who sign up to the project's programmes will receive a Personal Health Plan and a pre and post health assessment
7	2 cross border community forums will be established
8	Use digital /e-health technology to support health improvement and self-care resulting in enhanced participant outcomes.
9	Alternative / enhanced pathways for improving health will be devised and implemented
10	A small staff team will be recruited to manage the overall project

Source: CoH-Sync application form

Despite some initial delays, three hubs were established in the Republic of Ireland, three in Northern Ireland and two in Scotland. Locally established hubs could deliver more on behalf of the statutory sector, and the project provided the opportunity to break down barriers between the statutory and community sector. However, right from the outset and during the planning, it was clear that the community and voluntary sectors across the three jurisdictions had experienced different levels of investment and strategic positioning which had resulted in substantial differences in capacity. While the community sector in the UK tends to be vibrant, following years of work on community development and health as well as significant infrastructure, the Republic of Ireland is characterised by more fragmented infrastructure, that is smaller in scale, and a scarcity of community-led programmes. Other challenges encountered during implementation were mainly related to two areas: recruitment of staff and procurement of services. Recruitment of staff took longer than expected, leading to delays in project start dates and implementation. Moreover, staff turnover has been high throughout the project implementation, further hindering the project from reaching it targets in a timely fashion. Procurement for the eight hubs providers and for the purchase and implementation of the Data Collection and Reporting System (DCRS) was also delayed, meaning that the DCRS did not become operational until 2019. Retrospective work was therefore undertaken to upload client data from a variety of Health and Well-

being Plans prior to the launch of the DCRS. This involved considerable additional resources and time to complete which had not been initially factored into project planning. Nevertheless, despite these initial challenging delays, project outputs have been effectively achieved during the project duration.

The project managed to reach 10,052 beneficiaries, while training events involved 60 participants. Data has been collected through the Data Collection and Reporting System (DCRS) which is a national central data system developed by the Department of Health England and managed by NHS Midlands. During project implementation, community hubs were able to readily upload and track their client details on the DCRS, allowing for data collection throughout the project. On the basis of this data, a qualitative and quantitative analysis will be carried out to understand which factors have a greater influence in specific areas or target groups to make recommendations for future policy in this area.

Results and impact

According to the project Application Form, the project planned to achieve the following results:

- Healthier population: reductions in risk factors for long term conditions will directly lead to improvements in health and well-being. The project will assist people in improving their health behaviours and habits and to put change into actual practice.
- Reduction in health inequalities: health inequalities persist across the eligible area in that those most disadvantaged experience the poorest health outcomes, lower health status and poorer life expectancy. The community's capacity to tackle health and well-being issues at a local and cross border level will be enhanced.
- Improved health literacy: by improving people's access to health information and their capacity to use it effectively, health literacy is critical to citizen empowerment and increasing self-responsibility for one's own health.
- Increased support from primary care: Primary care (GPs, community pharmacy, members of Primary Care teams etc.) and other community-based health facilities will support early intervention and prevention activities.
- Strengthened and empowered community infrastructure: local community infrastructure and network will increase their capacity to implement local solutions, with enhanced skills, knowledge and talents
- Addressing Imbalances in the community and voluntary sector across the three jurisdictions.

The project ended in December 2021 and, according to the information collected, it managed to successfully deliver the planned actions and achieve the expected results.

Local communities have gained experience, skills and expertise and have established networks of cooperation. Skills of health trainers have been improved through their participation in accredited training programmes. The project enables many local women with no formal qualifications to receive accredited training and gain a formal qualification to work as a community health facilitator. This can be used to contribute further to the community, through next door health and wellbeing promotion or through their potential employment in the broader healthcare sector.

External factors

COVID-19 and Brexit were the two external factors affecting project implementation. However, after being reassured by the SEUPB that the funding would still be provided, Brexit did not represent a real factor hampering project implementation and partners continued delivering project activities in line with forecasts.

COVID-19

The effects of COVID-19 on the project were obviously negative, given the health-related nature of its activities. However, both the project board and project partners were proactive and quickly responded to the crisis developing new ways to deliver project activities to continue to meet targets. All project activities were moved online, and the result was extremely positive. Despite lockdowns, the transition to recruiting and delivering online was successful and opened up access to people from all age groups who would not have been

able to take part in the courses otherwise. Since there was no need to travel, it was also possible to access courses in another hub area, increasing inclusion and connections. New types of courses that could easily be delivered remotely were provided. It is worth mentioning that the positive aspect was related to learning a skill and improving health wellbeing but specially to connecting with other people.

Meanwhile, the Hubs made tremendous efforts to adapt to the needs of individuals and communities to ensure that support continued to be provided in a safe way. They continued to effectively deliver health and well-being plans, along with one-to-one support to clients. They not only adapted their services, but also extended service and supports on offer during the height of the COVID-19 pandemic and, thanks to SEUPB's flexibility, volunteers came together to provide not only mental forms of support (phone calls, online interventions, social media interactions, etc.) through project courses but also physical forms of support such as delivering grocery shopping or pharmaceuticals to people living alone or self-isolating. Additional support was provided to vulnerable people during lockdown also as a result of cooperation with the Innovation Recovery (iRecovery) project, which focused more on mental health issues.

Cross-border added value

Significant additional advantages stemming from cross-border cooperation which could not be achieved if working independently include the following:

- Resources, expertise and learning are shared among partners;
- Possibility to work jointly depends on geographical/ cultural proximity and not jurisdiction;
- Developing social capital, strengthening a sense of belonging and identity and increased understanding among the statutory, community and voluntary sector staff engaged in cross border work.
- Improved access to services for citizens on a cross border basis with reduced travel times and inconvenience
- Cooperation among organisations allows for the delivery of services beyond jurisdictional borders, helping to address imbalances.

