Client: Special EU Programmes Body – SEUPB

IMPACT EVALUATION

INTERREG VA - PRIORITY AXIS 4 HEALTH & SOCIAL CARE

KA3. Assessment of the programme's contribution to change

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Table of contents

List of tables

INTRODUCTION

The objective of the impact evaluation is to test the intervention logic of priority axis 4 "Health and Social Care" of the INTERREG VA Northern Ireland – Ireland - Western Scotland programme and, in line with the provisions of the evaluation plan, determine:

1. the effectiveness of the programme, i.e. the attainment of the specific objectives 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 will explore 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. Other factors could include additional sources of investment, policy initiatives, changes in the regional economy and population socio-economic conditions. The evaluation will be longitudinal and will identify relevant lessons for the remainder of the programme and potential future programming periods.

METHODOLOGY

In line with the Terms of Reference and the approach adopted in the Project Initiation Document (PID)[1], the first report regarding the Programme's contribution to change in the Health priority axis aims to answer the following evaluation questions:

(Chapter 1)	• 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)	• To what extent has the result indicator "The number of episodes of care delivered on a cross border basis" been achieved? • What has been the impact of cross-border interventions? • Are there barriers to cross-border cooperation that the priority axis is not addressing?
(Chapter 3)	• What level of mainstreaming has occurred for cross-border delivery of health services? • What is the contribution of the priority axis to the EU 2020 objectives?

The first chapter aims to provide an overview of project implementation in Priority Axis 4. Starting from programme-level information, the report then moves to analysing the establishment and effectiveness of cross-border partnerships and projects' financial and output progress. The results are based on the desk analysis of programme and project

[1] See page 24 of the PID, regarding "KA3. Assessment of the programme's contribution to change".

documentation (i.e. application forms, progress reports, eMS data) and on the analysis of responses to the online questionnaire from eight projects[2] (see template in Annex). Project leaders have been consulted in the months of August and September 2018 through the online questionnaire using Problem Trees[3] as a starting point for the discussion on each project. Following the online consultation, the evaluation team was able to compile a comprehensive overview of the main factors contributing to the projects' financial and physical progress under the health and social care priority.

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. In light of the new proposed system of ERDF-CF indicators after 2020[4], which includes the new category of direct result indicators, a number of programme outputs related to Priority Axis 4 have been treated / considered closer to project *results*, that measure the immediate and short-term effects and the direct benefit and outcome of the intervention for the direct addressees (target groups). New direct result indicators in the area of health and social care include, for instance, 'People using supported health care infrastructure' and 'Children using supported child care facilities'. Through an analysis of programme and project documentation, a number of current outputs in the health priority axis have been selected on the basis that they could be considered as direct results.

Following the analysis of the projects' progress towards achieving results, project-specific literature reviews have been conducted to assess external factors affecting projects' contribution to programme impact. An analysis of external factors has taken into account the specificities of 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 contribution of interventions under the Health priority axis to local, national as well as EU policy objectives. Based on the online consultation of projects, the first part focuses on the projects' concrete efforts to ensure the transferability and mainstreaming of results into the local and national policy contexts beyond the project duration, as well as obstacles hindering this process. The section then moves to an analysis of the programme's contribution to wider EU objectives, such as EU2020.

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[2] Acute Services, Changing Lives, CHITIN, CoH-Sync, iRecovery, MACE, mPower, Need To Talk (first Call).
[3] 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.
[4] European Commission (2018), *Development of a system of common indicators for European Regional Development Fund and Cohesion Fund interventions after 2020*.

This impact evaluation report embraced 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 of considering 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 used i.e. a) the societal perspective (comprising all costs and benefits associated with a health programmes, including the so-called externalities); b) the perspective of the service providers (which considers only the perspective of the service providers budget), and c) the users perspective. While evaluating the impact of the programme we will adopt the wider societal perspective but, at the same time, we will distinguish whenever possible whether the observed changes mostly affect 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. Other 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 at different time points relevant lessons, which might potentially inform the remainder of the programme and potential future programming periods.

According to this strategy, the evaluation team combined qualitative methods, such as interviews, surveys and case studies among beneficiaries, with the quantitative data available, programme monitoring data and survey data (see Table 1). The triangulation of the data collected using different methodologies allowed the preliminary definition of the causal pathways underpinning the observed changes and trends.

Table 1. Overall organisation of the report in relation to data sources

Chapter Error! Reference source not found. – **Progress in project implementation**	 Desk analysis of the cooperation programme, application forms and progress reports, data retrieved from the electronic monitoring system (eMS).  Online questionnaire: information on current financial and output progress; input on partnerships
Chapter Error! Reference source not found. – **Progress towards results**	 Online questionnaire: input on current progress towards results and possible external factors  Desk analysis of the Cooperation Programme, application forms and progress reports, data retrieved from the electronic Monitoring system (eMS). Desk analysis of clinical and public health literature to assess external factors.
Chapter Error! Reference source not found. – **Contribution to wider policy objectives**	 Online questionnaire: input on project transferability and mainstreaming  Desk analysis of EU policy objectives and strategies

It should be noted, however, that the early stage of project implementation and delays in delivery prevented the evaluation team from performing a complete assessment of the programme's contribution to change. A more thorough assessment will be included in the reports due in December 2020 and 2022.

KEY FINDINGS

Theme	Related evaluation questions	Key findings
Health priority axis performance	• 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?	The projects have experienced a slow start due to internal and external obstacles (e.g. procurement and recruitment issues, uncertainty in relation to Brexit) and this is reflected in low levels of financial and output progress. Most cross-border frameworks and services have not yet been completed which makes it challenging to assess their effectiveness at this stage. This is also the case in relation to impact on accessibility and quality of equipment and services.
Cross-border partnerships	• 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?	The new partnerships created represent the reinforcement of existing cooperation. The programme's health priority axis has not only provided an opportunity to build on and enhance the composition and work of historical collaborative relationships, but also to test new ways of working to tackle common health care challenges in the programme area.
Progress towards results	• To what extent has the result indicator "The number of episodes of care delivered on a cross border basis" been achieved? • What has been the impact of cross-border interventions?	Little can be said on the impact of cross-border interventions and cooperation at this early stage of project implementation. The progress towards project results appears slow, but more advanced when compared to the financial and output progress. There is therefore a possible inconsistency between the services created (none or little progress)

Theme	Related evaluation questions	Key findings
		and the number of beneficiaries (e.g. patients, families, clients etc.) reached. This inconsistency suggests that indicator definitions and monitoring should be revisited.
External factors	• Are there barriers to cross-border cooperation that the priority axis is not addressing?	The main barriers reported are those related to the Brexit process and the concerns about the future availability of dedicated funding. Other external trends identified by the report include: ageing of the population, trends in poverty and social exclusion, ongoing changes in the overall health system organization. Interestingly, trends are not always consistent in the cooperation territory, suggesting that the programme contribution to change might be affected by external factors to a different extent, according to the context.
Mainstreaming efforts	• What level of mainstreaming has occurred for cross-border delivery of health services?	The mainstreaming of cross-border delivery of health services is still at an early stage in all projects. However, actions to engage key stakeholders (e.g. communication) and ensure harmonisation of procedures are being undertaken or planned to ensure project cross-border services become *core* services in the local contexts. Several obstacles to mainstreaming have been identified, such as the uncertainty related to Brexit and austerity measures affecting the health care sector. The unrestricted movement of staff and clients across the Ireland-Northern Ireland border will be key to ensure the sustainability and mainstreaming of the new services and frameworks created. The willingness of local stakeholders to adopt new cross-border service delivery methods will also be crucial.

1 PERFORMANCE OF THE HEALTH PRIORITY AXIS

The following sections aim to provide an overview of the programme's progress under Priority Axis 4. Starting from programme-level information, the report moves into details of the projects' financial and output progress, based on the analysis of online questionnaires received from eight projects (i.e. those financed through the first call for proposals). Furthermore, a specific section is dedicated to the set-up and effectiveness of cross-border partnerships.

1.1 Overview of Priority Axis 4

The total budget dedicated to Priority Axis 4 amounts to EUR 62 million (ERDF: EUR 52,7 million). This axis supports actions which develop and implement cross-border health care services, in six key areas of health and social care:

1) Population health: support to positive health and well-being and prevention of ill health through an integrated approach;
2) Disability services: development of a social equality approach to promoting social inclusion, citizenship and better life outcomes for disabled people;
3) Mental health: promotion of cross-border mental/emotional resilience and recovery;
4) Children's services: early authoritative intervention with vulnerable families (focusing on the under-5-years population);
5) Primary care and older people services: support to caring communities and independent living (e.g. for Alzheimer's or dementia patients);
6) Acute services: development of new models of working both in scheduled and unscheduled care streams by better utilising scarce physical, financial and human resources.

By the end of 2017 the Programme had allocated a total of EUR 49 million (ERDF: EUR 41,7 mil, co-financing: EUR 7,4 mil) to eight projects under Priority 4[5] approved under a single call for proposals (2 October – 16 November 2015). An additional four projects were approved in 2018 through a second call, leading to an additional budget allocation of EUR 8.5 million (ERDF: EUR 7,2 mil, co-financing: EUR 1,3 mil).

