Category	Number	Project Name	Descriptor	Lead organisation	Health Regions	Attendee1	Attendee2
Arthritis	**56**	Arthritis Rehabilitation through the Management of Exercise and Diet (ARMED)	**This project will deliver Arthritis Rehabilitation through the Management of Exercise and Diet. There is currently no systematic management of exercise and weight management to the osteoarthritic knee population in primary care and ideally this is the first line of treatment prior to onward referral to hospital services.**	Our Lady's Hospital, Navan	**Health Area A**		Bourton Cassidy Lara
	222	Osteoarthritis Knee Pathway	**The project objective is to provide timely access to evidence-based treatment for osteoarthritis knees, at the most appropriate, cost-effective service level. It will shift the emphasis from acute hospital settings to a patient centred approach, in the primary care environment.**	CHO 2 & Saolta Hospital Group	**Health Area F**	Ohora John	Murphy Frank
Citizen Empowerment and Health and Well being	**8**	HSE - Child Digital Health	**Provide parents with right health information. Support parents to make informed choices in relation to their children's health. Build a meaningful relationship with parents using range of digital channels. Connect health services to patients with technology.**	HSE National	**National**	Cloney Ben	Connors Paul
	15	Dublin 8 Social Prescribing Project	**The aim of this project is to develop and broaden the existing Dublin 8 Social Prescribing Project to ensure its long term sustainability and establish a model for national replication. It will achieve this by developing programmes that support integration of people with different abilities to integrate in a community setting. Developing programmes that support the social interaction of socially isolated people. Includes patients living with cancer & beyond as a particular target within the Dublin 8 Cancer Services.**	Fatima Groups United FRC	**Health Area B**	Ryder Roisin	Ryder Roisin
	18	Sheds for Life	**This project aims to enhance the wellbeing of men's shed members, by improving knowledge and awareness, offering health advice and checks, facilitating behaviour change and attitudes towards health engagement and preventative measures and enhancing self-efficacy. At provider level SFL will strengthen community partnerships so that partner organisations can work together to understand best practice and implement effective health promotion strategies at population level.**	Irish Men's Sheds Association	**National**	Byrne Edel	Sheridan Barry
	21	Primetime for Older Adults	**This project will aim to upskill fitness instructors in Laois so that they can facilitate more opportunities for older adults to be physically active on an ongoing basis. This project will assist older adults in developing the evidence-based skills and knowledge they need to treat and manage their own conditions with evidence based physical activity sessions and lifestyle change.**	Laois Sports Partnership CLG	**Health Area B**	Myers Caroline	Myers Caroline
	31	Expansion of Social Prescribing service in Waterford and mainstreaming of pilot service in Waterford Metropolitan area	**This project will expand the Social Prescribing pilot in the Waterford Metropolitan area. Social prescribing is a means of enabling GPs, nurses and other primary and secondary care professionals to refer people to a range of local, non-clinical services.**	Sacred Heart Community & Childcare Project CLG	**Health Area C**		Kiely Heather

Citizen Empowerment and Health and Well being	**38**	Consolidating the Implementation of the Stanford Chronic Disease Self-Management Programme in CHO Dublin North City & County	**This project will promote of Stanford Chronic Disease self-management to all of Dublin North City, West and County. The Stanford model Chronic Disease Self-management Programme supports people with long-term health conditions to acquire the generic skills required of them to become effective partners in their own health.**	CHO 9	**Health Area A**		O'Dea Ellen
	40	Student Sexual Health Service (Athlone Institute of Technology)	**This project will provide an equitable, accessible high quality sexual health service, education and information, awareness and follow-up for students on the Athlone Institute of Technology campus community which will cater for 500 students.**	Athlone Institute of Technology	**Health Area B**	Tully Laura	Tully Laura
	57	Integrating online STI testing with public STI services: A pilot to assess feasibility and impact.	**The goal of the pilot project is to assess the feasibility, acceptability and impact of integrating an online sexually transmitted infection (STI) service into existing public STI clinics in Ireland. Harnessing technological advances to deliver sexual health services online has been shown to improve efficiency, activity and access, whilst empowering patients to self-manage their care**	HSE Sexual Health & Crisis Pregnancy Programme	**National**		O'Brien Maeve
	61	Towards Selfcare in Headache	**The purpose of this proposal is to re-configure the management of headache /migraine in Ireland to: reduce reliance on secondary /tertiary care, harness existing resources within the community network (e.g. pharmacies) in supporting appropriately diagnosed patients, and to promote a programme of self-care and self-management for those with chronic headache disorders.**	Clinical Strategy and Programme Division	**Health Area A**		Hardiman Orla
	78	Delivery of the Stanford Chronic Disease Self Management across SECH	**This project will promote of Stanford Chronic Disease self-management to all of CHO 5. The Stanford model Chronic Disease Self-management Programme supports people with long-term health conditions to acquire the generic skills required of them to become effective partners in their own health.**	CHO 5	**Health Area C**	O'Connor Kate	Howley Derval
	84	North Dublin Integrated Community STI Service	**This project will reduce demands on the acute care system by accessing populations in the community for early intervention and treatment, with the added benefit of preventing the spread of STIs.**	Mater Misericordiae University Hospital	**Health Area A**		Lambert Jack
	98	Patient Self-Management of Chronic Disease	**The ICGP will develop and deliver an evidence-based education package to GPs and practice nurses on "Patient self-management of Chronic disease". The objective is to facilitate the development of a more confident, competent health-conscious community, as well as influence the reduction of unplanned hospital admissions, reduction in medication use, reduction in length of hospital stays, urgent care visits and missed appointments.**	ICGP	**National**	Fenlon Nick	Foy Fintan
	111	Telemedicine for CF	**The advent of telemedicine will allow a novel way of delivering more optimal results with better adherence improved lung function and reduced exacerbations. It would also facilitate early discharge and improving treatment when on iv therapy at home.**	Galway University Hospital	**Health Area F**		Kane Chris