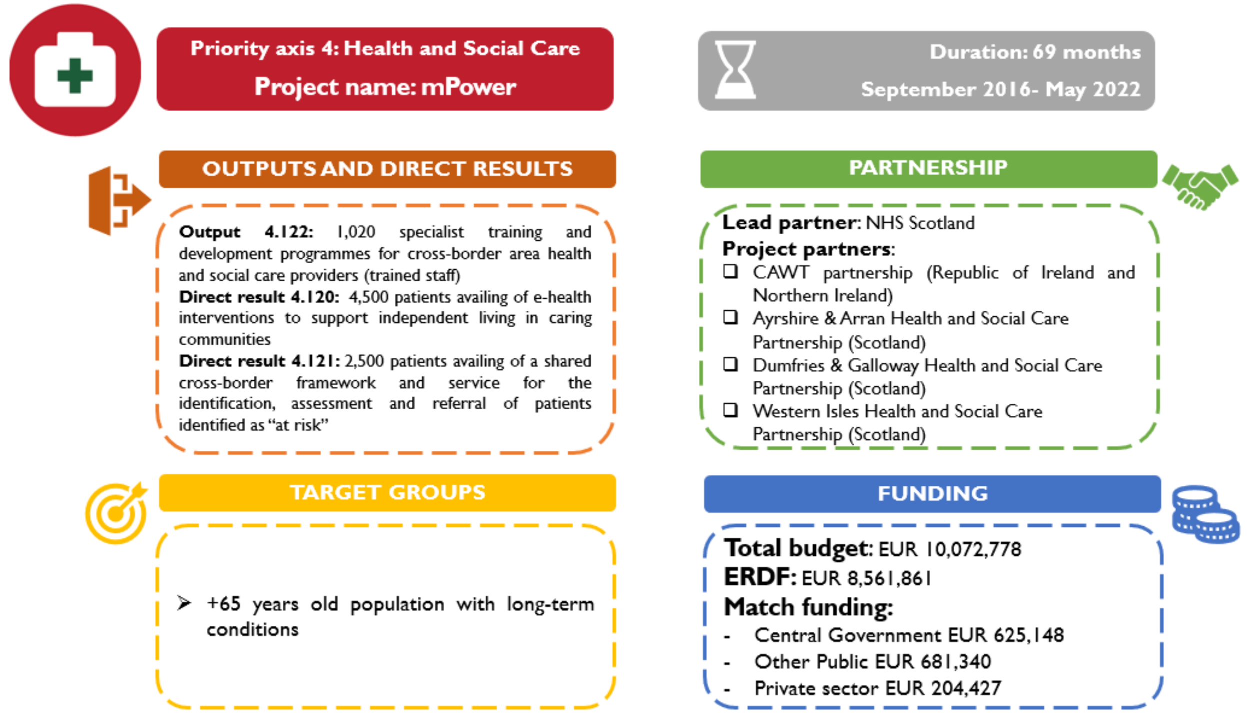
As mentioned above, differences in terms of community sector development across the various jurisdictions were significant. However, project partners managed to build up their capacities through a shared model of community interventions and through sharing expertise, training and resources. The cross-border aspect was facilitated by project staff and their strong team spirit who continued to meet and support each other on a regular basis exceeding formal top-down cooperation. Relationships have also been built amongst beneficiaries who connected around the project and continued transferring what they have learnt to their families and communities. Moreover, project officers met quarterly, jointly verified the data uploaded on the DCRS and returned to their hubs with advice for improvements, quality checks, and helped guide the hubs in making the changes necessary to achieve the targets. Actors across the three jurisdictions, which have such different levels of community health and wellbeing development would have never cooperated so efficiently and smoothly without EU funding.

Sustainability and mainstreaming

With the end of the project and the 2014-2020 programming period, there are no funds available to continue project activity. Some hubs have already moved to delivering other health and wellbeing plans. In general, the project was not designed with mainstreaming in mind but thanks to the data collected via DCRS and the analysis based on that, it will be possible to understand what can be mainstreamed and which activities from CoH Sync can be incorporated into ongoing projects and plans. Mobilising other types of funds is not possible for CAWT, due to its legal status as a cross-border partnership, but each partner such as HSE Republic of Ireland, Southern Trust and the Public Health Agency can learn from the project and consider how they can mainstream certain project activities within their own jurisdiction under other funding streams. The process of mainstreaming the project is further complicated by the lack of an internal evaluation. The project always foresaw and had funding available to undertake detailed internal evaluation throughout implementation, also included in the initial business plan. However, the evaluation did not take place due to changes to the project made in agreement with the SEUPB. This would have allowed for a gathering of robust information from the

beginning of the project that could have been used for an analysis and comparison of the before/after, underpinning the entire project and its possible mainstreaming. Updated and continuous information about project implementation could have also been sent to relevant lawmakers, such as Commission for Health and Social care to put the topic of mainstreaming at the top of the agenda. An internal evaluation was only included during the final stages of the project, and partners believe that it is not sufficient for an effective analysis of project activity and its potential mainstreaming.

mPOWER



Project description

The mPower project was developed around preventive medicine, through a shared approach regarding the correlation between health and wellbeing. It aims to transform services offered to older people in Ireland, Northern Ireland and Scotland, assisting people to improve their health conditions and live well, safely and independently in their own homes, self-managing their health in the community. The project mainly targets citizens from the '65+ older people at risk' age group and category, with an initial analysis to agree on the definition of 'at risk' across the three jurisdictions. The project will deliver social prescribing and eHealth interventions through Community Navigators (CNs). Following referrals from primary care staff or other sectors, CNs undertake home visits and guided conversations and co-produce personalised Wellbeing Plans, using a person-centred approach, focusing on prevention and connection to activities in the community and to technology to enhance support for health and wellbeing. Regarding eHealth interventions, three different types are carried out:

- Home & Mobile Health Monitoring, using a home hub unit or mobile phone for self-management of long-term health and care issues;
- Digital Health & Wellbeing Services & Apps;
- Video-enabled services to improve access to care, address isolation and promote wellbeing. Using their own device, users can receive an online medical consultation.