[5] Acute services, Changing Lives Initiative, CHITIN, CoH-Sync, iRecovery, MACE, mPower, Need to Talk.

Table 2. Budget overview

Priority 4 - Health	
Axis budget	€ 62.000.000
Budget allocated until 2017	€ 49.021.847
Budget allocated in 2018	€ 8.354.374
Total budget allocated	€ 57.518.585[6]
Of which ERDF	€ 48.890.798
N. of financed project	12
N. of partners	42

The financed projects have an average duration of 4 years and an average budget of EUR 6,130,000.

1.2 Financial progress

An overview of financial and physical progress under Priority axis 4 has been further developed through an analysis of project documentation (application forms, progress reports) and responses provided by individual projects to the online questionnaire. A significant delay in the implementation of the eight analysed projects has been identified, with financial data showing that projects have spent, on average, 7% of the budget allocated for their activities. **Error! Reference source not found.** below outlines expenditure declared up to May 2018 at the level of each individual project: four out of the eight approved projects have spent less than 2% of their allocated budget. The Changing Lives and Need to Talk projects have the highest declared expenditure so far, respectively 19% and 17% of their allocated budgets.

The low percentage of certified expenditure compared to declared expenditure in some projects (e.g. Changing Lives and Need To Talk) points to possible administrative delays which could be attributed to the programme or project level (e.g. slow certification procedures or frequent errors in the projects' financial reporting).

Worryingly, the total certified eligible expenditure amounts to EUR 1,283,263 to date, compared to a target of EUR 5,738,003 by the end of 2018 in the performance framework of the priority axis.

[6] This amount refers to all projects except Health promoting School + (budget not retrievable via eMS).

Table 3 Financial progress of each project

Project	Total project budget	Total declared expenditure	Total certified expenditure	% declared expenditure	% certified expenditure (of total budget)
Acute Services	9,013,058.87 €	639,749.00 €	276,328.88 €	7%	3%
Changing Lives	3,023,143.00 €	572,195.00 €	185,761.00 €	19%	6%
CHITIN	8,841,667.25 €	168,141.23 €	167,809.51 €	2%	2%
CoH-Sync	5,010,370.75 €	26,109.87 €	23,913.71 €	1%	0%
iRecovery	7,614,750.10 €	85,364.88 €	85,162.24 €	1%	1%
MACE	5,010,240.00 €	24,385.00 €	7,421.00 €	0%	0%
mPower	8,708,617.00 €	568,988.00 €	434,906.00 €	7%	5%
Need to Talk	1,942,365.00 €	303,506.50 €	101,961.00 €	16%	5%

1.3 Progress against outputs

Evaluation questions

- *How effective have cross-border frameworks been?*
- *How have the cross-border interventions affected accessibility in terms of equipment, consultants, service/procedures available?*
- *How have the cross-border interventions affected the quality of service delivered?*
- *Are there any obstacles that are hindering project implementation?*

Key findings

The projects have experienced a slow start due to internal and external obstacles (e.g. procurement and recruitment issues, Brexit) and this is reflected in the slow financial and output progress. Most cross-border frameworks and services have not been completed yet, which makes it challenging to assess their effectiveness at this stage. This is also true for the impact on accessibility and quality of equipment and services.

Alongside weak progress towards financial targets, progress towards the achievement of programme outputs appears problematic. Table 4 reports achievements against each output indicator to end May 2018. Projects with objectives relating to improved accessibility to

equipment and infrastructure show slow rates of advancement, whilst projects aiming to improve access to services tend to be progressing better in relation to their planned targets.

More specifically, none of the interventions to *support clients who have recovered from mental illness* (as scheduled in iRecovery project) or to deliver *cross-border area health care intervention trials for novel but unproven health care interventions to prevent and cure illness (*foreseen under the CHITIN project), have been completed.

On the contrary, the Need to Talk project has already developed two *new cross-border area community support services to support disabled people who are socially isolated,* thus achieving both project and programme targets.

Another positive example concerns the Community Health Sync project, which has been able to deliver seven out of eight *new interventions to support positive health and well-being and the prevention of ill health*.

Table 4: Level of achievement for each output indicator

Output indicator	Achievement 2018 (total)	Project targets (total)	Programme target (2023)
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)	2	2	2
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)	0	1	1
New border area frameworks for early intervention with vulnerable families	0[7]	1	2
Number of new interventions to support positive health and wellbeing and the prevention of ill health	7	8	12
E -health research and evaluation mechanism for the evaluation of e-health and m-health solution	-	-	1

[7] This output indicator belongs to two different projects: Changing Lives and MACE- The result should be considered cumulative.

Output indicator	Achievement 2018 (total)	Project targets (total)	Programme target (2023)
Develop infrastructure and deliver cross-border area health care intervention trials for novel but unproven health care interventions to prevent and cure illness	0	10	10
Specialist training and development programmes for cross-border area health and social care providers	126	1380	3800
Establish cross-border frameworks, for scheduled and unscheduled care streams, to improve utilisation of scarce human, physical and financial resources	0	3	4

No achievement can be reported against the output *e-health research and evaluation mechanism for the evaluation of e-health and m-health solution* as it is not relevant, and hence not included, under any of the eight projects.

The achievement reported against the output indicator *Specialist training and development programmes for cross-border area health and social care providers* represents the sum achieved by all funded projects except the Changing Lives Initiative which is the only project which doesn't contribute towards it. However, progress is visible under only two projects, namely mPower and Need to Talk: the former has implemented 120 training initiatives (corresponding to 29% of the project target) and the latter organised 6 courses (corresponding to 13% of the project target).

Possible internal obstacles hindering project implementation include a significant delay in the issuing of the Letters of Offer to projects. Six projects had a planned start date of 1 September 2016 and two of 1 January 2017, yet all Letters of Offer, bar one, were issued on 14 June 2017, delaying the start of operational activities by ten months for most projects.

The delay seems to be mostly linked to uncertainties in the aftermath of the referendum on the UK's membership of the EU.

Consulted project managers indicated that this particular delay caused a domino-effect which subsequently affected procurement processes related to the purchase of goods and staff recruitment. Certain projects also experienced delays in recruitment because of specific internal procedures in the statutory health and social care systems of the Republic of Ireland

and Northern Ireland. Lower than expected response rates to job advertisements were also considered to be linked to negative publicity surrounding 'Brexit', which discouraged people from applying for EU-funded posts.

PHYSICAL PROGRESS

Experiences from the survey among beneficiaries

iRecovery

Output indicator: *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.*

Target: 1

Achieved: 0

The project failed to achieve the target due to difficulties related to the tendering process to secure three cross-border community and voluntary organisations to deliver activity on the ground. Several procurement exercises have been undertaken, but they have been mostly unsuccessful: one tendering procedure resulted in only one applicant meeting the budgetary requirements causing delays in project mobilisation.

MACE

Output indicator: *Develop and implement new border area frameworks for early intervention to benefit vulnerable families*

Target: 2

Achieved: 0

The recruitment of project staff took longer than anticipated, in particular with regard to the Project Manager who was only appointed in January 2018. The unsuccessful recruitment exercise was probably due to the scarce availability of skilled staff and to the lack of experienced service providers in certain rural/peripheral areas for specific

Source: t33 elaboration on online consultation data (2018)

1.4 Cross-border partnerships

Evaluation questions

- *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?*

Key findings

The new partnerships created represent the reinforcement of existing cooperation. The programme's Health priority axis has not only provided an opportunity to build on and enhance the composition and work of historical collaborative relationships, but also to test new ways of working to tackle common health care challenges in the programme area.

In terms of beneficiaries, the table below provides an own elaboration of categories (types) of partners involved in the projects. The great majority of partners are public health bodies, followed (at much lower levels of participation) by NGOs/foundations and universities.

Table 5. Types of partners

Type of partner	N.	%
Public Health Body	**25**	60%
Private Association	1	2%
University/ schools	6	14%
Public social services provider	2	5%
Charity/ Foundation/ NGO	8	19%
Total	42	100%

In relation to geographical distribution, six out of 12 lead partners and almost half of the partner organisations are located in Northern Ireland.

Table 6. Country distribution

Partner country	N.	%	LP
Ireland	16	38%	5
Northern Ireland	**19**	45%	**6**
Scotland	9	21%	1
Total	42		0

As reported by the interviewed project leaders, most of the partnerships set up under the framework of Priority Axis 4 are the result of existing rather than new relationships between organisations involved in the delivery of health care services.

Four of the eight analysed projects are managed by the CAWT (Cooperation and Working

Together) partnership, namely Acute Service, iRecovery, MACE and Community Health Sync. The CAWT partnership has been implementing health care initiatives on a cross-border basis since 1992 and is composed by Health Service Executive (RoI), the Southern Health and Social Care trust (NI), the Western Health and Social Care Trust (NI), the Health and Social Care Board (NI) and the Public Health Agency (NI). Of the four projects managed by CAWT, only iRecovery represents a CAWT-only composition, whilst for the other three, further partners were included according to the specificity of the project and to the intervention area the project covers (see projects' experiences in the box below).

