OUTPUT INDICATOR GUIDANCE

INTERREG VA

Cross-border Programme for Territorial Co-operation 2014-2020, Northern Ireland, Border Region of Ireland and Western Scotland

Thematic Objective 9
Promoting social inclusion, combating poverty and any discrimination

Priority Axis 4
Health

Investment Priority 4.a

Investing in health and social infrastructure

Specific Objective 4.1

Through collaboration on a cross-border basis, to improve the health and well-being of people living in the region by enabling them to access quality health and social care services in the most appropriate setting to their needs

Document Control

Document History		
Version	**Date**	**Changes**
1.0	January 2016	Drafted by Carly Gordon (NISRA)
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3.0	July 2023	Drafted by Mary Cousins (SEUPB)

INTRODUCTION

INTERREG VA - United Kingdom - Ireland is a European Territorial Cooperation programme that aims to promote greater economic, social and territorial cohesion. The eligible region for this programme comprises Northern Ireland, the Border Region of Ireland, and Western Scotland.

Ireland and Northern Ireland share a land border, whilst the border between Ireland and Scotland is a maritime border. Northern Ireland and Scotland are also separated by the North Channel. In all cases the regions concerned are peripheral to the main economic centres of their respective Member States. The contrasting nature of the borders within the eligible area means that different approaches to promoting cross-border co-operation need to be adopted, depending on the nature of the border and the sector involved.

The following strategic areas of investment have been prioritised by the Member States for the 2014-2020 period:

- Smart Growth Priority: Thematic Objective 1 – Strengthening Research, Technological Development and Innovation - The programme will contribute to the objective within EU2020 of increasing the spend on Research and Development (R&D) to 3% of GDP by 2020, by establishing increased cross-border R&D competence building, for Life and Health Sciences and Renewable Energy. Additionally, R&D into renewable energy technologies may contribute to EU2020 targets and lead to reductions in the use of carbon resources and emissions.
- Sustainable Growth Priority: Thematic Objective 6 – Preserving and Protecting the Environment and Promoting Resource Efficiency- The inclusion in the programme of the protection and preservation of habitats and species, an emphasis on water and marine management will contribute to enhancing the region's sustainability and is congruent with the priority for sustainable growth outlined in strategy EU2020.
- Sustainable Growth Priority: Thematic Objective 7 – Promoting Sustainable transport and removing bottlenecks in key network infrastructures – The promotion of electric vehicles; greenways; and multimodal transport links have the purpose of reducing the reliance upon carbon forms of transport in the region and underpins the EU2020 strategic objective of creating sustainable growth.
- Inclusive Growth Priority: Thematic Objective 9 – Promoting Social Inclusion, Combating Poverty and any discrimination. The needs analysis of the region has

identified inequalities in health care provision for those citizens living in the border area. The inclusion of improved access to cross-border health services is in line with the EU 2020 strategy to generate inclusive growth.

This document provides descriptions and definitions for the output indicators under priority axis 4 presented in the new INTERREG VA Programme 2014 – 2020.

Priority axes (PA) are the building blocks of programmes; the PAs are defined as follows: PA *1 – Research and Innovation*, *PA 2 – Environment*, *PA 3 – Sustainable Transport*, and *PA 4 – Health.* This document includes a diagram highlighting the investment priorities, specific objectives, result and output indicators, as well as descriptions and definitions of the priority axis 4 output indicators in detail.

GENERAL DEFINITIONS

The Programme's impact will be monitored through the use of output and result indicators[1]. This section provides a definition of output and result indicators. Projects receiving funding through INTERREG VA will be expected to report progress against output indicators only, as such this document goes on to outline definitions and guidance relating to output indicators only.

Output Indicators: Link to activities of operation. They are measured in physical or monetary units (e.g. length of road constructed, number of firms financially supported) and contribute to result indicators.

Output indicators cover all investment priorities of a programme (art. 27.4(b), 96.2(b) CPR). They should be derived from the intervention logic of the programme, expressing its actions. Output indicators from the list of common indicators may be insufficient to reflect the actions of a certain programme; in this case it was necessary to also identify programme specific output indicators.
The programme shall set *cumulative targets* for output indicators for 2023 (art. 6, ERDF regulation; art. 5, CF regulation; art. 16, ETC regulation). Baselines for output indicators are not required.

Result Indicators: Relate to specific objectives and capture the expected change.

Each priority axis includes one or more investment priorities according to their specific needs and context. The specific objective is the expression of what each investment priority aims to achieve (see art.2.34, CPR for legal definition of a specific objective). The change sought by the specific objective is expressed in one *result indicator*, or as few as possible.[2]

Result indicators shall meet certain quality criteria. They should be:

a) responsive to policy: closely linked to the policy interventions supported. They should capture the essence of a result according to a reasonable argument about which features they can and cannot represent;

[1] Ecorys Academy. (2014). Training to Managing Authorities: Intervention logic - Explaining the result orientation of 2014-2020.
[2] EC (2014). The programming period 2014-2020: Guidance document on monitoring and evaluation. Retrieved from: http://ec.europa.eu/regional_policy/sources/docoffic/2014/working/wd_2014_en.pdf

b) normative: having a clear and accepted normative interpretation (i.e. there must be agreement that a movement in a particular direction is a favourable or an unfavourable result);
c) robust: reliable, statistically validated;
d) timely: available when needed, with room built in for debate and for revision when needed and justified.

