



SPÓRT ÉIREANN
SPORT IRELAND

Sport Ireland Physical Activity for Health Evaluation

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An Roinn Sláinte
Department of Health







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Glossary

- **HSE** – Health Service Executive
- **HCPs** – Healthcare Professionals
- **LAs** – Local Authorities
- **LSPs** – Local Sports Partnerships
- **PAFH** – Physical Activity for Health Programme
- **PAFHO** – Physical Activity for Health Officer
- **PAFHOs** – Physical Activity for Health Officers
- **PwCC** – People with Chronic Conditions



SECTION 1: The PAFH Initiative

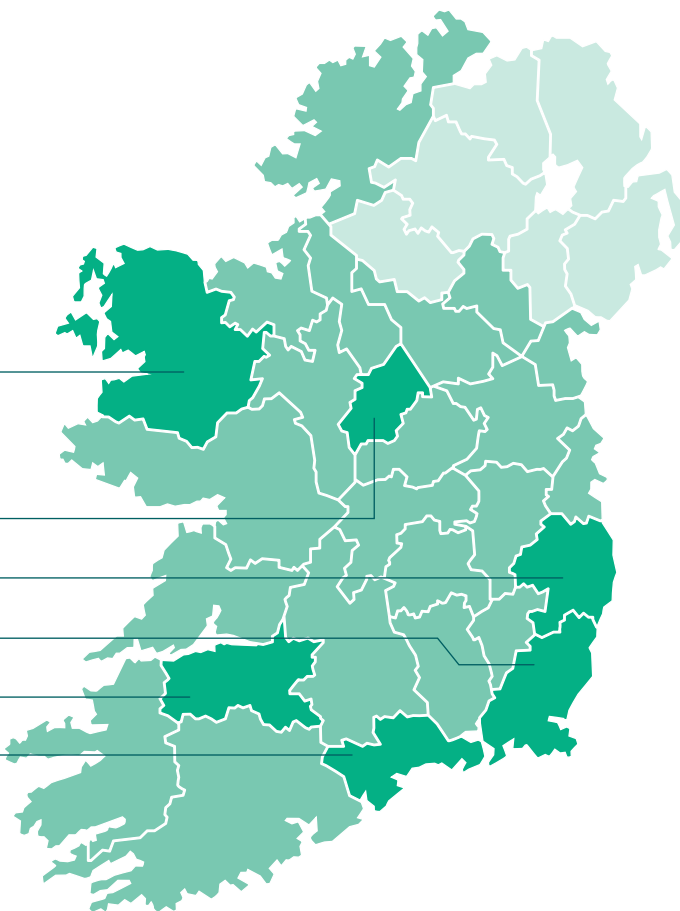


Introduction

PAFH is a pilot initiative developed and administered by Sport Ireland, supported by funding from Department of Health - Sláintecare and HSE Health & Wellbeing. The primary focus is to improve pathways to physical activity opportunities for individuals living with chronic conditions, enabling them to engage in community-based physical activity.

The LSPs led the pilot, which was delivered across six areas:

- Mayo
- Longford
- Wicklow
- Wexford
- Limerick
- and Waterford.



Sport Ireland supports a national network of 29 LSPs whose mission is to coordinate and promote sport and physical activity at a local level, ensuring resources are used effectively to increase participation and improve physical and mental wellbeing. LSPs undertake a wide range of actions to increase participation in sport and physical activities in their local communities.

These actions are grouped within four outcome areas:

- Working to develop clubs, coaches and volunteers and supporting partnerships between local sports clubs, community-based organisations and sector agencies.
- Creating greater opportunities for access to training and education about sports and physical activity provision.
- Provision of targeted programmes, events and initiatives to increase physical activity and sport participation.
- Providing information about sport and physical activity to create awareness and access.



LSPs in Limerick, Longford, Wicklow, Wexford, Waterford, and Mayo were selected to participate in the pilot following an expression of interest and application process. The criteria for participation in the pilot were agreed between Sport Ireland and HSE. LSPs can operate as substructures of local authorities or as independent limited companies, in both cases LSPs are typically supported by key local stakeholders (Councils, HSE, Education & Training Boards, NGBs, etc.). Within the PAFH Pilot, two of the LSPs are independent Limited Companies, with four operating as a substructure of the Local Authority.

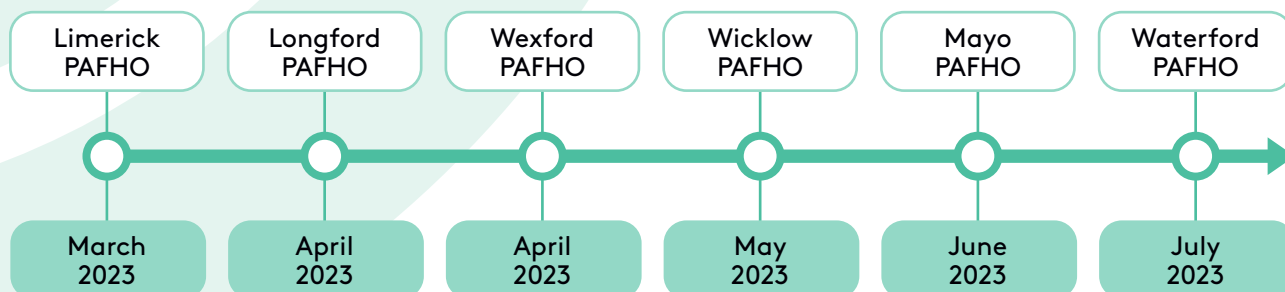
The PAFH Pilot was designed to strengthen how health and physical activity systems work together to support people living with chronic conditions. At a national level, the programme focused on formalising collaboration between PAFHOs, LSPs, and the HSE, and on coordinating and quality assuring structured physical activity programmes co-designed with HCPs. These programmes aimed to build participants' skills, confidence, and independence, with follow-up support to encourage sustained engagement in recreational physical activity, while also improving practitioner capacity and healthcare awareness of local activity opportunities.

At a local level, the pilot translated these objectives into clear participation pathways, with PAFHOs playing a key role in bridging the gap between health services and community-based provision. This included facilitating appropriate signposting, enrolling participants into subsidised programmes, and providing additional support where needed until individuals were ready to transition into mainstream community physical activity.



Six Physical Activity for Health Officers (PAFHs) were appointed (one per LSP) to lead on the development and delivery of PAFH at a local level. PAFHs came into their roles during the period from March 2023 to July 2023.