Citizen Empowerment and Health and Well being	**121**	My Slainte Community Lifestyle Programme	**The 'MySlainte' community lifestyle programme will expand on the success of 'MyAction' to address common lifestyle drivers of preventable chronic disease. It will see improvements in physical activity levels, improvements in smoking cessation quit rate, reduction in weight and body mass index, achievement of specific dietary goals, improvements in psychosocial health , improvement in those achieving the optimal medical risk factors targets such as cholesterol, blood pressure, and glucose control.**	National Institute for Prevention and Cardiovascular Health	**Health Area F**		Gibson Irene
	123	Online Citizen Health Guides	**The aim of this project is to ensure that people in Ireland can easily access safe, nationally relevant, health information online by providing 300 health guides on the new HSE website. Citizens will be better able to manage their own care by being more informed.**	HSE National	**National**	McMenamin Anne	Hanlon David
	135	promoting physical activity programmes for people with neurological conditions in the community	**The aim of this project is to employ an integrated care approach to delivering health promoting physical activity programmes for adults with neurological conditions in the community in the Mid West Region which encompasses Clare, Limerick and North Tipperary/East Limerick.**	Multiple Sclerosis Ireland	**Health Area E**		Battles Ava
	137	SMILE Supporting Multimorbidity selfcare	**This project is a new innovative way for citizens to proactively self-manage their care. The objectives are to prevent deterioration in participant conditions, empower citizens to engage with their own health within the community setting and to avoid hospital admissions.**	Caredoc	**Health Area C**	Kearns Michelle	Kearns Michelle
	140	WellComm Active Well Communities Connect Project 2	**This project will empower citizens to manage their own health through increased physical activity and improved diet. It demonstrates principles of service redesign and shift to care in the community.**	Cork Sports Partnership	**Health Area D**	Broderick Sheelagh	Meenaghan Kristine
	161	Assistive Technology Mobile Community Service	**This project represents a change in the model of care, with mobile assessment teams and the facilities to assess older people and people with disabilities in their own environment, thereby saving time and long journeys for clients. This will promote hospital avoidance in ensuring patients know how to effectively use their equipment by ensuring the device meets the client's needs within their own environment and with their local support carers and HSE team.**	Central Remedial Clinic	**Health Area A**		Manahan Stephanie
	162	Adult Social Prescribing for Individual Resilience and Empowerment	**Social prescribing will empower citizens to manage their own health and wellbeing through community support thereby reducing GP visits. It takes a holistic and strengths-based approach to the health of a person and aims to build on the capacity of a person to improve and maintain their health and wellbeing with appropriate and adequate community support, thereby shifting the support the person receives from a clinical to a community setting.**	Bray Area Partnership	**Health Area C**	D'Arcy Jennifer	D'Arcy Jennifer
	185	Extension of Stanford Chronic Disease self-mgt to all of CHO 1	**This project will promote of Stanford Chronic Disease self-management to all of Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan. The Stanford model Chronic Disease Self-management Programme supports people with long-term health conditions to acquire the generic skills required of them to become effective partners in their own health.**	CHO 1	**Health Area F**	McKeon Maeve	O'Neill Cara

Citizen Empowerment and Health and Well being	**202**	Supporting Pregnant Women to Quit and Stay Quit - A Co-design Community Based Integrated Approach	**The project aims to better diagnose and treat smoking during pregnancy in a maternity setting.**	CHO 5	**Health Area C**		Howley Derval
	219	Stanford Chronic Disease Self-Management Programme in CHO 2	**This project will promote of Stanford Chronic Disease self-management to all of CHO 2. The Stanford model Chronic Disease Self-management Programme supports people with long-term health conditions to acquire the generic skills required of them to become effective partners in their own health.**	CHO 2	**Health Area F**	Houlihan Ailish	Greaney Martin
	223	Smoke Free Start	**This project aims to support women who are engaged with maternity services to stop smoking, with successful tobacco cessation services linked with reduced presentation of health complications in new-borns/children. The project aims to develop capacity and capability in a maternity setting to better diagnose and treat smoking during pregnancy on a national level.**	HSE National	**National**		Blake Martina
	249	Active for Life	**This project seeks to increase sport and physical activity participation across a number of key target groups (children, young people, women, unemployed, sedentary adults) through programmes and initiatives delivered in the community setting. Health literacy help engage sedentary individuals and those with chronic illnesses and empower them in the management of their own health and wellbeing prior to hospital admission.**	Kilkenny Recreation and Sports Partnership	**Health Area C**		Keeshan Nicola
	252	HealthEIR: A Journey to Improving Health and Wellbeing Through Community-Based Social Self-Care	**The overall project goal is to design, implement, and evaluate the HealthEIR care model in ten sites. HealthEIR is an innovative model that reframes unavoidable waiting time in routine community health services as opportunity to promote and support healthy behaviours. It integrates and operationalises the HSE Healthy Ireland Framework and Making Every Contact Count initiatives and links primary care, community, and voluntary sectors.**	RCSI	**National**		Flood Michelle
	267	Rehabilitative Palliative Care	**This project will provide an innovative model of rehabilitative palliative care to empower people with life-limiting conditions to self-manage their condition, enabling them to live fully and enjoy the best quality of life possible at home. The project will span hospital and community and will incorporate the contribution of allied health professionals in the development of the rapid response element of this model**	Mater Misericordiae Hospital & St Francis Hospice	**Health Area A**		Ryan Karen
	280	Skin Cancer Prevention	**The primary aim of this project is to stem the rapid rise in skin cancer incidence in Ireland. A Skin Cancer Prevention Project Officer is required to co-ordinate the implementation of the skin cancer prevention plan.**	National Cancer Control Programme	**National**		McCarthy Triona