GUIDANCE FOR MEASURING AND RECORDING ACHIEVEMENT FOR INDICATORS

The following is some general advice to take into account when recording achievement against output indicators on the database in relation to project monitoring for the 2014-2020 Programme (eMS). The purpose of this is to ensure that all projects record accurately and consistently; ensuring that Programme level reporting on progress against indicators is reflective of each of the projects that have received funding and are contributing to Programme aims and objectives.

- The lead partner is the source of data for all indicators, as they should collect and/or collate relevant data from project partners and managers to report against each of the output indicators relevant to their project.

- Achievement should be updated on a quarterly basis, even if there is nothing to report (in this case a '0' should be entered).

- In addition to indicators and targets, Lead Partners will also have to agree milestones, where relevant. These will be project specific, included in the Letter of Offer and will have to be reported against regularly to show progress towards achieving an output indicator.

- Level of recording - Activity/achievement should only be entered at one level i.e. preferably only the lead partner will enter any achievement against their project, to avoid any possibility of duplicate recording and ensure consistency. Entries will then be quality assured by the Joint Secretariat and the Financial Control Unit in SEUPB. Where monitoring data is being collected by, for instance, service providers as opposed to the lead partner; the lead partner should take responsibility for collating monitoring data from the various sub-projects/project managers/service providers, and record activity on eMS on a quarterly basis.

- Projects should also note that activity should be recorded in the reporting periodto which it is related, rather than the date it was entered, i.e. if an activity took place in December of 2017 but not recorded until January 2018, the entry should be made under 2017. Achievement should only be recorded upon completion of the target activity (e.g. beneficiaries completing a health and wellbeing programme), and not in anticipation of its completion (e.g. individuals registering for a health and wellbeing