According to the online consultation with project leaders, interaction between partners has been positive and successful partially as a result of historical collaboration on the provision of health services on a cross-border basis.

The existence of a CAWT Development Centre, composed of a specialised team is an important factor in partnership relations, ensuring the provision of dedicated support in the areas of cross-border strategic development and operational guidance. Each project within the Development Centre is managed by a Project Manager who coordinates project staff and provides partners with information and data on project progress or any factors that may adversely affect the implementation of the project. This organisational structure has proved particularly helpful in the planning stage in terms of submitting application and preparing project business plans.

The programme area has a long tradition of working together in the health care sector on a cross border basis that predates Interreg funding for the area. Strategy groups within the CAWT structure meet a number of times each year to identify themes for cross border collaboration and possible projects for future funding bids.

PARTNERSHIPS

Experiences from the survey among beneficiaries

Acute services – CAWT partnership

This partnership includes three new members, the National Ambulance Services from NI, RoI and Scotland, in the implementation of a new pre-hospital intervention framework The project reinforces the competences of ambulance staff in the programme area and improves their ability to treat patients in their communities and in their own home, thus avoiding unnecessary hospital admission.

"*As part of the overall CAWT acute project, the ambulance services for the republic of Ireland, northern Ireland and Scotland are collaborating in the development and implementation of a community paramedicine project to improve the lives for patients in border and rural areas[…]. This approach has enabled community paramedic to make decisions which ensure more people are seen and treated in their own home and communities, thus reducing significantly the quantity of people that would have been transported to busy hospital emergency departments. This approach is also helping to alleviate some of the pressure on the front-line ambulances in this area."* (Acute services project manager)

MACE – CAWT partnership

The involvement of TUSLA, an Irish agency responsible for improving children's wellbeing represents a new partnership dimension for CAWT. Their participation is considered essential to enable the development of specific solutions to issues, such as Adverse Childhood Experiences.

mPower

This is the largest partnership among the eight analysed and is composed of nine public health bodies from the Republic of Ireland and Northern Ireland, a Scottish voluntary organisation and a Scottish university. This structure was established with the idea that

Source: t33 elaboration of replies to online consultation (2018).

The remaining four projects (Changing Lives Initiative, Need to Talk, mPower and CHITIN) have distinctive partnership structures. In the case of the Changing Lives Initiatives, for instance, the project partnership has been set up thanks to a pre-existing collaboration among partners from RoI and NI, but new relationships have also been formed with Scotland as a result of its inclusion in the current Interreg V-A Programme.

mPower is the only project with a Scottish lead partner, NHS 24 (one of Scotland's seven special health boards[8]) and involves public health bodies from Republic of Ireland and Northern Ireland, and two Scottish partners, i.e. a voluntary organisation and the University of the Highlands and Islands. The establishment of a new collaborative partnership has allowed for an exchange of good practice and lessons learnt amongst partners; they seek to ensure cooperation is sustainable beyond the end of the project funding.

Similarly, the Need to Talk project builds on a new partnership between the National Institutes for Blind People of Northern Ireland and Scotland and a charity from Republic of Ireland committed to research into treatments and cures for blindness. Working together with public institutes at national level has allowed the Fighting Blindness charity to enrich its offer through the delivery of innovative specialised courses, such as “Living with Sight Loss”.

[8] Special NHS Boards support the regional NHS Boards by providing specialist and national services (NHS 24, NHS Education for Scotland, NHS Health Scotland, NHS Inform, Scottish Ambulance Service, State Hospitals Board for Scotland).

	New ways of working/partnerships/relationships reported	Preliminary cooperation impacts reported
Acute Services	New partnerships are being established among medical specialists involved in the different sub-projects (e.g. the case of training and education of Dermatologists).	A positive impact has been reported, especially in terms of reduced travel distances for people living in the Border corridor between Ireland and NI. Barriers are reported in terms of heterogeneity of the legislation and structure of the Health Services, and of poor infrastructure in the rural areas.
Changing Lives	New relationships formed with Scottish partners.	Cross-border collaboration allowed resources sharing among local partners. Reported barriers include differences in the legislation and costs for travel which cannot be reduced even with the use of new ICT
CHITIN	New partnerships are expected.	Benefits are expected. Specific expected impacts include interoperability and enlargement of the recruitment base for the clinical trials. The impact of Brexit impact is already mentioned as a barrier to the current project implementation.
CoH-Sync	New partnerships are reported, especially in Scotland. Novel collaborations are also established by Hub providers.	Benefits are expected as in the project proposal. A Strong cross-border collaboration is reported prior to project submission. Obstacles reported include: different jurisdictions, difficulties in ensuring an effective management of this ambitious project and ongoing health

	New ways of working/partnerships/relationships reported	Preliminary cooperation impacts reported
		system reforms (with consequent changing priorities).
iRecovery	A Scottish partner has been involved in the project. New cross-border community and voluntary sector services have been set up to better reflect local needs.	The creation of economies of scale and avoidance of duplications (i.e. a unified approach across borders) have been identified as expected impacts. Differing legislation and the administrative burden of cross-border projects are cited as barriers, as well as ongoing health reforms.
MACE	Collaboration with a new partner is reported (Tusla). New collaborations have been established across different disciplines involved in the project.	New collaborations are reported as reducing risks of duplication. Benefits are expected as in the project proposal. Obstacles reported include: different jurisdictions, difficulties in ensuring an effective management of this ambitious project and ongoing health system reforms (with consequent changing priorities).
mPower	Too early to report but expected.	Cross-fertilisation is already reported, especially thanks to the presence of a Scottish Partner.
Need To Talk	New training activities are available for the target group of the project.	Reported added-value is the possibility to have first-hand experiences of users' needs. The main barrier reported is the difference between national legislations.

Source: t33 elaboration of replies to online consultation (2018).

2 PROGRESS TOWARDS RESULTS

2.1 Programme result indicator

Evaluation question

❖ *To what extent has the result indicator been achieved?*

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 border areas, as a result of the existence of the border. Through projects financed through the Health priority axis, the Programme aims to increase the level of access to and the quality of health care for communities in the region.

The cooperation programme sets 2018, 2020 and 2023 as milestones to measure the progress of the result indicator, starting from a baseline of 4700 episodes per annum in 2015 to a target of 9000 per annum at the end of the programme. This data is collected by the responsible Irish and UK health trusts in the programme area although data collection methods are not provided in the programme.

At the time of writing, no data on the progress of the result indicator has been made available.

Result indicator	Baseline	Target
The number of episodes of health, community and social care delivered on a cross-border basis (episodes per annum)	4700	9000

2.2 Progress towards project results

Evaluation questions

- *What has been the impact of cross-border interventions?*
- *What cooperation impacts have resulted through delivery on this axis?*
- *How did waiting times change for cross-border patients and for Northern and Southern patients?*

Key findings

Little can be said on the impact of cross-border interventions and cooperation at this early stage of project implementation.

The progress towards project results appears slow, although more advanced when compared to the financial and output progress. There is therefore a possible inconsistency between the services created (none or little progress) and the number of beneficiaries (e.g. patients, families, clients etc.) reached. This inconsistency calls for reflection on the adequacy of project / programme monitoring against indicators.

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, 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;
- 4.113 Beneficiaries supported by new cross-border area initiatives for disabled people of all ages who are socially isolated;
- 4.115 Cross-border area clients in receipt of mental illness recovery services;
- 4.117 Vulnerable families in receipt of an intervention;
- 4.119 Patients benefitting from scheduled and unscheduled care streams;
- 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 project and programme

targets, based on data collected from the responses to the online questionnaire from the eight analysed projects.

Table 7. Progress against direct result indicators

Direct result indicator	Total project targets	Total achievement to date	Programme target (2023)	% progress
Beneficiaries supported by new cross-border area initiatives for disabled people of all ages who are socially isolated	1628	134	4000	3.4%
Cross-border area clients in receipt of mental illness recovery services	8000	148	8000	1.9%
Beneficiaries supported by new cross-border area initiatives for positive health and wellbeing and the prevention of ill health	10,000	360	150,000 (2018 milestone: 2500)	0.2% (against milestone: 14.4%)
Vulnerable families in receipt of an intervention	2000	233	5000	4.7%
Patients availing of e-health interventions to support independent living in caring communities	5100	358[9]	4500 (2018 milestone: 700)	8% (against milestone: 51.1%)
Patients benefitting from scheduled and unscheduled care streams	13,000	744	15,000 (2018 milestone: 2500)	5% (against milestone: 29.8%)
Patients availing of a shared cross-border framework and service for the identification, assessment and referral of patients identified as "at risk"	2500	42	2500	1.7%

Overall, progress towards indicator targets is low. This is particularly the case for indicators included in the performance framework (*Beneficiaries supported by new cross-border area*

[9] This direct result indicator is common to two projects: mPower and Need to talk, so the results reported here reflect achievements under both.

initiatives for positive health and wellbeing and the prevention of ill health, Patients availing of e-health interventions to support independent living in caring communities, Patients benefitting from scheduled and unscheduled care streams), which are still far from achieving their respective 2018 milestone targets.