Citizen Empowerment and Health and Well being	**284**	Social Prescribing for improved Health and Wellbeing	**This project aims to develop and roll out a social prescribing service in partnership with the community and voluntary sector across the counties of Cavan, Monaghan, Sligo and Leitrim using a partnership approach between GPs, Clinicians (Hospital and Community), Family Resource Centres and where they exist, Community Health Fora. This project will increase supports to people who are feeling vulnerable, isolated, and lonely. It will also support people on discharge from acute mental health units by bridging and supporting people to access supports in their local communities.**	CHO 1	**Health Area F**		Hayes John
	287	Empowering Communities to support language Development in young children	**This project will empower Laois / Offaly communities, specifically parents and pre-school staff, to facilitate language development in their o own local context. It will reduce referrals of pre-school children to SLT services and treat children with mild-moderate language delay in community settings using a universal and targeted approach**	CHO 8	**Health Area B**		Gonoud Emma
	308	HealthSENSEapp	**The project will develop a fully functioning mobile app engaging Irish health citizens in the Sláintecare reform journey from now over the next 10 years. It is primarily a public participation tool to communicate, engage, and encourage active health citizenship as well as a medium of gathering research and behavioural data around decision making.**	UCD & Smartlab CLG	**National**		Goodman Lizbeth
	338	Prevention is better than cure - Community Mothers Programme	**This project aims to strengthen, standardise and update a home visiting programme developed by the HSE Public Health Nursing Service over 30 years ago.**	National College for Ireland	**National**		Bleach Josephine
	370	The LAMP Project - Social Prescribing Integration in the Acute Care Sector	**Social prescribing is the practice of referring a patient to non-medical services to help support health and wellness. The project is innovative in creating and testing the first hospital 'catchment' scale implementation of social prescribing**	St James Hospital	**Health Area B**		Robinson David
	371	A pathway to empower patients to engage with antimicrobial stewardship	**This project will be the design and evaluation of an intervention package to empower patients to become more integrated with decision making in infection management.**	St James Hospital	**Health Area B**	Hughes Gerry	Bergin Colm
	407	Smart triage of kidney and lung transplant patients	**This project will allow stable kidney and lung transplant patients to undergo remote monitoring from home, supported by the hospital specialist team.**	Beaumont Hospital & Mater Misericordiae University Hospital	**Health Area A**	Oseaghdha Conall	O'Seaghdha Conall
	413	Stanford Chronic Disease Self-Management Programme in Community Healthcare East	**This project will promote of Stanford Chronic Disease self-management to all of CHO 6. The Stanford model Chronic Disease Self-management Programme supports people with long-term health conditions to acquire the generic skills required of them to become effective partners in their own health.**	CHO 6	**Health Area C**	Gowing Mary	Fitzpatrick Siobhan
	418	The roll out Chronic Disease Self Management Programme	**This project will promote of Stanford Chronic Disease self-management to all of Laois/Offaly, Longford/Westmeath, Louth/Meath. The Stanford model Chronic Disease Self-management Programme supports people with long-term health conditions to acquire the generic skills required of them to become effective partners in their own health.**	CHO 8	**Health Area B**		Murphy Fiona
	463	Pain management education programme	**Reduction in hospital admissions/reduced LOS/increase in bed-days saved/reduction in waiting times/improved streamlining of service**	Sligo University Hospital	**Health Area F**	Oconnor Therese	McCann Grainne

Diabetes Care	**9**	HSE - Digital information, signposting and support for people with chronic conditions	**This project will deliver new digital supports to patients, families and carers to help them live well with a chronic condition including an online directory of self management support services; information guide on the four major chronic conditions and how to self manage; social media communities for diabetes; digital supports and sign posting to guide patients through the early stages of their journey with a chronic condition.**	HSE National	**National**	Cloney Ben	Connors Paul
	152	National Diabetes Registry	**This project will deliver a National Diabetes Registry for Ireland. The functions of a National Diabetes Registry are: To improve patient care; To assist service planning; To enable further quality assurance and evaluation and to generate new knowledge.**	HSE Primary Care Planning Chronic Disease Commissioning Team	**National**	Gleeson Mairead	Buckley Claire
	153	End to end implementation of the Model of Integrated Care for Type 2 diabetes within 2 CHOs	**This project will deliver end to end implementation of integrated Care for Type 2 diabetes in the Tuam, Athenry Loughrea Community Health Network and the North West Cork Community Health Network. Combined these Community Healthcare Networks have an estimated diabetes population of 8,295 people. All GP practices within these networks will be able to access this integrated diabetes care service. This will have a significant impact on the patient's experience, self-management skills, complication rates, outpatient referral rates, admission rates and/or bed-days.**	HSE Primary Care Planning Chronic Di	**National**	O'Mahony Cliodhna	Dineen Sean
	154	Development and Implementation of a Digitally Enhanced HSE Type 2 Diabetes Self Management Education Programme	**This project will use the expert knowledge, skills and experience of the team we will design, develop and implement a HSE led Type 2 Diabetes Self-Management Education (DSME) Programme before the end of 2020.**	HSE Primary Care Planning Chronic Di	**National**		Humphreys Margaret
	155	National Self Management Education IT System Implementation and Expansion	**This system will provide delivery of type 2 diabetes Self-Management education (SME). It will provide web enabled access to self-management course bookings, health link referrals from GPs and booking, patient and educator data for planning, monitoring and evaluation. The system can then be upgraded to add other chronic disease SME programmes.**	HSE Primary Care Planning Chronic Di	**National**		Humphreys Margaret
	156	Development and Implementation of a National Diabetes Prevention Self-Management Education Programme by 2021	**The output of this project will be a national, evidence based, targeted diabetes prevention programme which will reduce diabetes related complications for patients such as heart, kidney and eye disease.**	HSE Primary Care Planning Chronic Di	**National**		Humphreys Margaret
	167	Waterford Thrive with Diabetes Project	**This wil Increase in % Type 1 Diabetes Patients with haemoglobin A1c (HbA1c) level < 53mmol/mol**	University Hospital Waterford	**Health Area C**		Rothwell Grace
	175	Expansion of the Model of Diabetes Integrated Care throughout SligoLeitrimWest Cavan	**A further 19 General Practices support from a CNS Diabetes Integrated Care/Develop an additional ANP Diabetes Integrated Care clinic in a Primary Care Setting**	CHO 1	**Health Area F**	Murray Patricia	Monaghan Dermot
	190	Integrated Foot Protection Service for residents of Community Healthcare East	**This project will provide one point of entry to service for the patients, reduce wait times and journey steps to care, reduce hospitalization, reduce readmission rates and length of stay, promote self-management, improve care pathway and governance and achieve cost-savings.**	CHO 6	**Health Area C**	Murray Anita	Kennedy Loraine