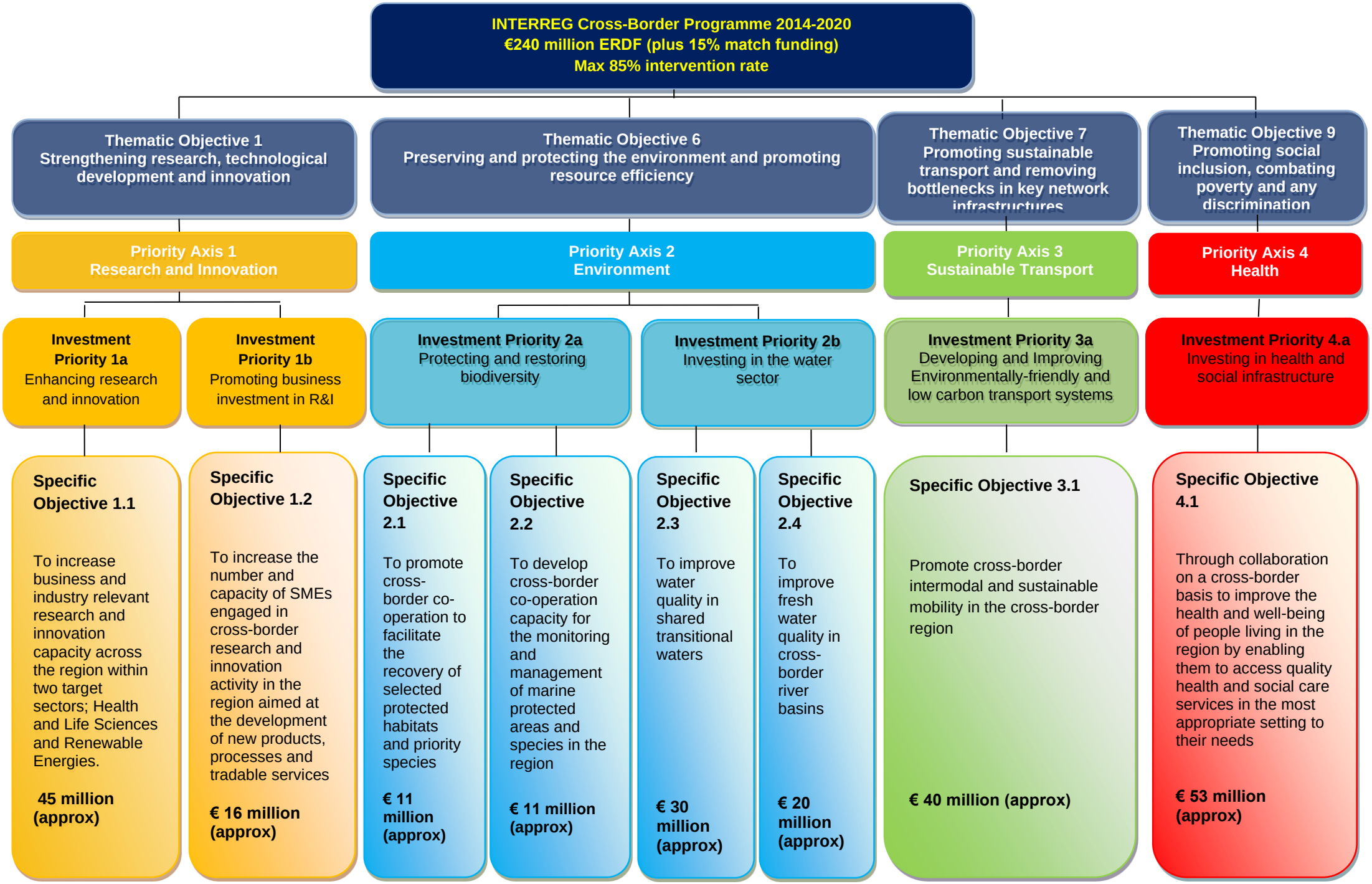
programme),

- In all cases the term year refers to the calendar year January to December.

- Record achievement as information becomes available - Achievement against output indicators at the INTERREG Programme level is reported on at several times during the year (including Spring and Autumn Programme Monitoring Committees and the Annual Implementation Report that is produced by calendar year). Ideally, projects should not wait until the year end to enter all achievement in one go. It would be more beneficial to report achievement at regular intervals, ideally not later than the end of each quarter, to ensure that Programme level reports are as accurate and up to date as possible, reflecting the output achievement of all projects at that point in time. Projects should note that even if there is no achievement against certain output indicators there is still the need to update monitoring entries. In this case projects, should enter zero.

- Check wording and definitions - this document contains a list of the relevant indicators and associated definitions and units. Please ensure you are reporting accurate, relevant information, avoiding double counting and using the correct unit (e.g. enterprises, patients, percentage etc).

  For example, 'number of enterprises engaging an intern'; the unit here is enterprises, so you should not record the number of interns as this may lead to double counting if an enterprise employs more than one intern. It should be the number of enterprises and each enterprise should only be counted once.


INTERREG Cross-Border Programme 2014-2020
€240 million ERDF (plus 15% match funding)
Max 85% intervention rate
Thematic Objective 1
Strengthening research, technological development and innovation
Thematic Objective 6
Preserving and protecting the environment and promoting resource efficiency
Thematic Objective 7
Promoting sustainable transport and removing bottlenecks in key network infrastructures
Thematic Objective 9
Promoting social inclusion, combating poverty and any discrimination
Priority Axis 1
Research and Innovation
Priority Axis 2
Environment
Priority Axis 3
Sustainable Transport
Priority Axis 4
Health
Investment Priority 1a
Enhancing research and innovation
Investment Priority 1b
Promoting business investment in R&I
Investment Priority 2a
Protecting and restoring biodiversity
Investment Priority 2b
Investing in the water sector
Investment Priority 3a
Developing and Improving Environmentally-friendly and low carbon transport systems
Investment Priority 4.a
Investing in health and social infrastructure
Specific Objective 1.1
To increase business and industry relevant research and innovation capacity across the region within two target sectors; Health and Life Sciences and Renewable Energies.
45 million (approx)
Specific Objective 1.2
To increase the number and capacity of SMEs engaged in cross-border research and innovation activity in the region aimed at the development of new products, processes and tradable services
€ 16 million (approx)
Specific Objective 2.1
To promote cross-border co-operation to facilitate the recovery of selected protected habitats and priority species
€ 11 million (approx)
Specific Objective 2.2
To develop cross-border co-operation capacity for the monitoring and management of marine protected areas and species in the region
€ 11 million (approx)
Specific Objective 2.3
To improve water quality in shared transitional waters
€ 30 million (approx)
Specific Objective 2.4
To improve fresh water quality in cross-border river basins
€ 20 million (approx)
Specific Objective 3.1
Promote cross-border intermodal and sustainable mobility in the cross-border region
€ 40 million (approx)
Specific Objective 4.1
Through collaboration on a cross-border basis to improve the health and well-being of people living in the region by enabling them to access quality health and social care services in the most appropriate setting to their needs
€ 53 million (approx)

Thematic Objective 9
Promoting social inclusion, combating poverty and any discrimination

Priority Axis 4 – Health

Investment Priority 4a
Investing in health and social infrastructure

Specific Objective 4.1

Through collaboration on a cross-border basis, to improve the health and well-being of people living in the region by enabling them to access quality health and social care services in the most appropriate setting to their needs

Result Indicator: The number of episodes of care delivered on a cross-border basis.