The project aims to result in improved health and wellbeing for citizens, delivering 7,000 additional episodes of health, community and social care on a cross-border basis.

Project implementation

The project intended to address three programme specific output indicators, namely:

- 4.120 –people availing of digital health interventions to support independent living in caring communities (target: 4,500; achieved: 5077);

- 4.121 – Patients availing of a shared cross-border framework and service for the identification, assessment and referral of people identified as 'at risk' (target: 2,500; achieved 2525);
- 4.122 - Specialist training and development programmes for cross-border area health and social care providers (target: 1,00; achieved 1265).

The original end of the project, as approved on the first Letter of Offer, was December 2021 but the project was granted a seven-month extension until May 2022, due to unavoidable delays in recruitment, approval of the expanded Shared Learning work package and impact of COVID-19 on implementation. Over the timeframe of the project, mPower aimed to support 2,500 people through the development of wellbeing plans and 4,500 digital health interventions. Both have been achieved and exceeded. Despite the difficulties of not being able to meet in person and having to undertake activities remotely, shared learning and training events increased.

There were no major issues throughout project implementation. The partnership proved to be stable and worked well. Due to COVID-19 the loss of in-person events impacted on relationships among partners, but the move to virtual collaboration was embraced and it provided opportunities to share learning and solve problems more creatively. Nonetheless, some differences in the pace of implementation arose soon after the start. For example, while the recruitment process took around 3 months in Scotland, in the Republic of Ireland it took around 6 months, slightly delaying the project start. Another issue was linked to data sharing. Compliance with EU GDPR rules, exacerbated within the context of Brexit and changing/varying legislative frameworks, further slowed and complicated project activities.

In addition, procurement requirements further hampered project implementation. Within Interreg V-A rules, health organisations are obliged to use frameworks or centres of excellence, as they are generally faster to navigate and tend to offer value for money. SEUPB required partners to provide evidence of the establishment of a framework and this was problematic and onerous in many cases, requiring a significant amount of paperwork to claim reimbursement of expenses.

Results and impact

The mPower team have achieved considerable success in the area of digital intervention, increasing digital confidence and competence in the targeted audience. Through technological services, people learnt to better manage their health and social wellbeing, and in many cases to stay connected to family, friends and health and social care professionals. Services supported are numerous, to name a few: community physiotherapy, speech and language therapy, domiciliary care services, dietetics.

Partners from the different jurisdictions succeeded in exchanging practices and expertise. For example, HSE was ahead in terms of social prescribing and helped the NHS to improve this service, as well as better use of digital applications in health services. Thanks to mPower, HSE in the Republic of Ireland started using "Attend Anywhere", a video-enabled care system for virtual appointments. This tool was already being used in Scotland, providing around 330 virtual appointments per week, but with COVID-19 virtual appointments increased from 50 to 17,000 per week. The benefits of this tool are numerous and include reduced risk of COVID-19 infection, additional choice of engagement for the patient/client with their service provider, improved access for hard-to-reach groups such as people living on islands or with no access to private transport, thus providing an alternative to travel to a clinic - saving time, money and potentially the need for a family member to take time off work to accompany a relative to an appointment. The smooth implementation of the tool by HSE across the whole programme area in just nine weeks is due to the work previously done in Scotland and the sharing of videos, trainings, learning pathways etc. This activity showcased the value of cross-border working as it benefitted greatly from the openness of shared learning. Additionally, the project was able to echo and align to the wider context of existing national programmes which were unknown at the beginning of the project but were critical complements for shared outcomes. For example, in cooperation with Connecting Scotland, around 60,000 tablets were provided to people supporting digital connectivity in care homes. Training on how to use the tablets was also provided. Together with the Attend Anywhere national roll-out in the Republic of Ireland, this proved that when projects are not isolated from each other and the focus goes beyond numbers

and targets, the outcomes can be extremely positive and long-standing. Moreover, connections to and among local communities has also been greatly enhanced.

External factors

Brexit

Different partners experienced different consequences and impacts of Brexit depending on their location. Undoubtedly, Irish partners felt it more due to the physical presence of the border. In addition to uncertainty about the continuation of the funding, more practical consequences were linked to delays in the delivery of equipment and additional paperwork for data sharing and procurement. mPower staff had to navigate a protracted process that includes additional information such as commodity code, import duties, customs costs, freight and delivery costs and costs not expected. In addition, buying equipment or services in one jurisdiction but implementing them in another, which was already difficult, became insurmountable following Brexit.

COVID-19

COVID-19 obviously affected project implementation, with activities having to be cancelled or delayed. The Community Navigator service had the potential to reach those people who were socially excluded and disadvantaged within communities but enforced isolation made it impossible for them to meet with their patients on a face-to-face basis. In general, the project managed to re-profile with the support of the SEUPB. An example of re-profiling was to act more in sheltered housing and care homes to deliver access to digital connectivity, which benefitted the beneficiary in their home setting and had significant positive impact on their family and carers. Moreover, COVID-19 has made collection of data more difficult as access to people and systems has been more restricted.