Timeline for PAFHs Commencing Roles in LSPs



PAFHs came from education, health and wellbeing, sports, and physical activity backgrounds, including PAFHs with specific experience in teaching, physiology, physiotherapy, and occupational health. Furthermore, some of the appointed PAFHs had prior experience working as Sports Development Officers and Community Sports Officers within the LSPs. All six of the PAFHs originally appointed, have remained in post for the duration of the pilot. The PAFH roles were new to each LSP, with the specific remit to lead and deliver on all aspects of PAFH. The roles and responsibilities were wide-ranging, encompassing extensive stakeholder engagement and collaboration with HCPs, recruiting and supporting the development of tutors in each County, sourcing additional funding to support programme roll out, developing and designing tailored physical activity programmes as well as coordinating and quality-assuring the delivery of physical activity programmes for PwCC. The key objectives at both national and county level are further detailed in Appendix 2 and a break down of short, medium and long term outcomes can be found in Appendix 1.

The PAFH pilot was developed and administered by Sport Ireland, supported by funding from Department of Health - Sláintecare and HSE Health & Wellbeing. In addition, HSE Health & Wellbeing offered participating LSPs the opportunity to apply annually for seed funding which helped to support operational costs associated with the pilot.

The funding model and respective contributions are set out in the table below:

Table 1: Funding Model for PAFH

Year	Sport Ireland - Department of Health Funding	HSE Funding
2023	€330,000	-
2024	€330,000	€120,000
2025	€400,000	€120,000

SECTION 2: Strategic Relevance of Physical Activity for Health



2.1 World Health Organisation Guidelines

The World Health Organisation (WHO) has identified health services and HCPs particularly those working in primary care, as being uniquely placed to raise the topic of physical activity and deliver key messages to promote physical activity. In this context, health services play an essential role in the 'whole-systems' or 'whole of society' approach to increasing physical activity across the population.

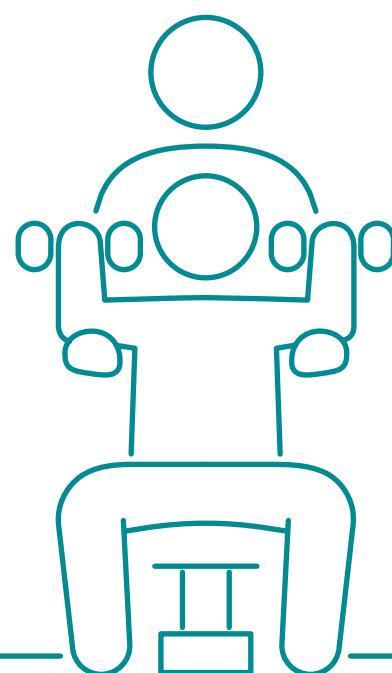


2.2 National Physical Activity Framework (2024-2040)

The National Physical Activity Framework (2024-2040) sets out a vision and strategy for a whole-of-society approach to increasing physical activity across the population. The updated National Physical Activity and Sedentary Behaviour Guidelines for Ireland, Every Move Counts, were published in 2024. An extension to the 2024 guidelines, included guidance for people living with chronic conditions. These national physical activity guidelines are public health guidelines for adults living with chronic conditions, irrespective of age, fitness level or previous physical activity. This includes people with more than one condition, known as multi-morbidity. For people living with chronic conditions, physical activity is generally safe and broadly beneficial for health and well-being. By engaging in regular physical activity, PwCC can, in many cases, slow the progression of their condition, prevent further complications and comorbidities, relieve symptoms, and reduce mortality. Regular physical activity can improve functional capacity, support self-management, reduce depression and anxiety and improve quality of life. There are both immediate health benefits from the last physical activity bout and longer-term adaptations from regular activity. Building capacity to implement the Physical Activity Pathway in Healthcare Model (PAPHM) is a key priority in the National Physical Activity Plan 2024-2029.

2.3 Physical Activity Pathway in Healthcare Model

A Physical Activity Pathway in Healthcare (PAPH) is a set of steps a healthcare professional can take to encourage people to be more physically active. These include screening, intervention, participation and review. All HCPs can integrate a PAPH into their clinical practice. Those working in primary care can reach a greater proportion of the population who are inactive. A Physical Activity Pathways in Healthcare Model (PAPHM) is a range of organisational enablers that build the capacity for individual HCPs to implement the PAPH in clinical practice. The PAFH programme emerged as a key recommendation in the PAPHM to 'Continue collaboration with Sport Ireland to develop and evaluate the Physical Activity for Health Officers (PAFHO) initiative'. Implementing a PAPHM for the Irish context is a key priority in the government's National Physical Activity Action Plan 2024-2029.



SECTION 3: Evaluation Methodology



3.1 Introduction

This evaluation took a process-focused approach to understand how the PAFH Pilot was delivered and how it developed over time. It examined key areas such as the extent to which the PAFH programmes reached their target population, how closely delivery aligned with the original aims and guidelines, the strength of partnership working, and the overall relevance of the programme to local needs. In addition, the evaluation explored the extent to which the PAFH pilot has achieved the short and medium term outcomes identified in its logic model which can be found in appendix 1.

3.2 Data Collection

The evaluation adopted a mixed method approach to data collection combining structured stakeholder consultation and secondary data collection and analysis. A shared Evaluation Framework and Logic Model guided consistent data gathering across six LSPs, focusing on outputs, outcomes, and impact. Evidence was drawn from a desk-based review, regular engagement with Sport Ireland, in-depth consultations with PAFHOs, HSE staff, LSP Coordinators, and tutors, alongside case studies illustrating local experiences and programme impact.

At the early stages of implementation, approaches to data collection varied across pilot areas, reflecting local capacity, systems, and learning as the programme evolved. The later introduction of a shared Evaluation Framework and Logic Model significantly strengthened alignment and consistency, providing a more coherent basis for reporting and establishing a strong foundation for future programme phases.

While the use of standardised quantitative tools (including M1 Single item measure of physical activity data) was explored to assess changes in physical activity levels, these proved challenging to apply consistently, particularly at post-programme follow-up. Despite challenges, the evaluation accessed pre and post M1 data for 181 participants, drawn from the overall M1 database managed by Sport Ireland. This data reinforces the qualitative findings in the report.

In response, the evaluation places a strong emphasis on qualitative evidence, including thematic analysis of stakeholder insights, participant feedback gathered through local processes, and detailed case studies. This approach provides a rich and nuanced understanding of how the pilot worked, the outcomes it supported, and the barriers it sought to address. Given the scale of activity across six pilot areas, direct engagement with participants was not always feasible. The evaluation therefore also draws on a robust body of secondary data, including feedback gathered by PAFHOs through local evaluations and participant reflections, ensuring that participant voice remains well represented. Collectively, this evidence offers a credible and valuable account of the PAFH Pilot.