Output Indicators

- Develop new cross-border area interventions to support positive health and well-being and the prevention of ill health
- Beneficiaries supported by new cross-border area initiatives for positive health and well-being and the prevention of ill health
- Develop 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)
- Beneficiaries supported by new cross-border area initiatives for disabled people of all ages who are socially isolated
- Develop a new cross-border area community and voluntary sector infrastructure to support clients who have recovered from mental illness
- Cross-border area clients in receipt of mental illness recovery services
- Develop and implement new border area frameworks for early intervention with vulnerable families
- Vulnerable families in receipt of an intervention
- Establish cross-border framework, for scheduled and unscheduled care streams, to improve utilisation of scarce human, physical and financial resources
- Patients benefitting from scheduled and unscheduled care streams
- Patients availing of e-health interventions to support independent living in caring communities
- Patients availing of a shared cross-border framework and service for the identification, assessment and referral of patients identified as “at risk”
- Specialist training and development programmes for cross-border area health and social care providers
- Develop infrastructure and deliver cross-border area health care intervention trials for novel but unproven healthcare interventions to prevent and cure illness
- E-health research and evaluation mechanisms for the evaluation of e-health and m-health solution

Specific Objective 4.1: Through collaboration on a cross-border basis, to improve the health and well-being of people living in the region by enabling them to access quality health and social care services in the most appropriate setting to their needs.

Achievement of the specific objective will require investment in improving local community based access to services, taking advantage of the opportunities presented by developments in ICT, increased cross-border mobility of personnel, increased cross-border integration of professional development opportunities and the achievement of greater economies of scale and effectiveness in healthcare trials. This will result in increased cross-border access and provision of healthcare services beyond the lifetime of the Programme.

Actions will be supported that develop and implement cross-border health care services in a number of critical areas:

- Population health: Supporting positive health and well-being and the prevention of ill health through an integrated approach;
- Disability services: Development of a social equality approach to promoting social inclusion, citizenship and better life outcomes for people with disabilities;
- Mental health: Promoting cross-border mental/emotional resilience and recovery;
- Children's services: Early authoritative intervention with vulnerable families (focusing on the under 5 years population);
- Primary care and older people services: supporting resilient and caring communities and independent living (which could incorporate, for example, Alzheimer's / Dementia initiatives, community capacity initiatives and reablement);
- Acute services: To develop new models of working both in scheduled and unscheduled care streams by better utilising scarce physical, financial and human resources.

SPECIFIC INDICATORS

The following is a list of the output indicators relevant to this call, with associated targets, definitions and reporting details.

This section includes guidance on reporting monitoring data against priority axis 4.1 specific output indicators, including who or what should be counted, how indicators relate to each other and when activity can be considered achievement.

The overall aim of this call is to improve the health and well-being of people living in the region by enabling them to access quality health and social care services in the most appropriate setting to their needs, through collaboration on a cross-border basis.

General points to consider

A person can only be counted once under a particular initiative (e.g. support to socially excluded people with disabilities), but may be counted more than once if benefiting from more than one initiative (e.g. support to socially excluded people with disabilities, **and** part of a vulnerable family availing of an intervention) as they will benefit in different ways from the separate interventions. But if receiving support more than once under the same critical area – they should only be counted once.

Indicator 4.110	Develop new cross-border area interventions to support positive health and wellbeing and the prevention of ill health
Measurement Unit	Number of new interventions
Target Value (2023)	12
Definition	• Cross-Border: Service/support should be available on both sides of the border or staff may cross the border to provide a service but with the result that residents on both sides can access the service. Beneficiaries may not all be cross-border in nature (e.g. a patient in Donegal accessing support in Donegal) but the intervention should be provided on a cross-border basis – i.e. both authorities taking a harmonised approach and both providing resources. • Intervention An activity undertaken to prevent, improve, or stabilize a medical condition[3]. These activities can take place via websites, audio/video messages and other mass media. They ultimately aim to improve health and quality of life. Interventions may include educational programs; new or stronger policies; improvements in the environment; a health promotion campaign; or a combination of these and other activities. These work by influencing individuals' knowledge, attitudes, beliefs and skills; increasing social support; and creating supportive environments, policies and resources. E.g. Hand washing, smoking, salt, sugar, safe sex, vaccinations such as flu jab.
Achievement	Interventions should be new and not continuations of existing services – this could be a service new to a cross-border area (that was previously not available in that area), or addressing a new health and wellbeing need (e.g. raising awareness of particular preventative conditions where there would previously have been little or no common knowledge of; or providing support with using digital technology and remote monitoring to support patient self-management (e.g. long-term conditions). Interventions should be counted as achievement when development is complete and services are in place and ready to deliver.

[3] http://medical-dictionary.thefreedictionary.com/health+intervention

Indicator 4.111	Beneficiaries supported by new cross-border area initiatives for positive health and well-being and the prevention of ill health
Measurement Unit	Number of beneficiaries
Target Value (2023)	15,000
Definition	• Beneficiaries An individual who received an intervention for positive health/well-being/prevention of ill health which was newly developed for the cross-border area (as in 4.110). The patient may not have crossed the border to access the service but should still be counted.
Achievement	Individuals participating in positive health and wellbeing initiatives will register and complete a structured health and well-being programme with defined personal outcomes. They should only be counted as achievement upon completion of the programme. The beneficiaries counted under 4.111 have to relate directly to the new interventions being developed and implemented under 4.110. Beneficiaries of these interventions must be unique, i.e. only counted once even if receiving support more than once from an initiative for positive health and wellbeing and prevention of ill health, during the lifetime of the project, so as to avoid double counting. Patients receiving support for positive health and wellbeing via e-health may also be counted as achievement under indicator 4.120.