Diabetes Care	**220**	Implement a structured exercise programme for people with Diabetes	**delivery of a structured education programme- DESMOND, by specialist dieticians and nurses to those newly-diagnosed. DESMOND enables and empowers people to make healthy choices around food and diet. This new project – called DESSIE will augment the DESMOND programme by providing a structured exercise and physical activity programme. This additional programme should enhance the ability of those undertaking the DESMOND programme to make healthier lifestyle choices and improve their ability to self-manage their condition.**	CHO 2 & Saolta Hospital Group	**Health Area F**	Hanley Olwyn	Murphy Frank
	278	Facilitating Integration of Childhood Obesity Services in Primary Care Through Education	**This project will facilitate a shift in care of childhood obesity to the community setting at a regional level from Dublin-based hospitals.**	RCSI	**National**		O'Malley Grace
	343	A Podiatry led pathway for timely provision of footwear and orthotics in the community	**This project aims to further develop a podiatry led pathway for the provision of footwear and orthotics process across the Midwest (CHO 3) with particular emphasis on: equity of access, timely response to client needs, value for money, reduction of OPD and acute service referrals, quality of service delivery, risk management, monitoring activity and trends. The objective of this project is to identify and initiate a preferred pathway for the provision of orthotics and footwear that would provide equitable access, reduce acute waiting lists, reduce hospital admissions due to inappropriate / insufficient offloading measures and seek to achieve maximum value for money, whilst providing best quality care for patients.**	CHO 3	**Health Area E**	Devine Carmel	Devine Carmel
	375	Integrated care for patients presenting with leg ulcers in Dublin South, Kildare and West Wicklow	**This project aims to improve the care of patients with leg ulcers through the provision of Doppler Assessment training to six nurses (PHNs and Community RNs), facilitating the assessment, development, implementation and monitoring of an appropriate treatment plan at local community clinics in Kildare, West Wicklow, and South Dublin**	Tallaght University Hospital	**Health Area B**		Kelly John
	427	Advanced Nurse Practitioner in Tissue Viability	**This project aims to help patients avoid hospital admission and improve patient outcomes through the implementation of a Registered Advanced Nurse Practitioner in Tissue Viability who will provide expert advice and consultation on complex wounds, early management of wounds while also leading and supporting latest evidence based practice**	Midland Regional Hospital Tullamore	**Health Area B**		Burke Louisea
Epilepsy	**251**	Developing a Pathway of Community Care Supports for People with Epilepsy in Ireland	**This project uses a joint approach of staff based in hospital, primary care and community settings working together to improve the level and depth of contact with people with epilepsy so that they can be better supported to self-manage their condition and receive care closer to home, reducing the need for hospital referral.**	Epilepsy Ireland	**National**	Smith Tara	Murphy Peter

Epilepsy	**366**	Keeping people with severe epilepsy independent	**This project will reduce the dependence of patients with severe epilepsy on the ED by intervening earlier in the patient journey to prevent ED presentations in two special groups of patients with Epilepsy – the long term homeless and people with intellectual disabilities with epilepsy living in residential care. This will be done by developing a pathway of care using a shared care model for long term homeless patients with epilepsy (LTHPE) and extending the use of an established community outreach programme for managing epilepsy in patients with ID and severe refractory epilepsy (IDSRE).**	St James Hospital	**Health Area B**		Doherty Colin P.
Gastrointestinal	**29**	Introduction of Molecular Laboratory in Microbiology	**This project will see the introduction of a new molecular platform for the identification of bacterial and viral pathogens responsible for meningitis, gastrointestinal (enteric) diseases and respiratory infections. The molecular platform, will help facilitate timely diagnosis and treatment of patients, will promote earlier discharge and lead to improved patient outcomes.**	MUH, Cork	**Health Area D**		Daly Sandra
	203	Urology Pathway- Proof of Concept Project	**This project will lead to a reduction in waiting times for patients due to the establishment of ANP clinics to see review patients from consultant review waiting lists in Saolta University Health Care Group, University Hospital Galway.**	Saolta Hospital Group	**Health Area F**		Cosgrove Ann
	334	Stool Bank Ireland	**The purpose of this project is to provide safe access to Faecal Microbiota Transplantation material for the purposes of treating refractory or recurrent lostridioides difficile infection, which is the major global cause of gastrointestinal infections within hospitals.**	RCSI Hospitals Group	**Health Area A**		Fitzpatrick Fidelma
	376	ANP for development of male LUTs and benign urology	**This project aims for the development of integrated referral pathways for male patients with Lower Urinary tract Symptoms and develop a secondary care nurse led urology clinic for benign urological symptoms. The aim is to deliver an increasing volume of urological care in the primary care setting, and meet Outpatient Waiting time targets.**	Tallaght University Hospital	**Health Area B**		Kelly John
	468	Electronic ordering for GP lab tests	**This project will provide a better the service to our GP patients needs, avoid process inefficiency due to duplicated data entry, allow shorter turn-around-time for test results. There will be less errors in booking in test, better compliance with the Irish National Accreditation Board standards. There will be less requirement for extra clerical personnel for booking in samples and more time for clerical staff to pursue other core duties. It will also improve compliance with GDPR legislation.**	Saolta Hospital Group	**Health Area F**	Keady Deirbhile	Cosgrove Ann
Heart Failure	**129**	Donegal Heart Failure Integrated Care Service	**This project will provide increased access for community diagnostics. The provision of community access to cardiac echocardiography equips the GP with clinically appropriate information allowing them to triage those who require referral to the hospital service. It also gives the Cardiologist sufficient information on the patient's first visit thus reducing the need for multiple hospital visits and reducing strain on the hospital cardiac diagnostic department and travel requirements of the patient.**	Letterkenny University Hospital	**Health Area F**	Farrell Cathy	Monaghan Dermot