For instance, Need to talk only reached six patients, corresponding to 1% of the target set by the end of 2018 for the indicator *Patients availing of e-health interventions to support independent living in caring communities*, while Community Health Sync was able to support 360 beneficiaries which represent 14% of the target for the indicator *Beneficiaries supported by new cross-border area initiatives for positive health and wellbeing and the prevention of ill health*.

The experience of Acute Services is worth particular attention: according to the results of the online consultation, the project reached 744 patients so far, corresponding to 30% of the 2018 performance framework milestone for the indicator *Patients benefitting from scheduled and unscheduled care streams*. Following more recent information received from the Acute Services project manager via e-mail, the number of patients rose to 1740 by 30 October 2018, approaching the milestone target.

However, if a comparison is drawn with the financial and output progress analysed in the previous section, the more advanced progress of these 'direct result' indicators seems contradictory. Table 8 presents a comparison between output and direct result indicators for each project. Changing Lives is, for example, performing better against the relevant direct result indicator, reaching 12% of its target in relation to vulnerable families. At the same time, however, no progress has occurred in the creation of new border area frameworks for early intervention and so the percentage of output progress is 0%. Further experiences confirming this inconsistency occurred in the iRecovery and MACE projects. In these cases, although the progress in direct results is low (both of them reached only 2% of the target group), the infrastructure and services aimed to assist patients have not been established yet (output progress in both is zero).

RESULTS

Survey responses from project managers

Community Health Sync

Result indicator: *Beneficiaries supported by new cross-border area initiatives for positive health and wellbeing and the prevention of ill health*

Target: *10,000*

Achieved: *360*

The project has reached 360 beneficiaries at the time of writing, far from the interim target of assisting 2500 patients by December 2018. The project has achieved good progress in the development of new cross-border area interventions, despite starting activity a year later than planned and having a reduced timeframe therefore in which to deliver against the targets. This has been a contributing factor in the lower number of tender responses received from the community and voluntary sectors.

Acute Services

Result indicator: *Patients benefitting from scheduled and unscheduled care streams*

Target: *2500*

Achieved: *744*

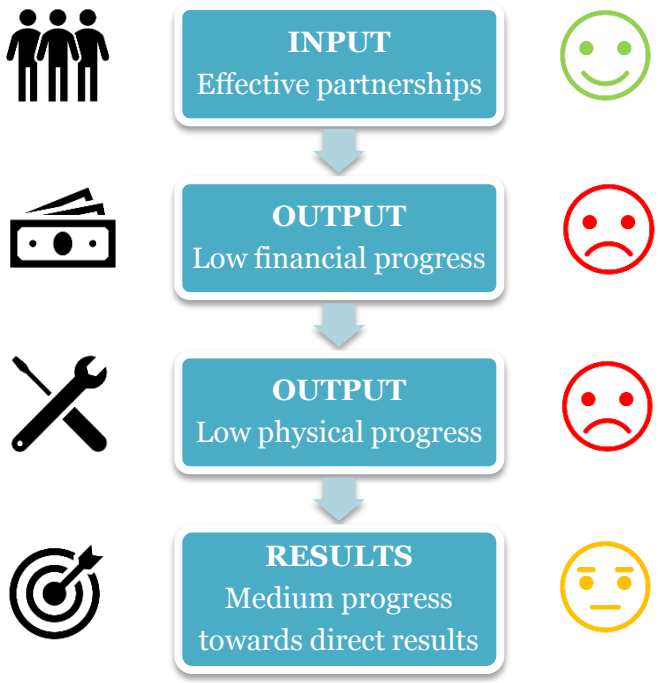
The majority of patients were treated due to already existing infrastructure and could benefit only from scheduled care streams (i.e. outpatients service) where modernisation had been planned for rather than a new physical construction. No patients were assisted under the Community Paramedic strand, designed to be delivered for the first time in the programme area.

This higher achievement of project direct results also contradicts the methodology outlined in the programme's "Indicator guidance" for calculating progress against indicators i.e. clients/patients should be counted only when benefitting from a new cross-border service or framework created by the project (e.g. "*Patients counted under 4.119 must relate to the new cross-border frameworks for scheduled and unscheduled care streams developed under 4.118"*).

Table 8. Comparison between financial, output and direct result progress

Project	% declared expenditure	% of output achievement	% of direct result achievement
Acute Services	7%	0%	6%
Changing lives	19%	0%	12%
CHITIN	2%	0%	-
CoH Sync	1%	44%	4%
iRecovery	1%	0%	2%
MACE	0%	0%	2%
mPower	7%	15%	12%
Need to talk	16%	56%	5%

It is difficult to determine how target groups (e.g. patients, families, clients etc.) can access new services resulting from project interventions when little or no progress has been made towards achieving the outputs necessary to provide these services. This inconsistency (outlined in the figure below) suggests that the definition of and monitoring against indicators should be revisited.



2.3 External factors

Evaluation question

❖ *Are there barriers to cross-border cooperation that the priority axis is not addressing?*

Key findings

The main barriers reported are those related to the Brexit process and the concerns about the future availability of dedicated funding. Other external trends identified by the report include: ageing of the population, trends in poverty and social exclusion, ongoing changes in the overall health system organization. Interestingly, trends are not always consistent in the cooperation territory, suggesting that the programme contribution to change might be affected by external factors to a different extent, according to the context.

External factors reported by beneficiaries during the survey

The main barrier to cross-border cooperation emerging from the consultation with project managers relates to concerns around Brexit, which was seen to have become pervasive, leading to uncertainty and a lack of confidence in the future of cooperation. There is growing trepidation about the likely effects of leaving the EU, even though funding already contracted to UK partners under the programme (and other UK programmes) was guaranteed by the UK Government in August 2016 and the Joint Report agreed in December 2017 provided for the continuation of UK ESIF programmes until the end of the current programming period. One beneficiary even reported pessimism about the future availability of "in-kind" resources to co-finance the current project, as these resources might be re-aligned to other national priorities.

Table 9. External factors as reported by the beneficiaries

Project	External factors affecting the capability of the project to reach its targets (to date)
Acute Services	In relation to the Community Paramedic Service, the rurality of Scotland is hindering the ability to attract personnel to work in this area.
Changing Lives	Not reported.
CHITIN	Not reported.
CoH-Sync	Thanks to a range of political and economic developments, including access to EU funding, cross-border cooperation has become a fact of life and touches everybody from organisations to families and individuals in the border region. People travel across the border to work, shop, socialise and maintain family

Project	External factors affecting the capability of the project to reach its targets (to date)
	relations. There is growing trepidation and ongoing concern about the likely effects of leaving the EU including concern about the border and the likely threat to the ease in which people cross the border without even realising it. This worry about Brexit has become pervasive and is leading to a lack of confidence in and uncertainty about the future which is strongly evident to those involved in EU funding delivery. The longer the Brexit transition period continues the greater the worry and concern over the potential negative impacts of Brexit.
MACE	There is growing concern about the likely effects of the UK leaving the EU and the potential negative impacts. Although not scientific, there is anecdotal evidence that prospective recruits to EU funded project posts and also potential providers of services to EU funded projects have expressed concerns about the continuity of current and future EU funded programmes due to Brexit, despite Governmental guarantees being in place.
mPower	There is definitely an as yet indefinable impact of Brexit. Indefinable because we can only identify one or two specific instances but there is definite perception. Notable has been the emerging position in Scotland with a handful of stakeholders that as an EU project this will soon not be relevant and "in-kind" resources should be aligned to other priorities. I am working to mitigate. The lack of applications for remaining posts is potentially another impact of Brexit. Lastly, all health organisations are under increasing financial pressures and scrutiny. Despite external funding being secure, there remains a necessity to follow new more rigorous procedures which have caused delays in recruitment, spend and adopting new pathways.
Need to Talk	The lack of existing referral pathways (especially in Scotland) and the issues affecting the recruitment of volunteer counsellors are both external factors
iRecovery	The uncertainty and negative publicity relating to Brexit has been a factor in relation to the levels of interest in and applications for EU INTERREG VA positions. Although, in the event of Brexit, both Governments have underwritten the EU INTERREG VA Programme until the end date as planned. However, the general public and also those working in the public and community and voluntary sectors are uncertain and unclear about the future in the event of the UK leaving the EU. This may be part of the reason for reduced interest and applications.

A second main area of critical factors is that of funding. All organisations are currently under increasing financial pressures and scrutiny. In most EU countries the government is striving to transform health and social care services in the context of increasing demands placed on

services by the ageing population and constrained resources. However, in the UK, the NHS is currently halfway through the most austere decade in its history[10], where funding for new service developments is not permitted and many of the cuts have been made to staff and preventive services[11].