Indicator 4.112	**Develop 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)**
Measurement Unit	Number of Services
Target Value (2023)	2
Definition	• Community Support Services An organised system of care to assist people with long-term disabilities to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community.[4] Meaning of "disability" and "disabled person": (1) Subject to the provisions of Schedule 1, a person has a disability for the purposes of the Disability Discrimination Act[5] if he has a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities. - 'substantial' is more than minor or trivial – e.g. it takes much longer than it usually would to complete a daily task like getting dressed - 'long-term' means 12 months or more – e.g. a breathing condition that develops as a result of a lung infection • Social isolation[6] The virtual absence of interaction with others, outside of that required to perform basic life functions, such as food shopping, transportation, work and entertainment. Social isolation is common in the disabled, divorced and elderly, as well as in those with mental disorders and alcoholism, and is a risk factor for both suicide and deaths from all causes.
Achievement	Services should be new and not continuations of any existing services. They should be cross-border in nature, for example: - Using staff from both sides of the border - Open to users on either side of the border - Using a shared approach/design on both sides of the border Services should have active users before being counted as achievement against this indicator.

[4] http://medical-dictionary.thefreedictionary.com/community+support+system
[5] http://www.legislation.gov.uk/ukpga/1995/50/section/1
[6] *Segen's Medical Dictionary*. (2011). Retrieved January 25 2016 from http://medical-dictionary.thefreedictionary.com/social+isolation

Indicator 4.113	Beneficiaries supported by new cross-border area initiatives for disabled people of all ages who are socially isolated
Measurement Unit	Number of Beneficiaries
Target Value (2023)	4,000
Definitions	• Beneficiaries A person with a disability who is at risk of social isolation, in receipt of a programme of activities, or formal plan, aimed at promoting integration into the community. Can include for example: ○ People with a disability in receipt of a person centred plan involving cross-border teams of day opportunities staff supporting disabled people into becoming more fully integrated within their communities. ○ People with a disability participating on a cross-border basis in a formal programme of activities designed to promote integration into the community, and independent living (for example, training, education, paid and unpaid employment, social and leisure activities etc) • Disabled person[7] The Disability Discrimination Act (DDA) defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on the ability to carry out normal day-to-day activities. - 'substantial' is more than minor or trivial – e.g. it takes much longer than it usually would to complete a daily task like getting dressed - 'long-term' means 12 months or more – e.g. a breathing condition that develops as a result of a lung infection • Social isolation The virtual absence of interaction with others, outside of that required to perform basic life functions, such as food shopping, transportation, work and entertainment. Social isolation is common in the disabled, divorced and elderly, as well as in those with mental disorders and alcoholism, and is a risk factor for both suicide and deaths from all causes.

[7] https://www.gov.uk/definition-of-disability-under-equality-act-2010

Achievement	Once a plan or set of activities is reviewed and assessed as complete, the beneficiary can be counted as achievement against this indicator. Beneficiaries counted under 4.113 must relate to the new cross border areas community support services for socially isolated disabled people under 4.112. Beneficiaries of these interventions must be unique, i.e. only counted once even if receiving support more than once during the lifetime of the project, so as to avoid double counting. Beneficiaries supported by new cross-border area initiatives for disabled people making contact with a health professional via e-health may also be counted as achievement under indicator 4.120.

Indicator 4.114	**Develop a 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)**
Measurement Unit	Infrastructure
Target Value (2023)	1
Definition	Formalised structure in place to lead 'Recovery' on a cross border basis • Community and voluntary sector infrastructure **Community and voluntary sector**: The part of an economy or society comprising non-governmental and non-profit-making organizations or associations, including charities, voluntary and community groups, cooperatives, etc.[8] **Infrastructure (in this context)**: the underlying foundation or basic framework (as of a system or organization) to deliver and accommodate health support services. An infrastructure to support educational/employment/social and leisure opportunities and placements on a cross border basis for clients who have recovered from mental illness. • Mental illness Any of various conditions characterized by impairment of an individual's normal cognitive, emotional or behavioural functioning, and caused by social, psychological, biochemical, genetic or other factors, such as infection or head trauma. Also called *emotional illness*, *mental disease*, *and mental disorder*.[9] • Recovered Recovery within mental health is *'the belief that it is possible for all service users to achieve control of their lives, to recover their self-esteem, and move towards building a life where they experience a sense of belonging and participation.'*[10] Recovery model in enhancing the quality of life of people who have suffered from Mental health conditions enabling them to manage their condition, re-engage with their family and communities and participate more fully in society from an employment and educational perspective. • E-health E-health is the transfer of health resources and health care by electronic means, such as the delivery of health information for