Heart Failure	**165**	Integrated Ambulatory Care Heart Failure Project	**This project seeks to develop the Outreach heart failure services in Dungarvan/West Waterford to better meet the needs of the local heart failure population. This project aims to improve the quality of life of patients with HF, through improvements in access to diagnosis and quality of service delivery; delivered in the main in an appropriate primary care setting.**	University Hospital Waterford	**Health Area C**	Caples Norma	Rothwell Grace
	237	Heart Failure Virtual Consultation Service with clinical nurse specialist support in the community	**This project will help patients to access appropriate early intervention and reduce emergency hospitalisation through the consolidation and scale up of the Heart Failure Virtual Consultation Service, with integrated care clinical nurse specialist support in the community , in three sub-areas: Carlow/Kilkenny, South Dublin/Wicklow/North Wexford, MMUH/Dublin North.**	St Vincent's University Hospital - Ireland East Hospital Group	**Health Area C**	Black Regina	McDonald Ken
	248	Development of Community based Integrated Diagnostic and Care Initiative Cardiology	**This project will help patients to access faster and more efficient referral pathways, a more timely follow up, and reduce wait times for consultation with a Cardiologist through transfer and integrated working between primary care & acute care in relation to heart failure.**	Beaumont Hospital	**Health Area A**		Caffrey Valerie
	352	StrokeLINK Innovating Stroke Support	**StrokeLINK innovates care after stroke by providing a holistic support system that will move with the patient through the acute phase and into the community by providing personalised education and support tools. Two stroke clinical nurse specialists will support patients from their acute hospital stay through to community living.**	Mater Misericordiae University Hospital	**Health Area A**		Marnane Michael
	377	Heart Failure Service Integrated Care Project	**The key proposal is to establish integrated partnerships to join together the full range of heart failure services in the Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West. Dublin South Central area, including GPs, community health, hospital specialists, and other multidisciplinary team members. This has the potential to make a positive contribution to the delivery of care closer to home.**	Tallaght University Hospital	**Health Area B**		Kelly John
	378	Integrated Community Chest pain clinic TUH	**This project creates integrated care pathways thereby leading to hospital avoidance and decreased waiting lists.**	Tallaght University Hospital	**Health Area B**		Kelly John
	416	Heart Failure Improving Patient Outcomes and Health Service Efficiency by Comprehensive and Innovative Integration of Care Across the Continuum of Healthcare Settings	**This project aims at improving patient outcomes & health service efficiency by comprehensive & innovative integration of heart failure care services across the healthcare settings. This will mean every patient with heart failure symptoms is diagnosed correctly, in a service close to home, without delay, in cost-efficient manner. There will be timely patient access to specialist heart failure nursing services in the community and rapid access to consultant cardiologist expert opinion via Heart Failure Virtual Clinic.**	Portiuncula University Hospital/Primary Care Galway	**Health Area F**	Woods Siobhan	Keane James

Heart Failure	**430**	Cardiology Advance Nurse Practitioner Heart Failure	**With the assistance of the ANP Heart Failure it is anticipated to reduce the average length of stay by 0.5 days per patient; admission avoidance will be achieved by patient education & improvement of self-management skills for patients. Empowering patients to recognise deterioration sooner to enable treatment to commence sooner. This will be supported by the provision of at least 4 patient and family education sessions per year.**				
	469	Galway University Hospital Community Cardiac Diagnostics	**This project aims to deliver benefits for the patient through the early diagnosis of heart failure, provided by the implementation of a Community Cardiac Diagnostics Service. This would involve the recruitment of one Senior Cardiac Physiologist, 15 R test monitors and one portable echo machine and would aim to be seeing 40 patients per week by week 16 of service.**	Galway University Hospital	**Health Area F**	(blank)	Kane Chris
Mental Health	**23**	Community Living Mental Health Recovery Co-Ordinator	**This project will further develop a Peer Mentor Programme offering training to tenants and clients in the greater Dublin Area living with severe and enduring mental ill health. It will encourage meaningful and sustained recovery in a clients own home.**	HAIL Housing Association for Integrated Living	**National**	Fox Sandra	Fox Sandra
	73	Individual Placement and Support Adult Community mental health teams	**Individual Placement and Support (I.P.S.) is an evidence-based approach to supported employment for people with mental health difficulties. This project would involve the introduction of Employment Specialists to a further 4 teams in the area, namely North Strand Community Mental Health Team (CMHT), Kilbarrack East CMHT, Cabra CMT and West Blanchardstown CMT.**	CHO 9	**Health Area A**		Walsh Angela
	134	Jigsaw Online	**This project will scale up on online mental health and wellbeing portal. It will offer anonymous self-referred access. It will enable young people, families and educators to access supports outside of regular working hours. It will provide access to mental health professionals in a cost effective way and it will enable Jigsawonline.ie to broker peer to peer on-line forums which are known to be effective.**	Jigsaw	**National**	Mansfield Mike	Mansfield Mike
	169	Individual Placement and Support	**The project adds employment supports to mental health service delivery conducted by Community Mental Health Teams. It proposes extending this approach to three further Community Mental Health Teams across the Mid West.**	CHO 3	**Health Area E**	Wallace Niamh	Hoare Maurice
	171	My Home MHCIS	**The aim of the project is to deliver a new housing-led, community integrated recovery focused model in Galway / Roscommon Mental Health Services, involving: 1) The assessment of housing needs of all those resident in congregated settings and 2) The provision of a package of support which will enable a proportion of this cohort to live independently and become full participants in their communities.**	CHO 2	**Health Area F**	Kelly Lorraine	Meehan Charlie

Mental Health	**180**	Turn2me 360 Online Stepped Care Mental Health Pilot for Young People and Their Families	**To pilot an innovative three-tier stepped care model of integrated professional mental health support fully online to young people 13+ and their families - a 365 degree wraparound professional mental health service designed to integrate with existing services to provide multiple referral pathways from the comfort of their own home.**	Turn2Me eMental Health	**National**		Griffin Jennifer
	233	The Exercise Effect - Integrating Exercise Practitioners into the Irish Mental Health Service	**This projects will provide prescriptive professionally led community-based physical activity interventions to for people with mental health difficulties. It is aligned to best practice recovery focused care.**	Sports Active Waterford	**Health Area C**	Lowney Paula	Ronan Fran
	253	Cork Kerry Health & Wellbeing Community Referral	**This project is a partnership between Cork Kerry Community Healthcare, Health & Wellbeing and National Family Resource Centres which will link citizens to non-clinical supports within the community to improve physical, emotional and mental wellbeing. It will place a particular focus on socially excluded groups who have complex health needs and experience very poor health outcomes across a range of conditions**	National Family Resource Centre Mental Health Promotion Project	**Health Area D**		Cashman Clare
	286	Integrated psychological care for the older adult in Longford Westmeath	**This project will develop and expand on an existing scant dedicated psychology service to those over 65 years living in Longford Westmeath. The proposed new service is also based on partnership talks and interagency working with the Alzheimer's Society of Ireland (ASI).**	CHO 8	**Health Area B**	Clarke Niamh	Clarke Niamh
	320	Promoting cultural sensitivity in community mental health services in Ireland	**Research has shown that people from ethnic minority groups experience significant challenges in accessing mental health supports that appropriately meet their needs. This project seeks, through the development and delivery of training in cultural sensitivity, to enhance the capacity of community mental health staff to address such needs.**	Mental Health Reform	**National**		O'Féich Pádraig
Older Persons	**115**	Changing Gears	**The main goal of our 'Changing Gears' project is to implement a positive intervention for older people, especially vulnerable older people, resulting in reducing participants' reliance and demand on Ireland's healthcare system. The implementation, change management, sustainability and facilitation participant referrals will be delivered directly to older people in 5 settings including; two hospitals, a primary care centre, a day care centre and a prison located within CHO 9 area.**	Age and Opportunity	**Health Area A**		Horgan Karen
	173	Integrated Care for Older People Model for falls prevention and management	**This project aims to implement an Integrated Model for Falls prevention and Management across Donegal, Sligo/Leitrim/West Cavan, Cavan/Monaghan. It will reduce emergency attendance at acute hospitals by having the availability of the specialist service in the community, and reduce length of stay for patients in hospital by having an onward referral pathway. Reduce fractures in older persons as a result of a fall, improved health outcomes for service users and ensure more patient centred delivery of care.**	CHO 1 & Sligo University Hospital	**Health Area F**	Heffernan Maura	Morrison Frank
	183	Post Diagnostic Support worker for people with dementia Inishowen	**This project will provide a Post Diagnostic Support worker for people with dementia Inishowen. Having a dedicated person to link directly with people newly diagnosed with dementia is vital for continuity and the development of personalised care within an integrated system of provision.**	CHO 1 Older Persons Services	**Health Area F**	Donnelly Diane	Morrison Frank