During the first few months of the pandemic, NHS Scotland reports having re-allocated own resources to facing the emergency. These resources often were allocated to areas and themes still delivering the project, but in a way they would have not expected. Whilst posing significant challenges for mPower, as has been the case across all of society – and in particular health and social care services, the COVID-19 pandemic also created opportunities to further develop and adapt mPower to meet the needs of some of the most vulnerable older people. Additionally, certain areas of service delivery which were on the periphery of project planning became more central as a consequence of the pandemic. For example, referral pathways were planned to come directly from GPs and primary care. This evolved quite quickly, and a wider range of organisations could identify and refer vulnerable people. Moreover, some project activities which were already planned were delivered faster because of COVID-19, such as the Attend Anywhere video consultation.

Cross-border added value

The above-mentioned results have been achieved thanks to the cross-border cooperation. Although demanding and challenging in terms of rules, the added value is irreplaceable. Well-established partnerships and relationships with shared commitment and shared values were key to the project success. Existing bilateral agreements facilitated the cooperation, but they would have not been sufficient to deliver project activities with the same speed and scale. SEUPB helped to establish connections and strengthened the partnership commitment and the shared learning programme. People actively participated in the shared learning activities, establishing strong linkages across the programme area, allowing delivery to exceed that originally anticipated. For example, the ECHO network (which allows for better intervention at local level, reaching more people from rural and remote areas) delivered 6 additional sessions, to arrive at a total of 15 sessions on top of the 18 project assemblies.

However, as mentioned above, differences in terms of processes and regulations make it difficult to carry out identical activities across the project area. Adapting and localising under the shared mPower umbrella enabled exciting initiatives to flourish. Other partners were able to learn and then adopt appropriately locally and the focus on collaboration and cross-border working was retained from day one, with constant contacts and meetings among partners.

Through the delivery of a Community Fund, mPower has built capacity within the community and voluntary sector to enable and empower individuals. Partners such as Alzheimer's Scotland or The Alliance in Scotland, who were not formal project partners, became engaged and involved, increasing the out-reach and benefits of the initiatives.

Sustainability and mainstreaming

The Community Navigators model, which was however not unique to mPower, is very likely to be mainstreamed in Scotland and in the Republic of Ireland. The Digital Community Hub will be a key legacy of the project and will be further explored, in particular on the potential use of big data or artificial intelligence (AI) in the health care sector.

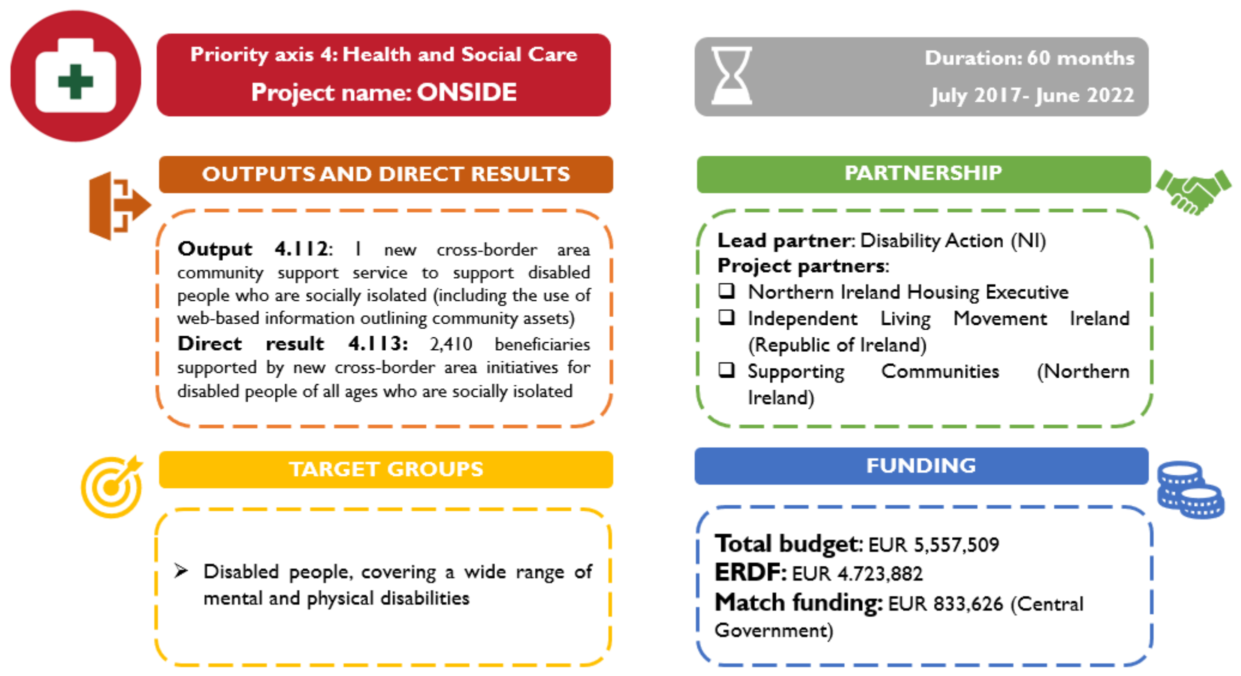
The Scottish government is already investing in a wider health perspective on mental health involving community, third sector and voluntary sector. Similarly, the expansion of social prescribing is a commitment in the Scottish 2021 Programme for Government and is an action in many recent strategies and polices such the Sláintecare programme[18]. In addition, a move towards Enhanced Community Care managed by HSE in the Republic of Ireland provides new integrated models of care that allow people to stay healthy in their homes and communities.

In terms of resources needed, additional funding is always welcome, especially in a period where the healthcare sector is exhausted both from a resource and mental point of view from the COVID-19 crisis. Partners are seeking funding opportunities within PEACE PLUS in the next programming period, but also from national funding (e.g. Connecting Scotland).

Some activities that could be continued and enhanced in the new programming period are linked to e.g. user engagement, digital appointments across the border, and delivery of mental health care services. Horizon Europe could also be explored for some strands of activities.