3.3 Data Analysis

Qualitative data analysis was conducted using both thematic and narrative approaches. Categories were developed, coded, and reduced using NVivo. Our evaluation observations, thematic data from interviews and secondary data was cross referenced to identify emergent themes and issues and to explore the relationships between issues. Participant sampling and data collection continued until no new conceptual insights were generated and the evaluation team felt they had gathered repeated evidence for the thematic analysis, thus reaching saturation.

SECTION 4: Evaluation Findings



4.1 Introduction

A clear and consistent delivery model has emerged across the PAFH Pilot. While local contexts vary, PAFHOs described a shared, staged pathway that reflects how the programme has evolved on the ground. This model, widely recognised and verified across the PAFHO network during the consultation process, comprises six interconnected stages. Each stage has been shaped by a range of enablers, barriers, and critical success factors, which are summarised below.

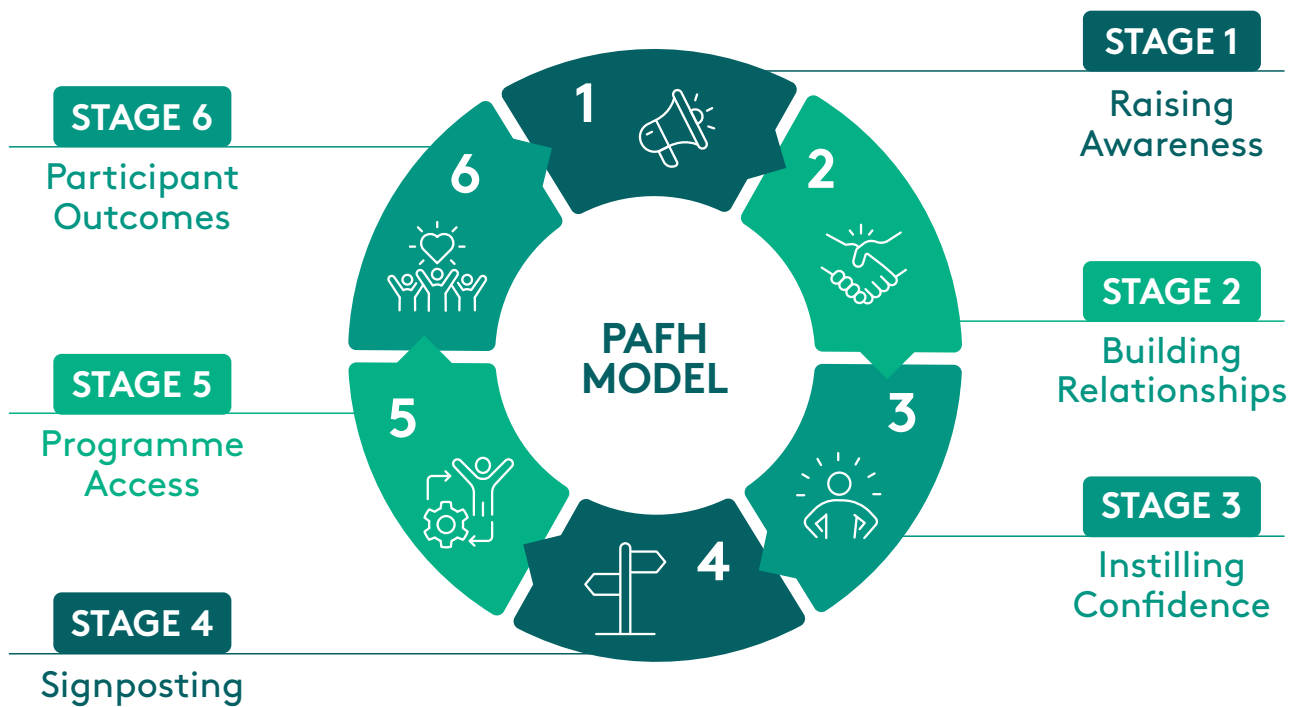


Figure 1: PAFH Model

4.2 The PAFH Model



STAGE 1

Raising Awareness

PAFH was the first multi-sectoral programme of its kind developed specifically to improve the physical activity levels of PwCC by improving referral pathways between HCPs and community based LSP physical activity programmes. For the past decade, the HSE recognised the need to integrate the promotion of physical activity into care pathways across the health services. The development of the National Exercise Referral Framework and the Making Every Contact Count initiative represented some of the steps taken within the HSE to support PwCC and prevent chronic disease. PAFH aimed to offer relevant, suitable and safe physical activity opportunities in community settings, enabling HCPs to refer patients effectively. From the outset, a key priority for PAFHOs was to raise the profile of the programme among key stakeholders. Many HCPs reported limited awareness of the LSP structure and its potential contribution to patient health outcomes. Addressing this gap required significant investment of time and effort, particularly during the early stages of the programme. PAFHOs took a proactive and personal approach to engagement, focusing on direct interaction with HCPs through attendance at HSE events, meetings, and information sessions. These efforts were instrumental in clarifying the aims of the pilot, building understanding of the PAFHO role, and illustrating how PAFH could complement the work of HCPs. While this work was both time-consuming and resource-intensive, it was essential in establishing trust and credibility and laid strong foundations for the programme's later success.

“

The PAFHO role is now on the radar of people in HSE. There is better awareness and examples already of proactively working to develop joint solutions.

- HSE

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This initial phase focused on strengthening the visibility and legitimacy of PAFH within both the health system and the wider community. Using existing LSP networks and partnerships, PAFHOs were able to access key contacts and leverage established channels to communicate the programme's purpose. They also differentiated the PAFH initiative from traditional sport development activity by emphasising its health-focused and non-competitive nature. This clarity of messaging helped HCPs see the relevance of PAFH to patient care, positioning it as a practical and credible component of the broader health promotion landscape.

The complexity of the multi-sectoral environment also meant that communication had to be tailored to different audiences, balancing the language of public health, physical activity, and community development. In addition, competing priorities and operational pressures within the health service often limited the availability of staff to engage with new initiatives, slowing early momentum. Feedback from HSE staff during the consultation process reaffirmed that the work undertaken at this stage helped develop their understanding of PAFH and how it could complement their clinical work.

“

This is a very new space we are all operating in. The PAFHO has had to get to know a lot of people in a short space of time. The real impact of this is only at the very early stages.