The Irish health system, instead is only now recovering from historic long-term underfunding, the effects of which are still being felt. Historic underspending, capacity constraints, a lack of universal primary care entitlements, and longer waiting list make the Irish healthcare at risk of poor value for money[12]. Therefore, despite external funding being secured, the necessity to follow rigorous procedures at national level, have caused delays in recruitment, spending and adopting new pathways.

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

External factors unrelated to Brexit which might create additional barriers to the project implementation have been identified and investigated. The following procedure has been applied. As an initial step, problem trees[13] were developed and sent for validation to the project managers during the online survey. These represented a starting point for discussion on each project and supported the identification of project-specific intervention logic. In a second step, the eight projects were clustered into four subgroups according to the primary challenge addressed, i.e.: "Improving access to care"; "Improving patients' empowerment/self-management"; "Improving lives of people with chronic/long-lasting health conditions"; and "Reducing social isolation of users". The table below presents how the projects have been clustered according to the challenges addressed.

Table 10. Challenges addressed by projects.

Primary Challenge	Project	Challenge addressed by the project
Improving access to care	**Acute Services**	"Difficulties to cope with the rising demand for scheduled and unscheduled cross-border care in the programme areas"

[10] Lafond, S., Charlesworth, A., & Roberts, A. (2016). *A perfect storm: an impossible climate for NHS providers' finances?* Health Foundation.
[11] Robertson, R., Wenzel, L., Thompson, J., & Charles, A. (2017). *Understanding NHS financial pressures. How are they affecting patient care?*
[12] Turner, B. (2018). Putting Ireland's health spending into perspective. *The Lancet*, *391*(10123), 833-834.
[13] 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.

Primary Challenge	Project	Challenge addressed by the project
	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"
Improving patients' empowerment/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"
Improving lives of people with chronic/long-lasting health conditions	**Changing lives**	"Vulnerability of ADHD children and their families in the project areas"
	CoH-Sync	"People living in border areas of the INTERREG VA eligible area are affected to a greater degree by known risk factors for some long-term conditions (chronic disease)"
Reducing social isolation of users	**mPower**	"Isolation of older population from local communities"
	Need to talk	"Social isolation of people affected by sight loss"

In order to identify additional external factors to be isolated, we reviewed the literature to retrieve the most comprehensive explanatory models for each of the four primary challenges. Thanks to these models, we have identified then a list of external factors and related indicators. Indicators have been retrieved from official sources and are presented in table 11 and in the Annex c). This framework of analysis will be expanded with further indicators and used in the two next reports of the evaluation, to interpret and anticipate concurrent external trends, which could contribute to the programme impact.

Identification of external factors affecting access to care. Improved access to care is recognised as an important goal of health policy and it is central to the performance of health care systems around the world[14]. The three projects addressing this overarching challenge

[14] Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International journal for equity in health*, *12*(1), 18.

are Acute Services, MACE and CHITIN. In this respect, the conceptual framework proposed by Aday & Andersen[15] 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*"[16], "*characteristics of the population at risk*"[17], "*characteristics of the delivery system*"[18], and "*consumer satisfaction*"[19].

Identification of external factors affecting empowerment and self-management of patients. The project most clearly addressing the issue of patients/users' empowerment is iRecovery. iRecovery aims at improving lives of people with mental health difficulties who typically rely heavily on statutory health services for medical/clinical support and often struggle to effectively self-manage their condition, resulting in higher risk of adverse outcomes and poor quality of life. For the identification of external factors which are likely to interfere with project activities and outcomes, we relied on the conceptual framework proposed by Bravo et al. (2015)[20]. The key elements of the conceptual framework are the "*patient level characteristics*", those of the "*health care provider*" and of the "*health care system overall*"[21]. Whilst the level of patient empowerment can be improved by specific health care interventions[22], this improvement is moderated by several other variables such as the health

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[15] Aday, L. A., & Andersen, R. (1974). A framework for the study of access to medical care. *Health services research*, *9*(3), 208.

[16] The delivery system might be seen as characterized by two main elements – resources (the labour and capital used in the health care, such as personnel, structures, equipment and materials) and organization (the way the resources are used, including the entry system, such as distance from the user, waiting lists, etc. and the treatment process, i.e. what happens to the patient after they enter the system).

[17] The characteristics of the population influencing access to the services include their health (or illness) status, age, sex, race, religion, and personal values, as well as perceived needs concerning health and illness, as well other external factors such as family, income, type of community and area where they live (e.g., rural or urban, region).

[18] E.g. the type of utilization refers to the kind of service received and who provided it: hospital, physician, dentist, pharmacist, etc. The site refers to the place where the care was received: physician's office, hospital outpatient department, emergency room, etc. The purpose of a visit relates to the reason why the care was received, e.g. for prevention purposes, or connected to a specific type of illness. The time interval may be expressed in terms of whether or not a person entered the medical care system in a certain period of time (equality of access); who gets into the system and how often they use it (e.g. re-admissions/number of visits); and the degree of fragmentation or rather linkage and coordination of medical services associated with a particular illness. Directly dependent from the characteristics of the delivery system, is the utilization of Health Care Services, which is also directly connected to all other aspects of the conceptual framework.

[19] An important part of the conceptual framework is the Consumer satisfaction, that is the users' satisfaction with the quantity or quality of care received.

[20] Empowering patients means putting them in the situation where they can e.g. participate in shared decision-making and making informed decisions about their health and health care, self-manage their condition by choosing meaningful and realistic goals and taking steps to achieve their goals, participate in collective activities such as patient support or advocacy groups, and search for reliable information about their health condition e.g., on the internet. Patient empowerment is likely to lead to better outcomes for the patient, such as better adaptation to their chronic disease, better quality of life and well-being, as well as improved clinical outcomes in the long term, and more independence from health care providers and carers. Bravo, P. et al. (2015). Conceptualising patient empowerment: a mixed methods study. *BMC Health Services Research*, 15:252.

[21] Patient level ethos: The patient has rights, responsibilities and opportunities relating to autonomy, self-determination, power within the health care relationship, and to optimising the use of health care service.
Health care provider level ethos: Health care providers have responsibilities to respect patient autonomy and adopt a partnership style within the health care relationship. Health care system level ethos: The health system has the duty to support patients with long-term/chronic conditions to maximise their health status and wellbeing, by promoting self-management and optimising health care service use.

[22] Examples of health care-system level interventions include training programmes for clinicians and/or patients, such as Personalised Care Planning, and patient education programmes.

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).

Identification of external factors affecting the lives of people with chronic/long-lasting conditions. The two projects directly addressing quality of life of people with chronic or long-last health conditions are Changing Lives and CoH-Sync. To some extent, the identification of external factors affecting these two projects can be guided by the conceptual framework created by the World Health Organization and the McColl Institute for Health care Innovation[23]. In addition to genetics, other interacting risk factors identified by the model are the "*policy environment*", "*community*", "*health care organization*". The conceptual framework highlights the need for comprehensive system design or change, by placing emphasis on different aspects of care for chronic conditions[24].

Identification of external factors influencing social inequalities and isolation. Social relationships have powerful effects on physical and mental health. For this reason, social isolation, as experienced by more vulnerable groups, may constitute an external barrier to successfully implementing mPower and Need to Talk. The conceptual framework theorised by Berkman et al.[25] 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-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

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[23] This framework is an adaptation of the original Chronic Care Model (CCM), resulting in the Innovative Care for Chronic Conditions (ICCC) framework which expands community and policy aspects of improving health care for chronic conditions and includes components at the micro (patient and family), meso (health care organisation and community), and macro (policy) levels[23]. These identified elements could either contribute or hinder the implementation of projects: both Changing lives and CoH-Sync are strongly dependent on community-related aspects relevant for both quality of life of ADHD children and other vulnerable population in the cross-border area who are exposed to several known risk factors of chronic diseases. Epping-Jordan JA (2002). Innovative care for chronic conditions: Building Block for actions: Global report. *WHO Library Cataloguing-in-Publication Data*

[24] The main point is the need for productive interactions between informed, motivated and prepared patients, the community around them (caregivers, family members, social network, etc.) and well-organised, well equipped, well trained, proactive teams of professionals. It is recommended that each member of the groups have the necessary skills to manage chronic conditions and is able to communicate and collaborate with the others. The community is an essential part of the support system, especially in reiterating essential messages about prevention and management of chronic problems. The larger health care organisation, who need to provide continuity and coordination of services, the broader community, and the policy environment influence and support the patient-team-community triad. A positive policy environment that supports care for chronic conditions is essential to reduce the burden of long-term health problems, especially in terms of legislation, including integration of policies, advocacy, financing, development and allocation of human resources, and strengthening of partnerships.

[25] 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.

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). By embedding social networks in this larger chain of causation, we can integrate “upstream" macro-social forces related to the political economy with social networks as mediating structures between the largest and smallest scale social forms. Thus, we can see the connection between the role of culture, rapid social change, industrialisation and urbanisation on the structure of networks, and health and wellbeing[26].