[18] Sláintecare is a proposed reform of the healthcare system of Ireland. The intent of the Sláintecare reforms is to achieve a universal single-tier health and social care system, which provides equitable access to services based on need, and not ability to pay.

ONSIDE



Project description

ONSIDE stands for Outreach, Navigation, Social Inclusion and Digital Engagement. The project aims to improve the health and wellbeing of disabled people who often experience social isolation. It adopts a pan-disability approach by working with people with physical, sensory, learning, mental health, or hidden disabilities. Despite significant advances in mainstreaming and inclusion, many people with disabilities still experience exclusion, especially among younger age groups. Evidence shows how positive relationships and shared activities contribute to the overall health and wellbeing but also how physical and attitudinal barriers created by society towards disability can create loneliness and social isolation. The ONSIDE team offers a cross-border community support service and identifies disabled people who are seeking to improve their health and wellbeing through increasing their social networks both in the community and online. It fully supports participants through a tailored development plan suited to their wants and needs, identifying and addressing the barriers that make it harder for them to access social networks in the community and online. The personal development plan offers participants independence, choice and control. Through one-on-one tailored support by dedicated community navigators, digital inclusion training, access to a digital disability community and support from volunteer peer advocates, individuals will be supported to access quality health and social care services in their locality, or on a cross-border basis, aligned to their needs and situation. The project has been designed following two main principles:

- Cooperation, with the Disability Housing Forum which provided advice and guidance;
- Person-centred approach, placing the individual at the heart of all the activities.

Project implementation

The ONSIDE project intends to address the following specific outputs:

- **4.112** New cross-border area community support services to support disabled people who are socially isolated (including the use of web-based information outlining community assets): target 1- achieved 1.

- **4.113 -** Beneficiaries supported by new cross-border area initiatives for disabled people of all ages who are socially isolated: target 2,410 - achieved 3,358.

The episodes of care primarily focus on providing digital solutions to address social isolation and poor health, creating connectivity to health improvement services in settings appropriate to the needs of participants. 1650 individuals (1,293 in NI and 357 in the border region) will be identified and 1500 supported to prepare personal development plans aligned to their needs.

Several obstacles during project implementation were due to:

- Specific priority axis terminology related to healthcare such as "patient" or "episodes of care", while the project focus was more on the social aspect.
- Technical issues with eMS regarding uploading reports to claim expenses, which hampered project implementation. Training sessions on how to use the platform would be very welcome, prior to the project start. Moreover, additional flexibility regarding emergency release of payments like the one provided by the programme during COVID-19 would facilitate project implementation.
- Delays at the start due to another project dropping out, whose target had to be covered by ONSIDE to meet the PA target.
- Challenges with procurement. For example, it was impossible to identify one single provider for wi-fi connection covering the whole project area. The risk was having to procure contracts for each one of the providers, which was simply unfeasible. Or a partner providing equipment to the project could not provide specific IT equipment, leading to additional contracts, documents and work.
- The release of payments was a cause of stress to small size organisations (NGOs, voluntary organisations, charities etc) who struggle with the running costs of the project and with meeting deadlines for reporting and verification. These made certain partners particularly reluctant to apply to Interreg in the future.

Results and impact

The project is still ongoing and, despite some delays, it should be able to deliver services to the anticipated number of beneficiaries. The majority of participants report high levels of satisfaction and state that the support and skills they have gained from ONSIDE has given them a new sense of independence. The project helped people who are usually isolated to feel more included, less isolated and to engage with people who might not go through the same exact disability but who share similar feelings. People with very low digital uptake have also increased their IT skills and feel more confident in their capabilities. They have learnt how to use several tools and online services such as e-banking, online shopping, online healthcare services to improve their day-to-day experience. Overall, the project had a positive impact on the target group's mental wellbeing, with moreover, some among the recipients feeling empowered enough to themselves become peer volunteers.

External factors

COVID-19

With the COVID-19 pandemic outbreak, the ONSIDE project had to adapt every aspect of the project to the new situation, starting from the IT equipment provider, whose factory was coincidentally located in Wuhan, China. These disruptions were not facilitated by the challenging procurement requirements, as mentioned above. The delivery of the equipment, the provision of wi-fi and training sessions were significantly affected by lockdown and mobility restrictions, not only locally but also in relation to cross-border project delivery.

Moreover, project target groups are often vulnerable people who may be frightened and reluctant to engage in activities and due to restrictions, it was not possible to meet them which hampered the implementation of project activities. The project team re-focused their efforts on equipping and digitally up-skilling as many participants as possible and maintained regular contact with past and present participants to offer practical

support. Digital training programmes were redesigned so that they could be delivered exclusively online by the Digital Training team and ONSIDE, which strategically pooled resources so that Disability, Health and Housing Officers could deliver equipment to participants' homes safely. All four partners worked strategically to ensure ONSIDE provided appropriate level of support to each participant so they could connect to digital training sessions. One positive aspect of this shift to digital was that the geographical barriers came down and more people were reached through online services. The original project plan entailed room-based sessions based on geographical outreach. Moreover, COVID-19 proved the value of the project and how important IT and online literacy and services can be for disabled people.

Brexit

The project had established very robust partnership and data sharing agreements, two areas particularly critical following Brexit. These agreements had to be revised and, in some cases, led to a change in service provider, like for example with SurveyMonkey for online surveys. Despite some concerns regarding the establishment of border checks which could have prevented the smooth delivery of the initiative, the final outcome of Brexit negotiations regarding the physical border was not particularly troublesome also because suddenly they had to transfer activity online. Moreover, uncertainties regarding Brexit caused sharper fluctuations between the currencies raising concerns regarding costs.

The nature of the project partners made it difficult for such small charitable organisations to keep abreast of the changing legislative and regulatory requirements but having an NGO partner, which had wider access to and knowledge of legal requirements and resources to help with data control and management was an invaluable help.