- HSE

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Work to raise awareness by PAFHOs also extended beyond HSE. A significant amount of time and effort was also invested in engaging with patient support organisations and the public. This process was critical to building awareness of and confidence in PAFH across the target areas. This appears to have been done to significant effect, considering the popularity of the programmes and the significant uptake.

“

Older people in the community are now aware of these opportunities. They tend to talk, sharing positive reviews with their peers which is creating more interest and driving up participation.

- HSE

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STAGE 2

Building Relationships

PAFH was developed on the premise of strengthening relationships between community-based physical activity providers and the HCPs. Relationships are crucial for creating system change between sectors because they foster trust, shared understanding, and collaboration, enabling organisations to work together towards common goals.



The PAFHO has created critical connectivity, a central point of contact for what is happening, when it is happening and where it is happening. Having someone in that position is very important in creating systems change.

- HSE



PAFHs deliberately targeted key parts of the HSE that would be best placed to promote and encourage the uptake of community-based physical activity opportunities for PwCC. The target audience included Health Improvement Teams, Primary Care Teams (specifically Physiotherapy and Occupational Therapy) and Chronic Disease Hubs. For Primary Care Teams and Chronic Disease Hubs in particular, there was limited to no prior engagement with LSPs, so relationships were essentially built from scratch. This stage was more than simply sharing information, it was about forming alliances with key personnel, building trust and understanding how collaborative working would help deliver better outcomes for patients with chronic conditions. This process required considerable time, patience, and persistence, helping to build bridges between sectors.

Some PAFHOs came from a clinical background and had the benefit of knowledge and insight into the relevant parts of the HSE. In some cases, this may have helped expedite relationship building and fast-tracked the implementation of programmes. The consistency and credibility of the PAFHO role over time also emerged as a key enabler of relationship development, creating a reliable point of contact within a complex multi-agency environment.

HSE staff cited that having a direct point of contact in the PAFHO was fundamental to the successful roll-out of PAFH. HSE staff described PAFH as having 'greater visibility within the healthcare space.'



It has been hugely valuable. Having a funded, dedicated post with protected time to develop pathways is the answer we have all been searching for. It has been an absolute godsend and nothing but a success.

- HSE



HSE staff recognised and welcomed the 'new space' that has been developed, which accommodates a practical collaboration with mutual benefits for all partners. This stage of relationship-building was pivotal in overcoming both real and perceived barriers to collaboration, paving the way for more seamless pathways that enable PwCC to access suitable physical activity opportunities in their communities. In several cases, these relationships were embedded into a local advisory group for PAFH, in others, the PAFHO integrated into existing networks to maintain relationships.



It was the view of LSP Coordinators that this was a collaborative model that was often ‘talked about’ around tables for many years, and PAFH was putting it into practice. LSPs noted that there had been some examples of collaboration with HSE before PAFH. However, they felt PAFH significantly changed the nature and extent of that relationship, moving from a sporadic and ad-hoc engagement usually in response to an available funding opportunity, to one that was consistent and enabled ‘follow up’. LSPs were now more confident about their role and how to engage with the HSE’s structures to bring about positive change. One LSP Co-ordinator described it as ‘night and day’, referring to the relationship with HSE before and after PAFH.

During the consultation, concerns were raised regarding the sustainability of key relationships underpinning the programme. In many cases, these connections are reliant on personal relationships between individual PAFHOs and HCPs. As such, when either party leaves their role, there is a risk that the relationship must be rebuilt from the beginning, highlighting the work required to embed institutional relationships between LSPs and the HSE. However, several positive examples were identified where formal structures such as service-level agreements (SLAs) or memoranda of understanding (MOUs) had been established to support collaboration. In these instances, the presence of formal agreements provided a clear mandate for new staff to continue joint working with the LSP. One live example came from one county where, after a full year of collaborative work on the PAFH programme, there was a change in personnel within Primary Care Physiotherapy Management. Because the relationship had been formalised through an MOU, the LSP and clinical team had a clear framework to continue the partnership. This demonstrated how formal agreements can help embed collaboration and ensure continuity despite staffing changes.

“

Awareness of the PAFHO role has improved, I would like to see even more integration for the PAFHO within the relevant forums of the HSE where they can further build trust and relationships with primary care clinicians. The role needs to maybe be a little more strategic than operationally and programmes based on need.

- HSE

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STAGE 3

Instilling Confidence

Most HSE staff were very receptive to the potential role of community-based physical activity in supporting patients with chronic conditions. This indicates a growing acknowledgment, both in policy and practice, within HSE of the importance of enhancing physical activity levels and the benefits that community-based physical activities can offer to individuals living with chronic conditions. The regulatory environment of the HSE can make collaboration with organisations outside of the statutory health service seem challenging. Part of the challenge in this context stems from concerns around to whom and to what patients are being signposted to. HSE staff needed reassurance that the programmes offered via PAFH were suitable, relevant and safe for PwCC. They needed to know that the programmes were delivered by competent people who had the knowledge and expertise to provide safe programmes as a step down from clinical care.

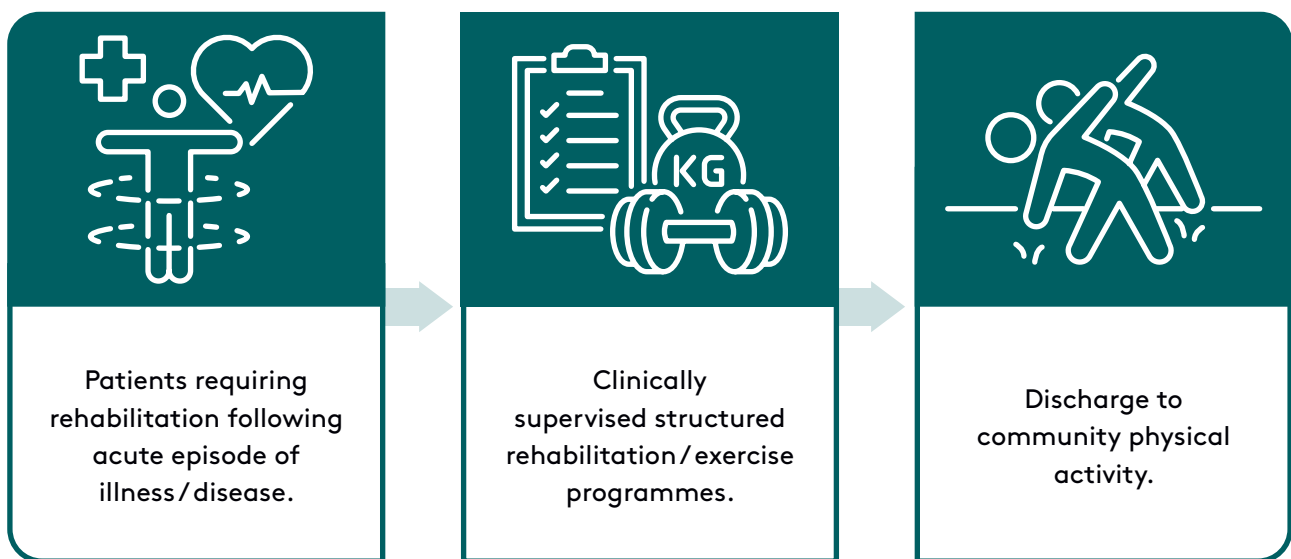


Figure 2: Step down model from clinically supervised programmes to community-based physical activity programmes.