Overview of the factors identified and related indicators. In line with the variables identified in the different theoretical frameworks, we have identified a set of indicators related to external factors, which should be considered as potentially contributing to each project outcome. The indicators list and related trends are shown in the table below. In order to ensure cross-border comparability of the indicators, we have used EuroStat. For some indicators, it is yet not possible to make a trend comparison, given that currently only one-time point data is available. Nonetheless, we have included all the indicators in the table, given the possibility to update the analysis in the next evaluation report, due in 2020.

[26] Social isolation, therefore, deprives the individual of the emotional (love and care also from e.g. neighbours), instrumental (help, aid or assistance with tangible needs such as getting groceries, getting to appointments, phoning, cooking, cleaning or paying bills), appraisal (decision making, feedback) and informational (advice) support (Weiss, 1974) that the social network normally provides. Social networks also encourage social participation and social engagement, which reinforce meaningful social roles and in turn, provide a sense of value, belonging, and attachment.

Table 11. 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 EuroStats	*Healthcare policy*	*Characteristics of the health delivery system*	*Characteristics population at risk*	*Consumer satisfaction*	*Patient context, personal values, characteristics*	*Healthcare provider characteristics*	*Healthcare system characteristics*
BMI			n.a.		n.a.		
DRINKING			n.a.		n.a.		
SMOKING			n.a.		n.a.		
DAILY CONSUMPTION OF FRUIT AND VEGETABLES			n.a.		n.a.		
PHYSICAL ACTIVITY			n.a.		n.a.		
TIME SPENT ON PHYSICAL ACTIVITY			n.a.		n.a.		
FREQUENCY OF CONTACT			n.a.		n.a.		
DISABILITY			n.a.		n.a.		
SELF PERCEIVED HEALTH			n.a.		n.a.		
PERCEIVED SOCIAL SUPPORT			n.a.		n.a.		
PERSON PROVIDING INFORMAL CARE			n.a.		n.a.		
GDP	mixed trends (a)						mixed trends (a)
HEALTHCARE EXPENDITURE	mixed trends (a)						mixed trends (a)
EXPENDITURE ON SOCIAL PROTECTION	mixed trends (a)						mixed trends (a)
HEALTH PERSONNEL		increase				increase	
HOSPITAL BEDS		mixed trends (a)				mixed trends (a)	
LONG TERM CARE BEDS		mixed trends (a)				mixed trends (a)	
LIFE EXPECTANCY			increase		increase		
HEALTHY LIFE YEARS			mixed trends (a)		mixed trends (a)		
RISK OF POVERTY AND SOCIAL EXCLUSION			decrease		decrease		
LONG TERM ILLNESS			mixed trends (b)		mixed trends (b)		
UNMET HEALTHCARE NEEDS			increase		increase		
USE OF HOME CARE SERVICES		n.a.					n.a.
POPULATION 65+			increase		increase		

n.a.: not available as trends, but to be evaluated in the next report; mixed trends (a)= positive trends in the Irish areas, negative trends in the UK ones; mixed trends (b)= positive trends in the UK areas, negative trends in the Irish ones

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 EuroStats	*Policy environment*	*Community*	*Healthcare organization*	*Social structural conditions*	*Social networks*	*Psychosocial mechanisms*
BMI		n.a.				
DRINKING		n.a.				
SMOKING		n.a.				
DAILY CONSUMPTION OF FRUIT AND VEGETABLES		n.a.				
PHYSICAL ACTIVITY		n.a.				
TIME SPENT ON PHYSICAL ACTIVITY		n.a.				
FREQUENCY OF CONTACT		n.a.			n.a.	
DISABILITY		n.a.		n.a.		
SELF PERCEIVED HEALTH		n.a.		n.a.		
GDP	mixed trends (a)			mixed trends (a)		
HEALTHCARE EXPENDITURE	mixed trends (a)			mixed trends (a)		
EXPENDITURE ON SOCIAL PROTECTION	mixed trends (a)			mixed trends (a)		
HEALTH PERSONNEL				increase		
HOSPITAL BEDS			mixed trends (a)		mixed trends (a)	
LONG TERM CARE BEDS			mixed trends (a)		mixed trends (a)	
RISK OF POVERTY AND SOCIAL EXCLUSION		decrease			decrease	
LONG TERM ILLNESS		mixed trends (b)			mixed trends (b)	
UNMET HEALTHCARE NEEDS		increase				
USE OF HOME CARE SERVICES			n.a.		n.a.	
POPULATION 65+		increase		increase		
PERCEIVED SOCIAL SUPPORT						n.a.
PERSON PROVIDING INFORMAL CARE					n.a.	

n.a.: not available as trends, but to be evaluated in the next report; mixed trends (a)= positive trends in the Irish areas, negative trends in the UK ones; mixed trends (b)= positive trends in the UK areas, negative trends in the Irish ones

3 CONTRIBUTION TO WIDER POLICY OBJECTIVES

3.1 Local and national mainstreaming

Evaluation questions

- *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?*

Key findings

The mainstreaming of cross-border delivery of health services is still at an early stage in all projects. However, actions to engage key stakeholders and to harmonise procedures are being undertaken or planned by most projects to ensure project cross-border services become *core* services in the local contexts.

Several obstacles to mainstreaming have been identified, such as the uncertainty related to Brexit and budget cuts affecting the health care sector. The unrestricted movement of staff and clients across the Ireland-Northern Ireland border will be key to ensure the sustainability and mainstreaming of new services and frameworks. The willingness of local stakeholders to adopt new cross-border service delivery methods will also be crucial.

The contribution to change of the Programme's cross-border health care interventions have been assessed against the concrete actions taken by 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.

At this stage in project implementation, the adequacy of activities undertaken and the ability of each project to mainstream the cross-border frameworks/services created are still difficult to evaluate. In many cases, mainstreaming strategies and activities are yet to be thoroughly decided and implemented. Nonetheless, a specific set of questions in the online consultation allowed first-hand experiences and practices of projects to be gathered with regard to sustainability and mainstreaming actions and their respective drivers and obstacles.

In terms of sustainability, several projects aim to ensure the sustainability of their interventions by building knowledge and skills (i.e. training) 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 managers have reported, sustainability strictly depends on the capacity of the project to provide robust evidence on its positive impact on the lives of people. The iRecovery project, for instance, deals with mental illness cases that represent a huge burden on the health and social care services and on society, yet in a time of austerity and competing demands, the project will need to evidence its outcomes and impacts for mainstreaming in the long term. In this regard, a detailed project evaluation can be useful to capture and analyse service user feedback as well as the impact of delivery of such a large-scale project on a cross-border basis.

Cross-cutting factors which risk hampering project sustainability are the uncertainty related to the terms of the UK's withdrawal from the EU as well as 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 should therefore be explored even if different from the methods initially designed and proposed by projects.

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

Communication activities (conferences, awareness raising events, social media etc.) are usually cited as the main type of action conducted to keep stakeholders updated on the projects' progress and to increase the potential for future 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.

Similarly, obstacles to mainstreaming project interventions include budget cuts and a general lack of resources at department and government level. However, the uncertainty related to the UK's withdrawal from the EU is cited the most frequently. In particular, the continued unrestricted movement of staff and clients across the border region of Ireland and Northern Ireland to enable them to access services in either jurisdiction is considered vital. To a lesser degree, the openness of service providers to using different models of service delivery is perceived as an important factor in ensuring or facilitating mainstreaming of activity.

	Activities to ensure sustainability of project initiatives already in place	Expected barriers to sustainability	Actions to ensure mainstreaming of project initiatives already in place	Expected barriers to mainstreaming
Acute Services	Sustainability is sought through the establishment of support from high-level management and political levels. Hopes and expectations on new technologies.	Brexit and the inability to retain the scarce clinical skills in the Border area.	Reliance on an effective communication strategy to engage key stakeholders, combining traditional and new media	Brexit aftermath and lack of funding at Departmental level.
Changing Lives	Training of external agencies will start soon	Lack of resources.	The project is expected to provide a template for collaboration outside the project area. Outputs such as the project app will be available for use in other contexts.	Willingness of service providers to change.
CHITIN	Development of a sustainability framework and legacy plan	Lack of funding and Brexit.	Development of a sustainability framework and legacy plan	Lack of funding and Brexit.
CoH-Sync	The planned evaluation of the impact of the CoH-Sync Hubs is the most relevant factor which will determine the sustainability of the project results.	Lack of funding and amount of time needed for a real evaluation of impact (given the nature of the project outcome, i.e. changing life styles) which in turn affects the perceived value-for-money of the interventions.	Communication activities and impact on the general public (use of testimonials and case studies is planned).	Lack of funding and Brexit.
iRecovery	Key decision-makers are being regularly engaged to support the project´s sustainability efforts.	Lack of future funding and Brexit.	Communication activities through traditional and new media.	Lack of resources to fund an in-depth project evaluation to assess the impact. In a time of budget cuts, only projects that demonstrate strong impact will be mainstreamed.