Older Persons	**205**	Western Alzheimers Befriending Service	**This voluntary befriending service will be set up in Counties Galway, Mayo and Roscommon. The aim is to support people with dementia and give the primary carer a short break. We will match a volunteer befriender with a compatible companion. The support will range from companionship in the persons home to partaking in shared interests.**	Western Alzheimers	**Health Area F**		Homes Pat
	221	Integrated Population based Falls Model for Mayo	**This project will help patients to avoid falls and potential hospital admissions through the provision of a falls screening tool, bone health information, falls prevention classes and the establishment of links and referral pathways with fracture clinics for patients to easily access these falls prevention and bone health information sessions in Mayo.**	CHO 2 & Mayo University Hospital	**Health Area F**	Kelly Maura	Kelly Maura
	255	Urgent Ambulatory Care and Virtual Ward for the Older Person	**This project will set-up a virtual ward in the community and an ambulatory model of assessment, diagnosis, by transferring care to the community, within the Cork and Kerry area in collaboration with South/SouthWest Hospital Group. A cohort of patients will be supported to have their medical needs managed at home and remain there using a virtual ward case management approach and supported by an older person outreach team to embed a hospital at home approach. This project will reduce the demand for acute hospital services.**	CHO 4	**Health Area D**		Reaney Ger
	263	AgeWell Programme	**AgeWell offers a unique care coordination model for older people, combining peer-based social engagement, continuous health assessment and mobile technology to improve health outcomes and well-being. AgeWell provides monitoring of health in the community and is proven to reduce demand on the acute care system.**	Third Age Foundation CLG	**National**		Hevey Avril
	269	Mullingar Frailty Intervention Team (MFIT)	**This project will establish a Service User Driven Pathway of care with flexible responsive workforce delivering the right care, in the right place, at the right time, by the right person, within the Laois/Offaly, Longford/Westmeath, Louth/Meath & Ireland East Hospital Group. It will provide education to service users in community and acute service and support self-management by service users and their carers- helping to increase patients' skills and confidence in managing their own condition and promote the use of the language and concepts of frailty in all healthcare interactions.**	CHO 8 & Ireland East Hospital Group	**Health Area A**	Burke Noeleen	Brennan Anita
	277	ALONE BConnect; linking healthcare, social care and community care together using technology and services	**This project aims to provide technology and services to support older people to better manage their health and remain living at home for longer and to enable the community to deliver supports and services to older people. It will also risks in this population group.**	ALONE	**National**	Ainscough Sophie	Moynihan Sean

Older Persons	**340**	Accelerating Integrated Care for Older Persons	**This proposal is founded on insights into implementing Integrated care for Older Persons (ICP OP (2018). It incorporates new the strategic development of Community Healthcare Networks (CHNs). Both (ICP OP and CHNs) form part of the shift from acute centred health service model towards a broader model of primary and community health and social care services.** **This project will:** **1. Will increase the spread of ICPOP sites in tandem with Community Health Network development in Learning sites at St. Luke's Kilkenny & North Kilkenny CHN, Mater Hospital & Ballymun CHN & Cork University Hospital & Bandon/Kinsale/Carrigaline CHN.** **2. Build at scale in Waterford within established ICP OP site.** **3. Implement spread in 4 new pioneer sites in Cavan, Galway City/Tuam/Athenry, Wexford & Mullingar.**	HSE ICPOP	**National**		Healy Pat
	382	Frailty Programme	**The aim of this project is the establishment of a frailty assessment and intervention team (FIT) with full integration between the acute and community services. This project will help to enhance existing services and develop new ones to address the needs of older people and their carers in Wexford**	CHO 5 & Wexford General Hospital	**Health Area C**		Hackett Patricia
	388	Wicklow Frailty First Response Team	**This project will develop a weekend Frailty First Response Team for low and moderate risk calls in Wicklow/South Dublin involving Older People. This project aims to move care of Older People with low to medium acuity presentations from hospital environments to their own homes. It also aims to better link patients to health resources already available in the local community.**	St Vincent's University Hospital	**Health Area C**		Gorman Noel
	392	Beaumont Hospital/National Ambulance Alternative Care Pathways Project	**This joint project from Beaumont Hospital Occupational Therapy (OT)/Physiotherapy (PT) Departments and the National Ambulance Service (NAS) aims to deliver benefits for patients over 75 year olds by giving them a 'treat and refer' ambulance service and helping them to avoid hospital admission. The team of an Advanced Paramedic (AP) and an Occupational Therapist (OT) or Physiotherapist (PT) will treat patients at the scene and if required, refer them to appropriate community based services, as an alternative to ED.**	Beaumont Hospital	**Health Area A**		Ackermann Pauline
Oncology	**247**	CIT Dublin North City and County Community Oncology Service	**The aim of the project is to expand the CIT Community Oncology Service to increase the number and type of infusions to patients outside of a hospital setting and in collaboration with those hospitals. This will assist in early discharge of patients from acute care, assist in hospital attendance avoidance and maximise the number of clients living with chronic disease to be cared for as much as possible in the community of Dublin North City and County.**	CHO 9	**Health Area A**	Carroll Deirdre	O'Flynn Des