We run clinically led programmes for people with pulmonary conditions from the Integrated Care Hubs. When people leave the hospital that is often where things fail, as they lose those structures and support. They now have a step-down programme which allows them to maintain and manage their condition to keep them physically active in the long term.

- HSE



Significant work was undertaken within the PAFH initiative to address concerns and develop a trusted programme that would meet the expectations of HCPs. This included investing in the upskilling of physical activity tutors, with many people across the target areas availing of professional training opportunities and qualifications recognised within the health sector. This complements work being done at national level to build capacity through the implementation of the Competency, Training and Accreditation Framework for Long Term Conditions Exercise Instructors. The PAFH initiative has built clinical physical activity capacity across the six LSP county areas, contributing to the longer-term sustainability of this work.

“

The PAFHO role has helped build bridges and that is important when trying to build trust and confidence.

- HSE

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There are examples of how physical activity tutors shadowed clinical programmes provided by HSE, allowing them to embed good practice into community-based and non-clinical programmes. In some cases, HSE staff were also invited to observe community-based programmes so that they could see first-hand the programmes being delivered. Both PAFHOs and HSE staff also appreciated the need for boundaries and a clear separation between programmes offered in a clinical setting and community-based physical activity opportunities.

“

It's not just about handing out a piece of paper. The PAFHO attends our Pulmonary Rehab Programme in person, gets chatting to people and builds relationships. This reaching out is labour intensive, but the payback is greater. Having our clinical practitioners side by side with the PAFHO is very reassuring for people.

- HSE

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As PAFH evolved, there appears to be a shift towards the delivery of more evidence-informed physical activity programmes, further instilling confidence in HCPs. Some of these programmes included a multi-component element, integrating aerobic exercise, muscle-strengthening activities, balance training, and flexibility exercises. While evidence-based programmes can enhance confidence among HCPs, LSPs emphasised the importance of maintaining a clear distinction from clinical practice. Both PAFHOs and LSP Coordinators highlighted the need to preserve the evidence-informed, non-clinical, community-based, and accessible ethos that defines the LSP model. This core strength can at times be at odds with clinical practice and strict fidelity protocols associated with evidence-based clinical programmes. Contributors noted the need to strike an appropriate balance-embedding evidence-informed provision where appropriate, while retaining the flexibility and responsiveness required to meet the needs of the target population in line with the LSP's community-centred approach.

The level and quality of communication between HSE staff and LSPs has also improved over time, with HSE staff reporting greater confidence in what the offering is and having sufficient lead time to signpost patients. There are examples of formal structures in local Advisory Groups for LSPs/PAFHs to engage with key stakeholders, including HSE staff. In some cases, this appears to have been a helpful forum, but perhaps not as effective in all, depending on the individual's commitments to these structures.

“

The local Advisory Group has brought together a group of stakeholders who all share a common interest but creates a space to allow people to speak to it and start taking action to develop local solutions.

- HSE

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Over time, as PAFHOs continued to build trust and as HCPs became more familiar with the LSPs' broader remit, confidence grew. There is evidence of better understanding and appreciation of the role and contribution of LSPs within HSE. HCPs have come to appreciate the LSP's community-based, non-clinical delivery as a unique strength, particularly in encouraging engagement among participants who might otherwise feel alienated by traditional healthcare pathways.

“

It is now easier to convince my colleagues in the HSE about the benefits of community-based physical activity opportunities. The PAFHO has helped build confidence among HSE staff because of the upskilling of exercise tutors and the strategic, evidence-based approach.

- HSE

”

The consultation highlighted an ongoing tension between the use of “evidence-informed” and “evidence-based” programmes. For some HCPs, the availability of a clearly evidence-based programme, such as Prime-Time Life, played an important role in building confidence. It provided assurance and credibility in a space that was new to them, making it easier for them to signpost individuals into community-based provision. As delivery evolved and relationships strengthened between the PAFHOs and HCPs, trust increased. Over time, this growing confidence made it easier for HSPs to signpost individuals not only to evidence-based programmes but also to those that are evidence-informed or adapted & developed by LSPs. This does not in any way undermine the qualifications, experience or credibility of the PAFHO. Rather, it reflects the practical realities and sensitivities involved when a health service professional refers an individual into a community-based programme.





STAGE 4
Signposting

Improved awareness, stronger relationships and greater confidence have paved the way for more effective signposting of PwCC between HSE and LSPs pathways.

Increasing numbers of PwCC are now being encouraged and supported to participate in community-based physical activity opportunities in the PAFH pilot areas. There is now a progressive and established, tiered pathway model in operation across many areas. This allows HCPs to progress patients from programmes delivered in clinical settings to suitable programmes in community settings. This aligns with the approach outlined in the HSE Physical Activity Pathway in Healthcare Model as illustrated below.