	Activities to ensure sustainability of project initiatives already in place	Expected barriers to sustainability	Actions to ensure mainstreaming of project initiatives already in place	Expected barriers to mainstreaming
MACE	Internal project data collection is aimed at ensuring a thorough project impact evaluation. Investment in the skills of the professional community. The E-portal of the project will be sustainable over time	Lack of funding and Brexit. It is vital that unrestricted movement of staff and clients across the border regions can continue.	Communication activities and impact on the general public (use of testimonials and case studies is planned).	Breakdown in the partnership working model Lack of funding Future policy development, including Brexit.
mPower	None reported; project managers believe that the project will follow the lead of previous CAWT project and the Scottish Government's Technology Enabled Care Programme	The delay in project implementation (e.g. staff recruitment delays) has been reported as a factor which might undermine sustainability.	None reported; project managers believe that the project will follow the lead of previous CAWT project and the Scottish Government's Technology Enabled Care Programme	The delay in project implementation (e.g. staff recruitment delays) has been reported as a factor which might undermine mainstreaming.
Need to Talk	Legacy issues are under discussion. The e-programs developed by the project will be sustainable beyond 2021.	Lack of support from local area referral pathways	Engagement of local organization 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.

3.2 Contribution to EU objectives and strategies

Evaluation question

❖ *What is the contribution of the priority axis to the EU 2020 objectives?*

The health priority axis contributes to the Inclusive Growth objective of the Europe 2020 strategy. This objective includes fighting poverty and modernising labour markets, training and social protection systems. In this respect, the strategy states that "*a major effort will be needed to combat poverty and social exclusion and reduce health inequalities to ensure that everybody can benefit from growth [...] Equally important will be the ability to meet the challenge of promoting a healthy and active ageing population to allow for social cohesion and higher productivity.*"

The needs analysis of the programme area, which has identified inequalities in health care provision for citizens living in the border area, led to the selection of Specific Objective 6 "To increase the health and welling of people in the programme area and reduce health inequalities through improved access to quality health and social care services, delivered in the setting most appropriate to their need", aiming to contribute to thematic objective 9 "Promoting Social Inclusion, Combating Poverty and any discrimination".

According to the cooperation programme, "*...improving the health of citizens across the programme area is important for the economic growth of the region as keeping people healthy and active for longer will have a positive impact on productivity and competitiveness. The delivery of cross-border health care services offers the opportunity to achieve improved patient outcomes and increased public sector efficiencies*."

The projects analysed so far have the potential of contributing to the EU2020 objective if they achieve the expected result of increasing access to health care services on a cross-border basis. This achievement will have the effect of improving the health conditions and reducing health inequalities for citizens living in remote (border) areas. Nonetheless, as earlier mentioned in this report, the early stage of implementation of most of the projects, de facto hinders the possibility to draw conclusions regarding their contribution to EU Strategies and objective at the moment.

4 ANNEX

a) Questions included in the online consultation to eight projects.

Problem Tree

The preliminary Problem Tree has been drafted based on the analysis of your project's business plan. It aims to illustrate your project's intervention logic: is the identified core problem correct? Are the causes and effects exhaustive and correctly placed?

Cross-border partnerships

How have you set up the partnership? / Has the interaction among partners been positive/fruitful? / How are the tasks distributed among partners? / Have any new ways of working or new partnerships been created as a result of activities carried out within the project? / What is the added value of working in a cross-border context? What are the obstacles?

Financial and physical progress

Please provide figures and comment on the progress of project outputs: Start (Baseline) - Now (2018) / Have you set up any project self- assessment instruments to measure the progress of your project? / Please provide: total declared expenditure - total certified expenditure - total project budget / Are there any internal procedural obstacles hindering project implementation? If so, have you managed to overcome them? How?

External factors

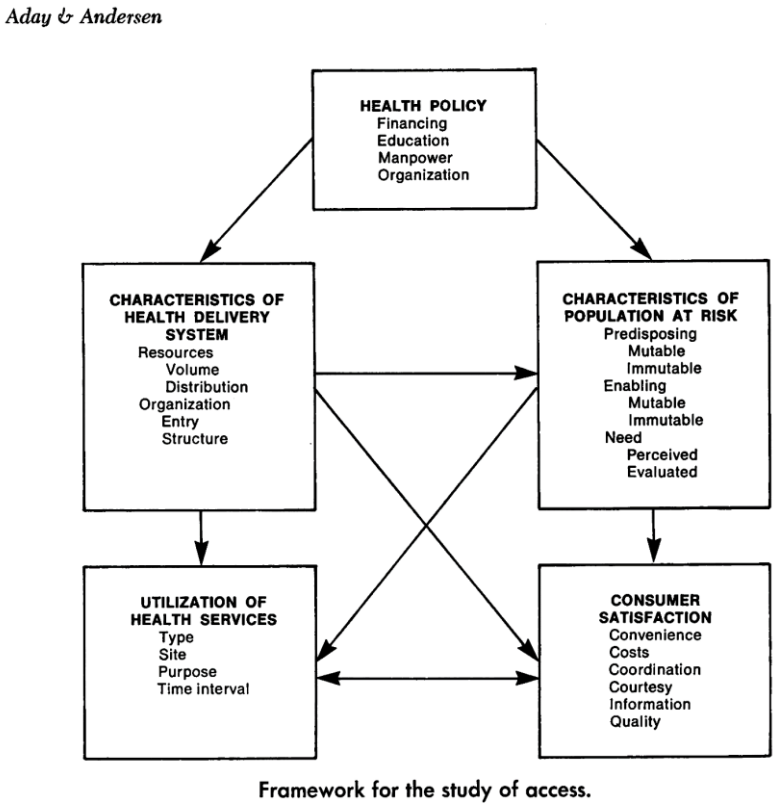
Social Factors - Economic Factors - Health-Related Factors / Taking also into account the scientific literature on your project's theme, are there other external factors which could influence your project's contribution in tackling the core problem?

Sustainability and mainstreaming

How are you mainstreaming the project activities? Do you receive support from the programme bodies? / What kind of concrete actions have you planned or implemented to ensure the sustainability of the project beyond its duration? / Which factors (could) facilitate/hinder the sustainability of the project beyond its duration? / What kind of concrete actions are you envisaging to ensure the transferability and capitalisation of project results within and beyond the project area? / Which factors (could) facilitate/hinder the transferability and capitalisation of project results beyond its duration?

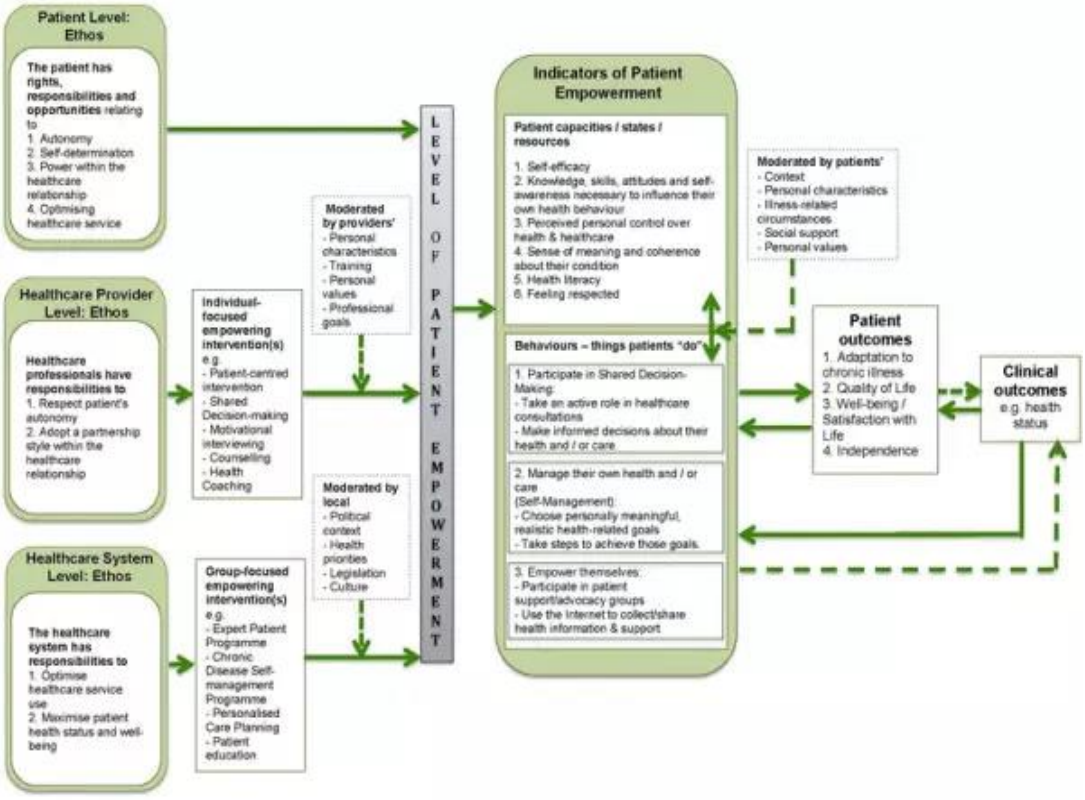
b) Conceptual models used for the analysis of the eight projects.