[8] http://www.oxforddictionaries.com/definition/english/third-sector
[9] http://www.thefreedictionary.com/mental+illness
[10] *Vision for Change, DOHC 2006, Protect Life – A shared vision (DHSSPSNI 2012-14)*, *Fit and Well* (2012-2022)

	health professionals and health consumers, through the Internet and telecommunications, for example.[11] Infrastructure can include staffing, online systems/services, new system for data transfer/patient record sharing, policies and action plans etc.
Achievement	Infrastructure must be new and not existing Infrastructure should be cross-border in nature, for example: - Using staff from both sides of the border - Open to users on either side of the border - Using a shared approach/design on both sides of the border - Patient record sharing etc. Infrastructure should be in place and actively supporting clients before being counted as achievement against this indicator.

[11] http://www.who.int/trade/glossary/story021/en/

Indicator 4.115	Cross-border area clients in receipt of mental illness recovery services
Measurement Unit	Number of clients with a recovery plan
Target Value (2023)	8,000
Definition	• Recovery plan A personalised step-by-step plan for people who would like to take control of their lives and recover from mental illness. It takes account of individual circumstances and involves a range of partners in supporting the recovery process e.g. family/carers, employers and other supported employment schemes, housing agencies, education establishments, community and voluntary sector agencies. Patients/clients supported by *cross border* team of community mental health staff/service users (expert patients) to reconstruct their lives after a period of mental illness. This may include supported employment, return to education, volunteering, participation in social and leisure events over a period of time. • Mental illness Any of various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioural functioning, and caused by social, psychological, biochemical, genetic or other factors, such as infection or head trauma. Also called *emotional illness*, *mental disease*, *mental disorder*.[12]
Achievement	Clients counted under 4.115 must relate to the new mental illness recovery services developed under 4.114. Clients in receipt of these mental illness recovery services must be unique, i.e. only counted once even if receiving support for mental illness recovery more than once during the lifetime of the project, so as to avoid double counting. Note: Only clients with plans that have been developed and implemented should be counted as achievement against this indicator. Clients in receipt of mental illness recovery services via e-health may also be counted as achievement under indicator 4.120.

[12] http://www.thefreedictionary.com/mental+illness

Indicator 4.116	Develop and implement new border area frameworks for early intervention with vulnerable families
Measurement Unit	Number of frameworks
Target Value (2023)	2
Definition	• Frameworks 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 cross-border framework in relation to health may include elements of the following (note: this is not an exhaustive list): ○ The development of interoperable solutions which will improve access to patient information to enable more effective and timely clinical decision making; patient management; and enhance patient safety. ○ Movement of staff across the border to provide a service not previously available – to the mutual benefit of both regions. ○ Movement of patients across the border to access services not previously available – to the mutual benefit of both regions. ○ Shared strategies or initiatives launched and run in both regions (e.g. health promotion initiatives, information seminars, training programmes etc). • Early intervention Early intervention is a system of coordinated services that promotes the child's age-appropriate growth and development and supports families during the critical **early** years (children aged under five years). • Vulnerable families Sometimes, the wellbeing of families and children might be threatened by individual, parental or family circumstances. It means that something about the child, parent or family is creating a risk of poor physical or mental health. Examples of factors that might lead to vulnerability are poverty, single parenting, unemployment, relationship problems, depression, drug and alcohol use, and social isolation.[13] • Family A family consists of any child or young person under the age of 18 (21 for young people leaving care and disabled young people) and their primary carers. A primary caretaker can be a parent, an

[13] http://raisingchildren.net.au/articles/families_with_vulnerabilities.html

	expectant mother or other biological relative or any person involved in bringing up the child or young person.
Achievement	Frameworks should be new and not continuations of any existing services. They should be cross-border in nature, for example: - Using staff from both sides of the border - Open to users on either side of the border - Using a shared approach/design on both sides of the border Frameworks should be in place and actively supporting vulnerable families before being counted as achievement against this indicator.

Indicator 4.117	Vulnerable families in receipt of an intervention
Measurement Unit	Number of families
Target Value (2023)	5,000
Definition	• Vulnerable families Sometimes, the wellbeing of families and children might be threatened by individual, parental or family circumstances. It means that something about the child, parent or family is creating a risk of poor physical or mental health. Examples of factors that might lead to vulnerability are poverty, single parenting, unemployment, relationship problems, depression, drug and alcohol use, and social isolation.[14] • Family A family consists of any child or young person under the age of 18 (21 for young people leaving care and disabled young people) and their primary caretakers. A primary caretaker can be a parent, an expectant mother or other biological relative or any person involved in bringing up the child or young person. • Intervention An activity undertaken to prevent, improve, or stabilize a medical condition[15]. These activities can take place via websites, audio/video messages and other mass media. They ultimately aim to improve health and quality of life. Interventions may include educational/training programs, new or stronger policies, improvements in the environment, signposting to relevant services or provision of new services, a health promotion campaign, or a combination of these and other activities. These work by influencing individuals' knowledge, attitudes, beliefs and skills; increasing social support; and creating supportive environments, policies and resources. E.g. Hand washing, smoking, salt, sugar, safe sex, vaccinations such as flu jab.
Achievement	Families counted under 4.117 must relate to the new border area frameworks for early intervention with vulnerable families developed under 4.116. A family should be counted as one unit, not the number of individuals within the family. A family should be counted only

[14] http://raisingchildren.net.au/articles/families_with_vulnerabilities.html
[15] http://medical-dictionary.thefreedictionary.com/health+intervention

	once, even if they receive support/interventions, in relation to frameworks for early intervention with vulnerable families, more than once during the project lifetime. Families in receipt of an intervention via e-health may also be counted as achievement under indicator 4.120 (one family =1 patient).