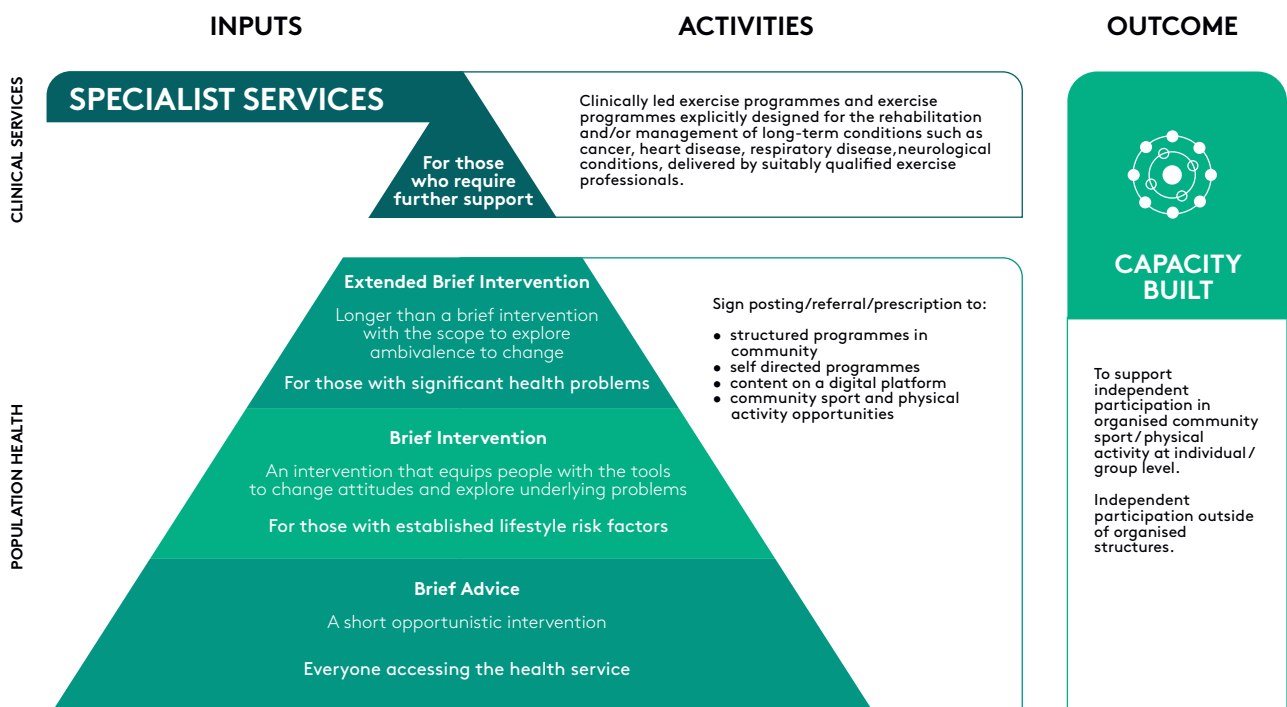


Figure 3: Physical Activity Pathway in Healthcare

Evidence from across the pilot programme indicates about 27% of participants coming particularly from physiotherapists, occupational therapists, and dietitians. Focus group feedback from LSP Coordinators suggested that approximately 8% of participants had been signposted to programmes at the outset of the PAFH pilot. However, because the evaluation commenced a year after implementation, a representative pre programme baseline could not be established across all sites. General Practitioners (GPs), however, remain more difficult to engage, but it should be noted that the main focus was on Primary Care Teams and Chronic Disease Hubs during the pilot. Whilst no baseline exists, the percentage of people commencing physical activity opportunities as a direct result of signposting has been heralded as a remarkable success by all stakeholders.

“

We would have had people attending our programmes that may have had a chronic condition. However, the volume has change significantly, with greater uptake by PwCC and increased levels of signposting.

- LSP Coordinator

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It is also worth noting that HCPs did not only focus on community-based physical activity opportunities when signposting clients. HSE staff were directed to encourage people to access a range of opportunities, including but not limited to exercise referral schemes, websites and initiatives (e.g. Get Ireland Active, Get Ireland Walking), social prescribing, and the increasing use of e-health and digital technology (HSE App).

HSE staff reported improved communication, more advanced notice of opportunities and greater consistency in the offering – all of which contributed to them signposting patients to suitable programmes in a more effective way. Both HSE and LSP staff also reported that signposting is now more likely through more established and formalised working relationships that have developed.

“

There have been significant changes and restructuring in the HSE, which we are all trying to navigate. There are also limitations in terms of the clinical programmes that HSE is delivering due to staffing constraints. This all impacts on developing signposting pathways.

- HSE

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Signposting processes vary across the LSPs. Some have developed more sophisticated back-end IT systems that HCPs can easily complete when meeting patients, and which are then picked up by PAFHOs who contact the referral. This approach appears to be quite impactful, as it lessens the workload of the clinical professional and allows for a more personalised intervention by the PAFHOs, which evidence suggests increases the likelihood of clients engaging in physical activity opportunities.

“

The social connect through the call is really important in getting someone to the activity in the first place.

- LSP Coordinator

”

In some cases, HCPs encourage clients to contact LSPs to register for specific programmes. This approach appears to carry a higher risk of non-uptake of physical activity opportunities among the target group. There are still several challenges faced in developing efficient and effective pathways. A constant view of HSE staff is that they are ‘time poor’ and not always in an informed position to give patients up-to-date information on opportunities within the community. Similarly, PAFHOs and LSPs more generally reported challenges in meeting the heavy administrative burden involved in signposting, which required them to contact people directly.

A key concern among HCPs was the unpredictability of future investments in PAFH, which posed a significant challenge and often created uncertainty for HSE staff. This uncertainty was believed to negatively affect the willingness of HSE staff to fully commit, as they feared it might become a pilot initiative that fails to evolve into a long-term investment.

“

There is a fear within the HSE that this is another new initiative that will be here now but disappears - undoing all the good work that has been done. The start has been really positive but this needs to be a long-term investment.

- HSE

”

Overall, there is emerging evidence that system-based approaches are being used in several of the pilot LSPs, resulting in a notable increase in the level of signposting from HCPs. This confirms that the awareness raising work undertaken in early phases of the project, compliment established signposting processes, leading to a more system wide approach to signposting.

“

Health is not [solely] the responsibility of HSE or the Department for Health. Involving and collaborating with community organisations in this way speaks to much of the Frameworks and Strategies that we have developed - it is now an exciting time to seeing this in action and watch some of this coming to fruition.

- HSE

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STAGE 5

Programme Access

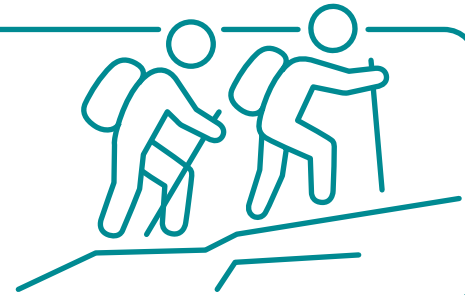
There has been a significant positive change in the number, range and quality of programmes delivered by LSPs for this specific target group because of PAFH. Across only two years, 253 programmes were offered in the community, with 4,615 PwCC benefiting. Retention on all programmes has been high, with post-programme evaluations confirming the value that participants placed on key areas such as accessibility, the knowledge and skills of the exercise tutor, and the suitability of the programme.

253

different programmes delivered by PAFHOs across the 6 counties during the pilot.