Ophthalmology	**79**	Implementation of Integrated Eye Care	**Ophthalmology is a hospital focused specialty, but the majority of services should be provided within the community setting. Integration of acute and community care services is essential in order to rebalance access and delivery of high-quality, consistent, efficient and effective care.** **Goal: increase capacity to deliver eye care to meet patient demand** **Strategy: Reconfigure the service away from an over reliance on hospital delivered care.** **Objective: Establish integrated eye care teams in the community** **The greatest current deficit in capacity is in the Eastern region. Community services are virtually non-existent in the CHOs centred on Dublin (CHO 6,7,9).** **2019 Phase 1; Establish integrated Eye Care Team in Dublin CHOs** **2020-2021 Phase 2; Establish integrated eye care teams nationally as geographically appropriate to meet demand, with link to relevant ophthalmic acute unit.**	Clinical Strategy and Programmes HSE and College of Ophthalmologists	**National**		Kelly Mary
	177	Selective Laser Trabeculoplasty for Community Ophthalmic Service Donegal	**Selective laser trabeculoplasty (SLT) is an outpatient procedure performed in a single treatment in the clinic which treats the trabecular meshwork, the internal drainage channel of the eye, to allow for increased drainage and reduction in pressure in the eye. The development of a SLT service at Community Ophthalmic Service Donegal will reduce the need for referral to Sligo University Hospital for glaucoma patients by at least 1-2 patients per week. It will also provide a new primary treatment option for patients newly diagnosed with open angle glaucoma or ocular hypertension of which there are approximately 3-5 per week.**	CHO 1	**Health Area F**		Monaghan Dermot
	186	Donegal Primary Care Optometrist	**This project will facilitate access for the population to early intervention and treatment in optometry and will reduce need for referral to hospital.**	CHO 1 HSE PCCC North West	**Health Area F**		Quinn Edel
	199	Initiate Specialist Medical Retina services and intravitreal injections in Community Ophthalmics Service, Co Donegal	**This project will reduce waiting list times in Sligo University Hospital and the people of Donegal will be able to avail of this service closer to home.**	CHO 1	**Health Area F**		Quinn Edel
Orthopaedic	**94**	Trauma Assessment Clinic	**This project aims to promote the Trauma Assessment Clinic (TAC) pathway of care by implement virtual clinic programmes. The TAC is a safe and efficient means of delivering trauma care.**	National Clinical Programme for Trauma and Orthopaedic Surgery	**National**		Farrell Catherine
	323	Mobile Telemedicine for Rapid GP Access to Specialist Opinion: A "Virtual" elective orthopaedic clinic	**This project will develop a "virtual" elective orthopaedic clinic/Telemedicine mobile Application and reduce the lengthy waiting time for an elective appointment in University Hospital Waterford. This project will deliver a significant improvement to patient care by facilitating quicker access to orthopaedic intervention for patients most in need and closer to home. It will also help to support GPs in their role to provide care in the community**	University Hospital Waterford	**Health Area C**		Cleary May

Orthopaedic	**324**	The Establishment of Novel Clinical Pathways for Orthopaedic Outpatient Referrals, integration of local community services and multidisciplinary triage	**The Muscular Skeletal Triage and Orthopaedic Department in University Hospital Waterford will roll out a Pilot Osteoarthritis (OA) Knee Pathway in 2019. The aim of the pathway is to create a more efficient access into orthopaedics for patients who are more likely to need surgical intervention. It will facilitate a shift from orthopaedics to primary care physiotherapy as the first point in the referral pathway for patients with knee OA. This will reduce the rate of referrals into orthopaedics, ensure a higher conversion-to-surgery rate from OPD consultations and facilitate a reduction in the global orthopaedic OPD waiting list.**	University Hospital Waterford	**Health Area C**	Corcoran Siobhan	Cleary May
	328	Therapy Led Primary Care Hand Therapy Clinic	**This service will improve patient pathway from GP to first appointment at outpatient clinic and improve patient pathway when hand surgery is indicated. The from referral to Hand Surgery Consultation. This project intends to integrate the focus of the service delivery from the hospital setting to the community and will reduce the orthopaedic waiting list.**	OLH Navan	**Health Area A**	Cureton Michael	Dugow Hassan
Respiratory (COPD) /Asthma	**41**	Develop a Respiratory Integrated Care Programme for COPD in CHO/DNCC Beaumont Hospital (Level 4)	**Introduce a Respiratory Integrated Care (RIC) Team to CHO Dublin North City, West and County / Beaumont Hospital area. The service will support GPs in the diagnosis and management of patients with COPD/Asthma and improve patient outcomes by providing integrated care across hospital and community services.**	CHO 9	**Health Area A**	Reynolds Regina	O'Dea Ellen
	100	Beating Breathlessness Asthma Society	**To provide an easily accessible support, education and information to people with asthma or COPD to help them to better understand and manage their condition. The "Beating Breathlessness" project involves a two-pronged approach to asthma (and COPD) education and self management –involving the creation of a six week self-management support programme delivered via text and an accompanying personalised nurse-led instant messaging service.**	Asthma Society	**National**		O'Connor Sarah
	105	Community based Pulmonary Rehab Programme	**The project will give patients a safe environment to build regular exercise into their lifestyle, staying healthier in their own community, and be able to identify and prevent symptoms that can aggravate their condition thereby reducing hospital attendance.**	CHO 6	**Health Area C**	Fitzpatrick Siobhan	Queally Martina
	132	Establishment of Oxygen assessment clinics in Primary Care Donegal	**This project will establish a community oxygen assessment service in Donegal. This service will reduce demand on Respiratory Physician outpatient clinics, attendances at the Emergency Department and hospital admissions, whilst reducing travel time (up to 3 hours' round trip).**	CHO 1	**Health Area F**	Kennedy Brid	O'Neill Cara
	133	Development of a Respiratory Team for Co Monaghan	**The aim of developing a community Respiratory Team for Co. Monaghan is to improve the management of respiratory patients in the primary care setting, by providing an end to end model of care within a geographically accessible area, bringing safe quality care closer to patients and into patients homes when required. The project will reduce hospital admissions and GP attendances by increasing access to PR, early supported discharge, development of self-management plans with patients and provision of telephone support to patients with the aim of admission avoidance.**	CHO 1	**Health Area F**	Kennedy Brid	Monaghan Dermot