Indicator 4.118	**Establish cross-border frameworks, for scheduled and unscheduled care streams, to improve utilisation of scarce human, physical and financial resources**
Measurement Unit	Improved utilisation frameworks
Target Value (2023)	4
Definition	• Cross-Border Framework 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 cross-border framework in relation to health may include elements of the following (note: this is not an exhaustive list): ○ The development of interoperable solutions which will improve access to patient information to enable more effective and timely clinical decision making; patient management; and enhance patient safety. ○ Movement of staff across the border to provide a service not previously available – to the mutual benefit of both regions ○ Movement of patients across the border to access services not previously available – to the mutual benefit of both regions ○ Shared strategies or initiatives launched and run in both regions (e.g. health promotion initiatives, information seminars, training programmes etc) • Care streams **Unscheduled care** is any unplanned contact with the health service provider by a person requiring or seeking help, care or advice. It follows that such demand can occur at any time, and that services must be available to meet this demand 24 hours a day. Unscheduled care includes urgent care and emergency care.[16] **Scheduled care** covers all services provided which are scheduled (planned) including all primary care, community and hospital services. This does not include emergency (unscheduled) care.

[16] http://www.londonprogrammes.nhs.uk/wp-content/uploads/2011/03/Unscheduled-care-commissioning-model.pdf

Achievement	Frameworks should be new and not continuations of any existing services. They should be cross-border in nature, for example: - Using staff from both sides of the border - Open to users on either side of the border - Using a shared approach/design on both sides of the border - Sharing patient records etc. Frameworks should be in place and actively coordinating care streams before being counted as achievement against this indicator.

Indicator 4.119	Patients benefitting from scheduled and unscheduled care streams
Measurement Unit	Number of patients
Target Value (2023)	15,000
Definition	• Patient Patients benefitting from scheduled and unscheduled care streams • Care streams **Unscheduled care** is any unplanned contact with the health service provider by a person requiring or seeking help, care or advice. It follows that such demand can occur at any time, and that services must be available to meet this demand 24 hours a day. Unscheduled care includes urgent care and emergency care.[17] **Scheduled care** covers all services provided which are scheduled (planned) including all primary care, community and hospital services. This does not include emergency (unscheduled) care.
Achievement	Patients counted under 4.119 must relate to the new cross-border frameworks for scheduled and unscheduled care streams developed under 4.118. Patients benefitting from scheduled and unscheduled care streams must be unique, i.e. only counted once even if benefiting more than once from scheduled and/or unscheduled care streams during the lifetime of the project, so as to avoid double counting. Patients benefitting from scheduled and unscheduled care streams via e-health may also be counted as achievement under indicator 4.120.

[17] http://www.londonprogrammes.nhs.uk/wp-content/uploads/2011/03/Unscheduled-care-commissioning-model.pdf

Indicator 4.120	Patients availing of e-health interventions to support independent living in caring communities
Measurement Unit	Number of patients
Target Value (2023)	4,500
Definition	• Patient In this instance, patients are individuals at risk of physical, mental and emotional decline and requiring statutory intervention/admission to hospital or residential care. • Intervention An activity undertaken to prevent, improve, or stabilize a medical condition[18]. These efforts can reach the population via websites, audio/video messages and other mass media. They ultimately aim to improve health and quality of life. Interventions may include educational programs, new or stronger policies, and improvements in the environment, a health promotion campaign, or a combination of these. These work by influencing individuals' knowledge, attitudes, beliefs and skills; increasing social support; and creating supportive environments, policies and resources. E.g. Hand washing, smoking, salt, sugar, safe sex, vaccinations such as flu jab. In this case support will be provided using assistive technologies, as opposed to face-to-face contact with a health professional. This should give additional independence and control to the patient in managing their condition. • Independent Living Patients having more choice and control over their lives by helping them to live at home rather than in residential accommodation.
Achievement	Activity reported should only include 'at risk' patients availing of packages of assistive technologies issued and managed on a cross border basis such as Telecare; Telehealth; remote monitoring packages issued; and virtual consultations enabled which support independent living and improved management of long term conditions. The number of patients availing of e-health interventions should be based on active individual registrations to avoid double

[18] http://medical-dictionary.thefreedictionary.com/health+intervention

	counting. A person should only be registered once and should be actively using the service, i.e.: Patients availing of e-health technologies eg Telecare, Telehealth, remote monitoring packages issued And/or Virtual consultations enabled which support independent living and improved management of long term conditions. Achievement for this indicator may be contributed to by other specialities under this theme; i.e. any individuals receiving care through the mode of e-health under any of the following indicators: 4.111, 4.113, 4.115, 4.117, 4.119 and 4.121. One patient having multiple consultations under the same speciality should only be counted once. One patient having multiple consultations across different mediums (e.g. Telecare and Telehealth) under the same speciality should only be counted once. A patient should only be counted once irrespective of speciality or mode used.