Cross-border added value

The biggest advantage stemming from cross-border cooperation is related to partnership cooperation and teamwork, which, to all extents and purposes, made the border disappear. All operations were carried out smoothly and delivered at cross-border level. Due to COVID-19, the project was unable to hold many in-person events, but cooperation was still fruitful and extremely positive. The project managed to bring people together, based on their needs and starting points rather than on their geographical location. On the other hand, partners exchanged a lot of information and good practices, established long-term linkages and learning opportunities.

Sustainability and mainstreaming

The legacy of the project in terms of products is that intellectual resources such as training and videos on YouTube will remain available online.

Although volunteers and participants demonstrate willingness to remain engaged beyond the scope of the project, the geographical reach of the project cannot be sustained unless the partners apply to Peace Plus, through which they could potentially submit a project to build upon ONSIDE. However, identifying a cross-border stream of the project that could work across all jurisdictions is very challenging, also due to the fact that each jurisdiction is developing national policies to digitalise healthcare services, which could potentially overlap with such a project or on the contrary represent a driving force for ONSIDE continuation.

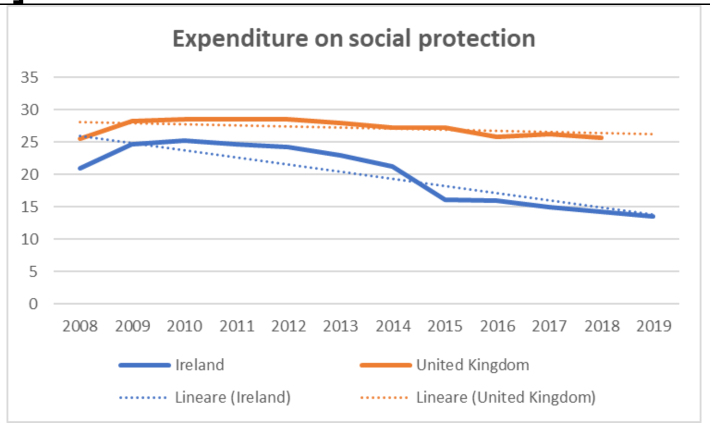
The ambition is to move participants to the next level, maintaining the momentum in terms of what has been done with participants so as not to lose the improvements produced nor the investments made in equipment and capital. To this end, a kind of 'bridge funding' opportunity would be needed not to suspend activities and lose participant engagement while waiting for the Peace Plus calls to be launched.

Annex II – Official statistics and literature on major external trends

Official Statistics[19] and literature related to the major external trends identified by the Evaluation Report

Expenditure on social protection [TPS00098]

Year	Ireland	United Kingdom
2008	20,9	25,5
2009	24,7	28,2
2010	25,2	28,5
2011	24,7	28,6
2012	24,2	28,6
2013	23	28
2014	21,2	27,2
2015	16,1	27,3
2016	15,9	25,9
2017	14,9	26,3
2018	14,2	25,7
2019	13,6	n.a.



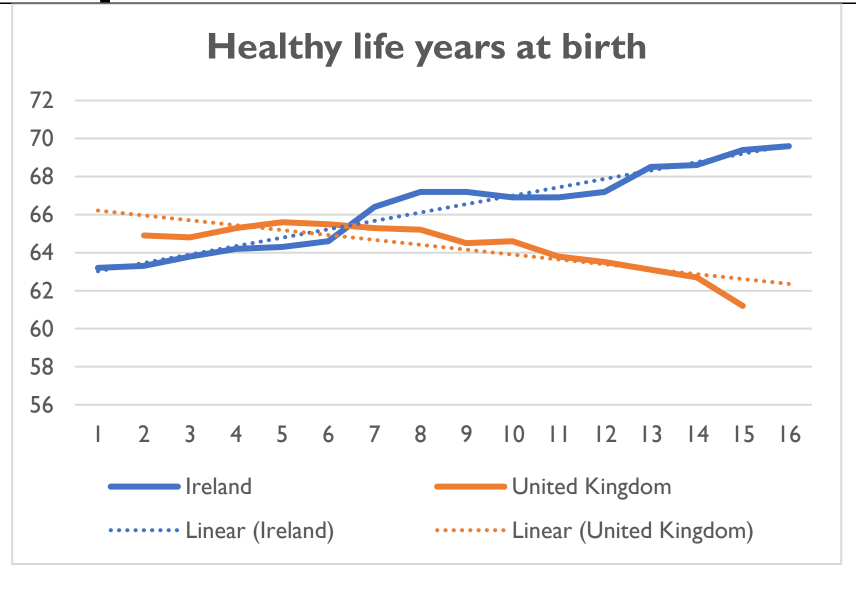
Gross domestic product, current prices [TEINA010]

Year	Ireland	United Kingdom
2019-Q1	86.401,00 €	628.992,20 €
2019-Q2	88.764,20 €	630.981,90 €
2019-Q3	89.425,80 €	618.880,60 €
2019-Q4	91.470,90 €	649.860,60 €
2020-Q1	93.029,50 €	642.870,40 €
2020-Q2	88.792,00 €	536.776,70 €
2020-Q3	96.873,10 €	596.839,90 €
2020-Q4	93.402,70 €	
2021-Q1	100.612,70 €	
2021-Q2	105.892,10 €	
2021-Q3	109.243,70 €	
2021-Q4	104.887,50 €	