Framework for improving access to care. Aday & Andersen:



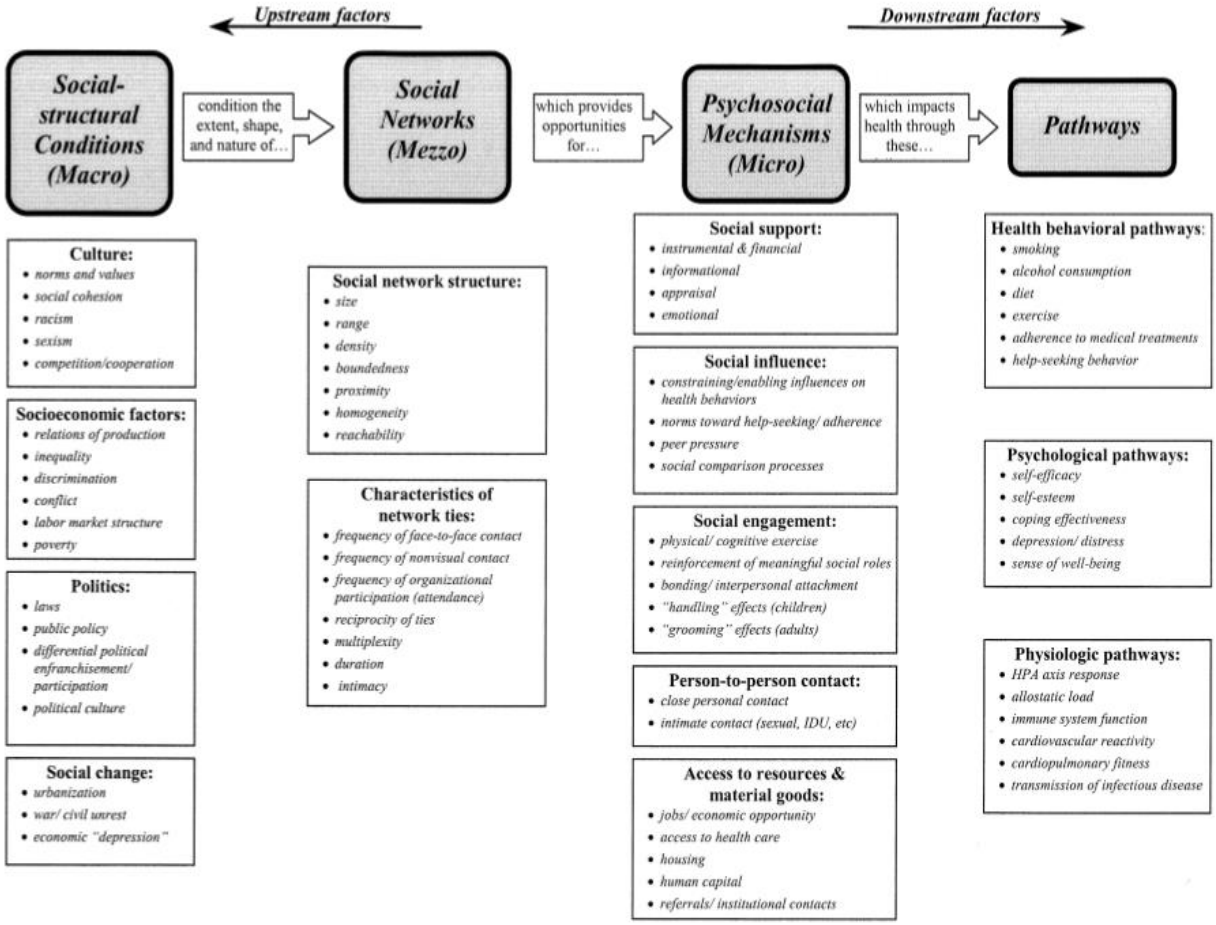
Framework for the study of access.

Framework for Improving patients' empowerment/self-management. Bravo, P. et al.:



Framework for improving improving lives of people with chronic/long-lasting conditions. Epping-Jordan JA

Framework for reducing social isolation of users Berkman et al.



c) Official Statistics[27] related to the major external trends identified by the Evaluation Report

		Nation	
year	Indicators	Ireland	UK
2015	EXPENDITURE ON SOCIAL PROTECTION (% of GDP)	15,8	27,6
2016	EXPENDITURE ON SOCIAL PROTECTION (% of GDP)	15,8	26,2
2017	EXPENDITURE ON SOCIAL PROTECTION (% of GDP)	n.a.	n.a.
2015	GDP (Current prices, million euro)	262466,2	2611924,1
2016	GDP (Current prices, million euro)	273238,2	2403382,6
2017	GDP (Current prices, million euro)	294110,1	2332087,3
2015	HEALTHCARE EXPENDITURE*	19511,42	254820,62
2016	HEALTHCARE EXPENDITURE*	20332,18	233886,44
2017	HEALTHCARE EXPENDITURE*	n.a.	n.a.
2015	HEALTHY LIFE YEARS females	67,9	63,3
2016	HEALTHY LIFE YEARS females	69,8	63,1
2017	HEALTHY LIFE YEARS females	n.a.	n.a.
2015	HEALTHY LIFE YEARS males	66,6	63,7
2016	HEALTHY LIFE YEARS males	67,3	63,0
2017	HEALTHY LIFE YEARS males	n.a.	n.a.
2015	LIFE EXPECTANCY at 65	19,8	19,8
2016	LIFE EXPECTANCY at 65	19,9	20,0
2017	LIFE EXPECTANCY at 65	n.a.	n.a.
2015	POPULATION 65+ WITH LONG-TERM ILLNESS	53,2	52,0
2016	POPULATION 65+ WITH LONG-TERM ILLNESS	59,1	64,5
2017	POPULATION 65+ WITH LONG-TERM ILLNESS	n.a.	n.a.
2015	SELF PERCEIVED HEALTH - BAD (percentage)	6,6	10,1
2015	SELF PERCEIVED HEALTH - FAIR (percentage)	26,2	33,5
2017	SELF PERCEIVED HEALTH 65+ -VERY GOOD OR GOOD (percentage)	65,6	52,6
2016	SELF PERCEIVED HEALTH 65+ - BAD (percentage)	6,2	10,3
2016	SELF PERCEIVED HEALTH 65+ - FAIR (percentage)	26,1	33,1
2016	SELF PERCEIVED HEALTH 65+ -VERY GOOD OR GOOD (percentage)	65,7	53,8
2017	SELF PERCEIVED HEALTH 65+ - BAD (percentage)	n.a.	n.a.
2017	SELF PERCEIVED HEALTH 65+ - FAIR (percentage)	n.a.	n.a.
2017	SELF PERCEIVED HEALTH 65+ -VERY GOOD OR GOOD (percentage)	n.a.	n.a.

*(All providers of health care; in million euros)

[27] Source: Eurostat https://ec.europa.eu/eurostat/data/database

		NUTS 2		
year	Indicators	Ireland	Border, Midland, Western	UK
2015	HEALTH PERSONNEL - Medical Doctors	14666,00	n.a.	181673,00
2016	HEALTH PERSONNEL - Medical Doctors	15178,00	n.a.	183938,00
2017	HEALTH PERSONNEL - Medical Doctors	15660,00	n.a.	n.a.
2015	HEALTH PERSONNEL - Nurses and Midwives	65203,00	n.a.	546009,00
2016	HEALTH PERSONNEL - Nurses and Midwives	67559,00	n.a.	548291,00
2017	HEALTH PERSONNEL - Nurses and Midwives	n.a.	n.a.	n.a.
2015	HOSPITAL BEDS	12010,00	3089,00	169995,00
2016	HOSPITAL BEDS	12359,00	3134,00	n.a
2017	HOSPITAL BEDS	n.a.	n.a.	n.a.
2015	LONG TERM CARE BEDS	30106,00	8417,00	548397,00
2016	LONG TERM CARE BEDS	30396,00	7731,00	545010,00
2017	LONG TERM CARE BEDS	30732,00	n.a.	542627,00
2015	RISK OF POVERTY AND SOCIAL EXCLUSION	26,0	n.a.	23,5
2016	RISK OF POVERTY AND SOCIAL EXCLUSION	24,2	n.a.	22,2
2017	RISK OF POVERTY AND SOCIAL EXCLUSION	n.a.	n.a.	n.a.

		NUTS 3											
year	**Indicators**	Ireland	Border	Dumfries & Galloway	East Ayrshire and North Ayrshire mainland	South Ayrshire	Lochaber, Skye & Lochalsh, Arran & Cumbrae and Argyll & Bute	Eilean Siar (Western Isles)	Belfast	Outer Belfast	East of Northern Ireland	North of Northern Ireland	West and South of Northern Ireland
2015	POPULATION 65+ (number of people)	604 861	72 356	36 038	49 985	26 569	24 707	6 506	41 801	68 211	74 296	44 771	60 657
2016	POPULATION 65+ (number of people)	624 519	74 676	36 587	51 226	27 002	24 407	6 609	41 763	69 479	75 985	46 003	62 112
2017	POPULATION 65+ (number of people)	646 517	77 279	37 143	52 033	27 489	24 783	6 708	43 230	72 544	79 731	48 139	65 336