Respiratory (COPD) /Asthma	**159**	End to End Respiratory Model at 2 Sites	**The community diagnostic spirometry service will be a novel service, integrating care between communities and local hospitals. The integrated care teams, will work closely with local GPs and with hospital Specialist teams, providing a coordinated approach to the management of respiratory patients. The respiratory integrated care service will improve health outcomes for patients and reduce referrals to hospitals.**	HSE Primary Care Planning Chronic Disease Commissioning Team	**Health Area C**		McDonnell Tim
	164	COPD Integrated Care Project	**The COPD Integrated Care Implementation Project will be run collaboratively between University Hospital Waterford (UHW) and South-East Community Healthcare. This project focuses on developing an integrated model of COPD care which will address identified priority service gaps and current inequalities in patient access to specialist respiratory services. Expected measurable benefits will include improved clinical outcomes for the patient, reduced COPD exacerbations and reduced emergency presentations, inpatient admissions/readmissions and hospital length of stay and reduced health care costs in terms of inpatient bed days used.**	University Hospital Waterford	**Health Area C**		Rothwell Grace
	216	Development of the physiotherapy led Pulmonary Rehab services in primary care Co Mayo	**This project proposes the further development of the physiotherapy led Pulmonary Rehab services in primary care Co. Mayo. It will improve patient access to Pulmonary Rehabilitation (PR) at locations in the community.**	Mayo University Hospital/Primary Care	**Health Area F**		Tansey Julianne
	305	Community Based Integrated Respiratory Service	**Establish a community based Integrated Respiratory Service (IRS)**	CHO 8	**Health Area B**	Power Sinead	Murphy Fiona
	311	Integrated Pulmonary Outreach in South Tipperary	**This project will provide 'Early Supported Discharge' for patients in an integrated care approach which is aligned to the COPD Outreach Programme Model of Care and will be run collaboratively between South Tipperary Hospital and South-East Community Healthcare. This will produce a shift from the acute service to the community setting by bridging the gap between hospital and community by providing a safe transition home enabling the patient to recuperate in their own environment with family support.**	South Tipperary General Hospital	**Health Area C**		Barry Maria
	364	Integrated Respiratory Rapid Response Team	**This project will establish a community based Integrated Respiratory Rapid Response Service for Kildare and West Wicklow. A dedicated integrated respiratory rapid response team will facilitate patients direct discharge from ED/AMAU and early supported discharge from Naas General Hospital. GP referrals for spirometry (currently 40-45 per month) will be facilitated in primary care, reducing the current waiting time of 4-6 months for this test and reduce waiting list for PRP which is currently 1 year. This project will lead to admission avoidance, reduce length of stay, reduced demand on the acute respiratory service (ED, inpatients beds, OPD services). GP referrals for spirometry (currently 40-45 per month) will be facilitated in primary care, reducing the current waiting time of 4-6 months for this test and reduce waiting list for Pulmonary Rehabilitation which is currently 1 year**	Naas General Hospital / CHO 7	**Health Area B**	Kearney Brian	Dempsey Catherine

Respiratory (COPD) /Asthma	**383**	Development of Respiratory Services for Chronic Obstructive Pulmonary Disease (COPD) patients in Co. Wexford	**It is proposed to support current COPD Outreach and RIC services in Wexford and to establish an additional pulmonary rehabilitation programme in Gorey, Co. Wexford.**	Wexford General Hospital	**Health Area C**		Hackett Patricia
	435	COPD Outreach Service	**Reduced number of admissions, ED presentations and hospital length of stay/objective measurement provided of the service using clinical audit and outcome measures/safe, planned early/ assisted discharge facilitated**	Midland Regional Hospital Portlaoise	**Health Area B**		Knowles Michael
Social inclusion	**2**	Sustain and expand TRY	**Try target groups of young men in a chaotic condition of drug and alcohol misuse, mental health issues, and educational and employment deficits dealing drugs in hotspots around urban communities. TRY implements an Outreach and Bridging Model where workers make contact with the target group where they gather, build relationships and act as role models through intensive outreach, and informal street-based activities. A core aim of the project is to turn a number of its target group into peer mentors to other alienated people.**	Donore (Community Drugs Team)	**Health Area B**	Anderson Lyndsey	Connolly Fearghal
	24	Linkworkers to support the coordination of health and social care for patients living in disadvantaged communities	**This project is a collaboration between GPs in Deep End Ireland and RCSI. The overarching aim is to implement and evaluate a Linkworker intervention in general practices in deprived areas. A Linkworker is a community worker who provides connections to health and social care supports for patients with mental, physical, and social problems in order to improve patient, provider and system outcomes.**	RCSI Department of General Practice	**National**		Smith Susan
	48	LGBT Champions Programme	**The project will address the inequalities of access to health and social care services experienced by older LGBT people, by equipping staff to deliver care in a more appropriate way. It is an advanced training and support programme for health and social care staff working with older people.**	LGBT Ireland	**National**		Fagan Paula
	181	Inclusion Health Specialist Outreach Team	**This project will focus on delivering care to homeless and other socially excluded people in a way that meets their needs both improving chronic disease outcomes and reducing avoidable admissions of homeless adults in St. James Hospital and Mater Hospital.**	St James Hospital and Mater Misericordiae	**Health Area A**		Ni Cheallaigh Cliona
	184	Improving Access to Healthcare : Spread and Scale-up of a HSE Health Passport for individuals with an Intellectual Disability in acute hospital and primary care settings	**This project will see the rollout of a health passport for people with intellectual disabilities in the Northwest Region. Health passports have been identified as an important mechanism to improve communication and patient safety for people with intellectual disabilities, during their journey through general hospital and community based services.**	CHO 1 & Saolta Hospital Group	**Health Area F**	Gallen Anne	Hayes John
	322	Inclusion Health Primary Care: Demonstration of an Integrated Care approach into a scalable model	**This project will provide for consistent GP care to hostel residents for earlier intervention resulting in reduced need for residents to present to acute hospitals.**	CHO 7	**Health Area B**	Radcliffe Maxine	DeBrun Concepta