[19] Source: Eurostat

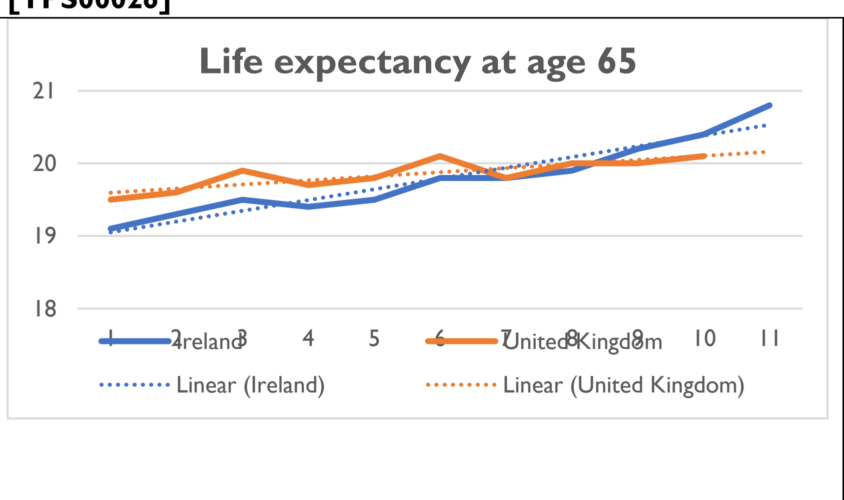
Healthy life years at birth [SDG_03_11]

Year	Ireland	United Kingdom
2004	63,2	
2005	63,3	64,9
2006	63,8	64,8
2007	64,2	65,3
2008	64,3	65,6
2009	64,6	65,5
2010	66,4	65,3
2011	67,2	65,2
2012	67,2	64,5
2013	66,9	64,6
2014	66,9	63,8
2015	67,2	63,5
2016	68,5	63,1
2017	68,6	62,7
2018	69,4	61,2
2019	69,6	



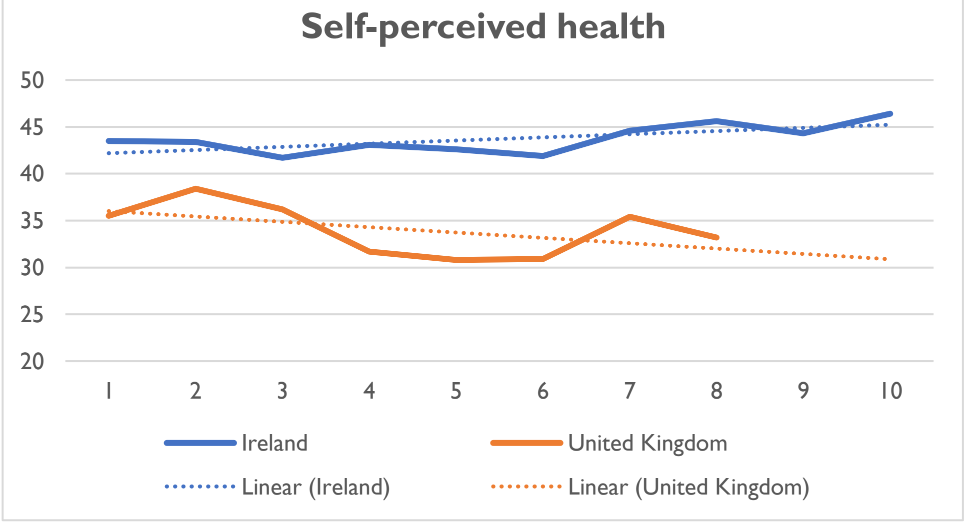
Life expectancy at age 65, by sex [TPS00026]

Year	Ireland	United Kingdom
2009	19,1	19,5
2010	19,3	19,6
2011	19,5	19,9
2012	19,4	19,7
2013	19,5	19,8
2014	19,8	20,1
2015	19,8	19,8
2016	19,9	20
2017	20,2	20
2018	20,4	20,1
2019	20,8	



Self-perceived health, % of those reporting "Very Good"

Year	Ireland	United Kingdom
2011	43,5	35,5
2012	43,4	38,4
2013	41,7	36,2
2014	43,1	31,7
2015	42,6	30,8
2016	41,9	30,9
2017	44,6	35,4
2018	45,6	33,2
2019	44,3	



2020	46,4	

General trends in physical Activity

- https://www.ul.ie/research/nation-couch-potatoes-physical-activity-sedentary-behaviour-and-health-ireland
- https://www.gov.uk/government/publications/physical-activity-applying-all-our-health/physical-activity-applying-all-our-health
- https://bmjopensem.bmj.com/content/7/1/e000960
- https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(21)00251-9/fulltext#:~:text=Population%20activity%20declined%20substantially%20after,CI)%2026%2D34%25)

General trends in Obesity

- https://www.irishexaminer.com/news/arid-40343039.html
- https://www.gov.uk/government/publications/adult-obesity-patterns-and-trends
- https://www.bmj.com/content/372/bmj.n411/rr-7

General trends in Smoking

- https://www.hse.ie/eng/about/who/tobaccocontrol/tobaccofreeireland/adult-smoking-in-ireland.pdf
- https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/bulletins/smokingprevalenceintheukandtheimpactofdatacollectionchanges/2020#measuring-the-data
- https://www.ons.gov.uk/releases/datacollectionchangesandtheirimpactonestimatingsmokingprevalenceintheuk2020