4,615

unique participants engaged in PAFH programmes across the 6 participating counties during the pilot. Participating numbers ranging from 1,318 to 319 in individual counties, reflective of variations in delivery models.



“

In the past, there was a lack of suitable physical activity opportunities to encourage people to engage. Having the variety of opportunities we now have in the community, and less medicalised, is absolutely brilliant.

- HSE

”

There is evidence of where HCPs have contributed to the evolution of these programmes through consultation and stakeholder engagement. However, some HSE staff reported that they would welcome more input into the co-design of programmes in the future.

The specific resource provided by the investment in PAFHOs has been a catalyst for significant growth and development in this area. LSPs were consistent in their view that this would not have been possible without a dedicated staff member who could lead on the extensive stakeholder engagement and relationship building outlined across previous stages. LSPs noted that this was an area that they had 'dabbled in' and had started to 'develop programmes for PwCC.' The change, though, from having a dedicated resource and focus through PAFH helped build significant new capacity, confidence and relationships that did not previously exist.

“

It is night and day for us (LSP). We have been doing small pieces in the past, but it's a massive change. We are engaging on a new level now with the HSE that previously wouldn't have been possible without the PAFHO role.

- LSP Coordinator

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Across all six LSPs, there is now a strong and established offering of programmes which are targeted and appropriate for PwCC. The offering has evolved considerably over the past two years, and there is now a more consistent suite of programmes being delivered, with an increasing number of evidence-informed programmes. HSE staff consistently reported greater visibility of suitable opportunities for PwCC.

“

The programmes developed are hitting the nail on the head and making a real difference.

- HSE

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“

There will be people benefiting from these programmes who are not attending the chronic disease hubs - but keeping those people out of the health service, then we are doing vital work.

- HSE

”

Some HSE staff did report a desire to see more programming across more locations but recognise the constraints of the programme. This view is supported by LSPs, who have consistently reported that the staffing resource is restrictive, meaning further expansion within each county is not possible without additional investment.

“

The infrastructure needs to be built where programmes are more established, consistent and long term if this is going to make a real sustainable impact.

- HSE

”

“

As a result of the pilot, demand for any new LSPs will be immediate and LSPs will need to be adequately resourced to deal with this.

- LSP Coordinator

”

“

We (LSP) can't expand this programme with the current resources. These are expensive programmes to deliver and that has to be recognised in the resource allocations.

- LSP Coordinator

”

Marketing and messaging have been key enablers in driving participation. Officers consistently emphasised the importance of using welcoming, non-clinical language in programme names and promotional materials. All LSPs have undertaken multi methods of communication to promote PAFH opportunities. This report has focused extensively on the implementation of signposting pathways. Still, it is essential to note that the majority of participants are coming through other channels (e.g. word of mouth, general PR, social media, etc.) Clearly, given the demand for the programmes across the target areas, this promotional work has been very effective.

There is also consensus that having participants contribute a small fee increases both their commitment and the perceived value of the programme. Where participants hold medical cards, some LSPs offer a refund mechanism, though this can sometimes create tensions within mixed groups.

Several HSE staff felt that it would be helpful if there were some feedback loops which provided an update on whether signposting had led to uptake of physical activity opportunities. This would help reinforce the value of signposting and encourage ongoing signposting although it is acknowledged that this would require tracking and monitoring of participants which is resource intensive and could stretch PAFHOs/LSPs already limited capacity.





STAGE 6

Participant Outcomes

Robust evidence exists suggesting that the opportunities provided through PAFH have made a positive impact on the lives of PwCC. Direct feedback from participants, PAFHOs, Tutors, and HSE staff provides a rich pool of quantitative and qualitative data, confirming a range of outcomes. There are numerous compelling stories of change experienced by many participants, evidencing the powerful life-changing impact of PAFH.



It gave me a reason to start exercising.

- Participant



It was really wonderful. Had a knee replacement/arthritis last year and it has been invaluable to spend time together every Friday.

- Participant



Being around others experiencing similar difficulties makes you feel seen and heard.

- Participant



This programme has changed my life. I feel in my everyday life I am fitter and healthier. Onwards and upwards.

- Participant



Health benefits reported by participants range from improved physical strength, cardiovascular health and balance. This has helped people effectively manage their chronic conditions and led to numerous examples of improved quality of life. Many reported improvements in being able to carry out critical everyday tasks such as standing, walking or tying shoelaces. The overriding feedback from participants points to the impact of the programmes on mental health and emotional well-being. Participants reported improved social interaction and reduced isolation as key outcomes of their participation. Importantly, for many, there was also great comfort taken from being in the company of people who face similar health challenges and conditions.



My specialist did the breathing test and he said that it had went up 20%, adding an extra 4 years to my life.

- Participant



“

My husband died at the end of September, and I found the isolation and loneliness huge. The only thing that kept me going was the physical exercise and my daily routine because of my condition. I liked the group changing room where people spoke to me. Sometimes, it was the only conversation of the day.

- Participant

”

“

My osteopath is amazed at the improvement in my body.

- Participant

”

“

This programme made my legs stronger especially while going up inclines and I am not in as much pain as I was before.

- Participant

”

When combined with the physical benefits outlined previously, this has all contributed to increased motivation levels to participate in physical activity. Participants are also better informed, more motivated and better placed to self-manage their health. Programmes have given participants better insight and understanding of the role physical activity can play in helping manage and alleviate the symptoms of chronic illnesses. This allows people to be better informed and better able to self-manage their health and contribute to longer-term sustainable change.

HSE staff referenced the value of the step-down model for PwCC, whilst there is also emerging evidence whereby people involved in PAFH before acquiring a chronic condition recover more effectively from procedures such as cardiac surgery. One participant, who later underwent a triple bypass, reported significant prehabilitation benefits from engaging with PAFH prior to surgery. Feedback relayed by HCPs to the PAFHO indicated that the participant's recovery was notably improved due to their prior involvement in physical activity. Following the procedure, the individual continued to engage with PAFH programmes as part of their ongoing recovery.

“

Our patients are benefiting from this new resource - from evidence-based programmes being delivered by professionals who can tailor the programmes to meet needs - the feedback from some of the programmes has been phenomenal.

- HSE

”

Analysis of Quantitative Data – M1

The Single item measure (M1) is a validated evaluation instrument which is used internationally by researchers to track changes in physical activity over time. Sport Ireland manages a systemic M1 data collection protocol across all LSPs in accordance with the Irish Physical Activity Research Collaboration Evaluation Toolkit. The Sport Ireland M1 process uses samples of programme participants to evaluate the effectiveness of LSP programmes in changing physical activity levels. In total, Sport Ireland has M1 data on over 15,400 programme participants across all LSP programmes.