Indicator 4.121	**Patients availing of a shared cross-border framework and service for the identification, assessment and referral of patients identified as "at risk"**
Measurement Unit	Number of 'at risk' patient interventions
Target Value (2023)	2,500
Definition	• "At risk" patient Patients at risk of physical, mental and emotional decline and requiring statutory intervention/admission to hospital or residential care with a primary focus on patients aged 65 and over. • Framework Framework for prevention/responding to 'at risk' people will be a new way of working agreed and developed based on assessment of risk to people. This includes development of a partnership approach between primary care and other agencies resulting in the creation of dynamic, connected communities which are sustainable, age friendly and provide support to 'at risk' people to optimise health and remain at home for as long as possible.
Achievement	In this case a patient is a person who has been identified as 'at risk', assessed and referred for appropriate intervention. The service provider should record the number of patients offered and receiving interventions (for example, referral to community service; linked with a volunteer to navigate available services; referral to reablement service; introduction of carer support etc.) as achievement against this indicator when the activity has been completed. Patients availing of these services should be unique, i.e. only counted once even if receiving support more than once during the lifetime of the project, so as to avoid double counting. Patients availing of these services via e-health may be also be counted as achievement under indicator 4.120.

Indicator 4.122	Specialist training and development programmes for cross-border area health and social care providers
Measurement Unit	Number of staff trained
Target Value (2023)	3,800
Definition	• Specialist training and development programmes Can cover any of the following (Note: this is not an exhaustive list): Quality and Safety Programmes Compassionate and person centred care Application of new technologies and e-health within health and social care Building staff resilience and more effective team working Specialist training initiatives specific to the service areas, for example: - management of complex behaviours, recovery model in mental health - responding to the needs of an aging population e.g. long term conditions (dementia, diabetes, stroke, respiratory) - role development /skills mix (nurses and social work)
Achievement	Figures for achievement against this indicator should be taken from training attendance records capturing all who have completed training courses as recorded by the course assessors. Health and social care providers trained should only be counted once i.e. a health and social care provider participating in more than one training programme should only be included once in the final total. Activity for this indicator is to be taken from staff trained in relation to any of the specialities under this theme e.g. staff trained in new systems introduced to improve utilisation of scarce human, physical and financial resources.

Indicator 4.123	**Develop infrastructure and deliver cross-border area health care intervention trials for novel but unproven healthcare interventions to prevent and cure illness**
Measurement Unit	Number of intervention trials
Target Value (2023)	10
Definition	*Infrastructure* Should include soft infrastructure such as computer systems, staffing, policies etc. *Intervention trial*[19] Intervention trials involve several stages: • Development (identifying research questions, existing evidence base, emerging theories; deciding on a methodology • Piloting (carrying out feasibility studies to test procedures and help determine required sample size) • Evaluation (the full evaluation of the trial intervention which includes a monitoring and data gathering process in order to answer the research questions; an evaluation of the processes used; and an economic evaluation assessing cost effectiveness) • Reporting (A detailed account of the intervention, as well as a standard report of the evaluation methods and findings, to enable replication studies, or wider scale implementation) If it is concluded that the trial is successful: • Implementation (Dissemination; Surveillance and monitoring; Long term follow-up)
Achievement	Trials must benefit the cross-border area and cross-border health care delivery explicitly. Activity should be completed up to, and including Reporting stage. Infrastructure should be in place; interventions evaluated; and research questions answered and reported on before activity can be reported as achievement under this indicator.

[19] www.mrc.ac.uk/complexinterventionsguidance

Indicator 4.124	E-health research and evaluation mechanism for the evaluation of e-health and m-health solution
Measurement Unit	Number of evaluation mechanisms
Target Value (2023)	1
Definition	Evaluation Mechanism – Tool that can be used for the evaluation of the use of e-health and m-health solutions, allowing conclusions to be drawn on the value of mainstreaming such solutions. The tool should provide a method for the measurement of baselines, outputs and outcome targets which evaluate the effectiveness of using e-health and m-health solutions for the delivery of health and social care interventions.
Achievement	Evaluation mechanism developed, agreed and put into practice. The mechanism should evaluate the impact of technologies on patient/client health and well-being outcomes. The tool should be fully developed and put into practice (i.e. establishing baselines and ongoing data collection) before it can be recorded as achievement against this indicator. The mechanism must be piloted successfully on a number of projects and signed off for mainstreaming.