General trends in drinking

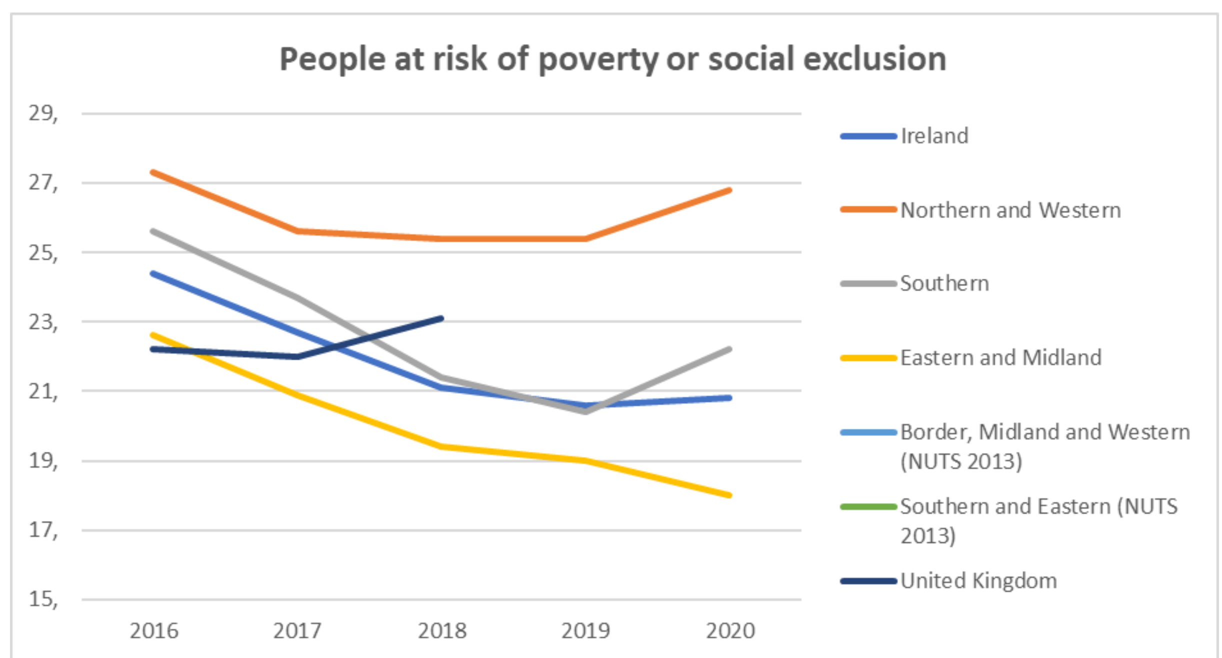
- https://drinkaware.ie/research/alcohol-consumption-in-ireland/?a=adult-per-capita-alcohol-consumption-in-ireland
- https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-statistics#:~:text=In%20England%20in%202018%2C%2082,the%20previous%20week%20%5B2%5D.
- https://www.gov.uk/government/publications/alcohol-consumption-and-harm-during-the-covid-19-pandemic/monitoring-alcohol-consumption-and-harm-during-the-covid-19-pandemic-summary#:~:text=These%20surveys%20suggest%20that%20respondents,risk%20and%20higher%20risk%20levels.
- https://drinkaware.ie/wp-content/uploads/2021/06/Families-Alcohol-COVID-19.-Barometer-2020-Research-Paper-Series.pdf

Data by NUTS 2 regions (when available)

Year	2016	2017	2018	2019	2020
Health personnel by NUTS 2 regions					
• Ireland	15.178	15.660	15.962	16.366	17.231
• United Kingdom	182.534	185.692	188.783	196.784	
Hospital beds by NUTS 2 regions					
• Ireland	14.073	14.279	14.475	14.213	
• Border, Midland and Western (NUTS 2013)	3.134				
• Southern and Eastern (NUTS 2013)	9.225				
• United Kingdom	168.934	167.589			
• Scotland	21.148	20.746			
• Northern Ireland (UK)	5.903	5.898			
Long-term care beds by NUTS 2 regions					
• Ireland	30.396	30.732	31.251	32.071	32.104
• Border, Midland and Western (NUTS 2013)	7.731				
• Southern and Eastern (NUTS 2013)	22.665				
• United Kingdom	545.010	542.627	529.467	525.704	

Prevalence of disability by sex, economic activity (NACE Rev. 1) and NUTS 2 regions			
Year 2002	**Total**	**Males**	**Females**
• Ireland	11,0	11,6	10,5
• Border, Midland and Western (NUTS 2013)	10,9	11,6	10,1
• Southern and Eastern (NUTS 2013)	11,0	11,5	10,6
• United Kingdom	27,2	26,7	27,8
• North-Eastern Scotland (NUTS 2003)	19,4	16,0	22,8
• Eastern Scotland (NUTS 2013)	25,3	24,7	25,9
• South-Western Scotland (NUTS 2013)	30,1	29,5	30,6
• Highlands and Islands (NUTS 2003)	24,5	23,8	25,1
• Northern Ireland (UK)	24,5	25,4	23,6

People at risk of poverty or social exclusion by NUTS regions					
Year	**2016**	**2017**	**2018**	**2019**	**2020**
• Ireland	24,4	22,7	21,1	20,6	20,8
• Northern and Western	27,3	25,6	25,4	25,4	26,8
• Southern	25,6	23,7	21,4	20,4	22,2
• Eastern and Midland	22,6	20,9	19,4	19,0	18,0
• United Kingdom	22,2	22,0	23,1		



Population on 1 January by NUTS 2 region					
Year	**2016**	**2017**	**2018**	**2019**	**2020**
• Northern and Western	839.204	848.383	856.252	867.947	877.832
• Southern	1.575.504	1.591.718	1.604.865	1.624.381	1.641.057
• Eastern and Midland	2.311.578	2.344.282	2.369.275	2.411.912	2.445.551
• North-Eastern Scotland	492.173	491.323	494.624	495.365	
• Highlands and Islands	468.903	469.420	470.743	470.990	
• Eastern Scotland	1.961.928	1.976.392	1.988.307	1.998.699	
• West Central Scotland	1.520.628	1.531.216	1.536.415	1.541.998	
• Southern Scotland	945.233	946.372	946.837	947.186	
• Northern Ireland (UK)	1.857.048	1.866.638	1.875.957