PAFHOs expressed challenges in collecting M1 data, particularly at time 2 and at the 3-month post programme follow up. Despite challenges, a sample of 374 PAFH programme participants provided M1 data at registration, 8.1% of all PAFH programme participants. M1 data was collected for the following PAFH programmes:

- Activator Poles Arklow
- Aqua Aerobics for Chronic Pain & Arthritis
- Aqua Aerobics for People with Chronic Pain & Arthritis
- Chair Pilates for People with Chronic Pain & Arthritis
- Get Active Stay Active
- Movewell: Activator Walking for Neuro Conditions
- Movewell: Activator Walking for Neuro Conditions
- Movewell: Aqua Move for Breast Cancer
- Movewell: Aqua Move for Chronic Pain & Arthritis
- Movewell: Breathe Well
- Movewell: Move Steady
- Movewell: Pilates for Chronic Pain & Arthritis
- Movewell: Pilates for Chronic Pain & Arthritis
- Phase 4 Cardiac Rehabilitation
- Strength & Balance
- WISE Programme (Wellness Independence Strength Exercise)



M1 post programme follow up data was provided by 181 PAFH programme participants (4% of all PAFH participants) which can be used evaluate real world effectiveness of the PAFH programmes. Using only the data from the 181 participants who provided pre and post programme data we can ascertain that at registration 16% of programme participants were categorised as inactive (0-1 days of PA), 56% were categorised as somewhat active (2-4 days of PA), and 28% were categorised as active (5 or more days of PA). At the end of the programme, **the proportion of inactive participants reduced to 9% from 16%**, 50% were somewhat active and the **proportion of people who were active rose to 41%**. Overall, this shows a **7% reduction in people who are categorised as inactive and a 13% increase in the people who are active**. In summary, PAFH programmes have a positive effect on the participants physical activity levels.

This level of impact is broadly consistent with the analysis and impact results of the full M1 dataset over the last 6 years. It is notable however that only a small number of PAFH programme participants submitted 3 month follow up data. The full M1 data set has 3 month follow up data for 3,378 programme participants and indicates that post programme effectiveness is sustained 3 months after the programme has ended. Given the similarity of findings between the larger M1 dataset and the PAFH dataset it could be hypothesised that programme effectiveness is also sustained for PAFH programme participants. However, securing 3 month follow up data from a sample of PAFH programme participants in the future would help to confirm the longer-term impact of the PAFH programme.

4.3 Conclusion

The evaluation findings present a comprehensive account of how the PAFH pilot has developed and matured over the two-year timeframe, culminating in the emergence of a six-stage delivery model that captures the full cycle of programme implementation from initial awareness-raising through to participant outcomes. Each stage of this model is characterised by a range of enablers, barriers, and challenges. Collectively, these stages demonstrate how PAFH has evolved from concept to practice, creating a coherent and replicable approach to integrating community-based physical activity within the care pathways for PwCC. While recognising ongoing challenges around sustainability, capacity, and consistency, the findings underscore the programme's success in achieving its intended outcomes and in establishing a strong foundation for future development and national scaling.

These findings are further illustrated through Case Studies below, which will elaborate on the programme level context and application of the model. Section 5 provides further analysis on the extent to which PAFH achieved its objectives.



4.4 Case Studies

Case Study 1: Sustainability/Longevity (Wicklow)

Wicklow LSP delivered Strength and Balance Programme and partnered with Shoreline Leisure to deliver the Phase 4 Cardiac Rehabilitation Programme in Greystones. Both programmes generated significant levels of engagement with participants reporting notable improvements in their overall health and wellbeing. Substantial improvements in pre- and post-programme assessment results further supported these outcomes.

After the successful delivery of three 8-week blocks of the Strength & Balance programme, and in response to strong participant interest, the centre chose to continue delivering the programme independently. Once completed, the centre assumed full responsibility for the continued delivery of the Phase 4 Cardiac Rehabilitation Programme.

The Strength and Balance programme has also been successfully established as a sustainable offering at Coral Leisure Centre, Arklow, following funding from the Local Sports Partnership (LSP) for two 8-week blocks.

These are examples of where the pilot has led to more sustainable, long-term delivery through improved capacity and collaborative working.



Case Study 2: Participant's Feedback (Wicklow, Prime Time of Life)

"I attended the Prime Time of Life classes as I have medical issues and the classes would benefit me. Unfortunately, prior to attending the classes, I fell and sustained a significant ankle injury with a full complete ligament tear which resulted me being put in a boot and on crutches. This injury in April left me unable to walk, drive or do anything really. I attended the class in my boot, as at that stage, I was in such bad form as I was unable to do anything. I had been prescribed pain relief and sleeping tablets as injury really affecting my whole wellbeing. I attended the class as I had been an active person prior to this and missing walking my dog.

The classes have been amazing and the intervention of these classes is a complete success story. I attended the classes and hobbled around in my boot and after a while Jay questioned how I was doing and about my injury and helping me with exercises for my level with my injury. Jay's expertise, advice, help and support have led to my success and this has complimented my ongoing rehabilitation recovery. I still can't run or jump on ankle but I'm making a great recovery. I can't stress enough the importance of this class and say how lucky am I to have been on enrolled on it. It has positively turned my life around and my recovery today is a direct result of these classes. Early intervention has played a vital role in my rehabilitation recovery and that's thanks to Jay's expertise and advice and this class. This class has allowed me exercises in a safe manner suitable to my injury as that's the beauty, it caters for all levels and supports all levels. It is so much fun as Jay and Lisa bring so much fun, spirit and craic to the class, it is so enjoyable. Lisa brings so much positivity and life to the class, always keeping the banter and fun going. The classes have been amazing and for me and sincere thanks to everyone involved. Thank you!"



Case Study 3: Better Balance Programme (Waterford)

Our Partners 

Overview

We piloted a ten week strength and balance programme for adults that can walk unaided.

Aims

- To add a structured strength and balance programme with measurable outcomes to our current programme offerings.
- To help prevent a deterioration in adults by challenging and training the main components needed for maintaining good independent movement.
- To work in partnership with the local HSE Primary Care Centre physiotherapy team to investigate effective physical activity programme models developed by other HSE colleagues and implemented in other counties by local sports partnerships.
- To support the health behaviour change work of the local HSE Primary Care Centre physiotherapy team by co ordinating suitable physical activity opportunities for adults to improve and maintain good health and longevity.

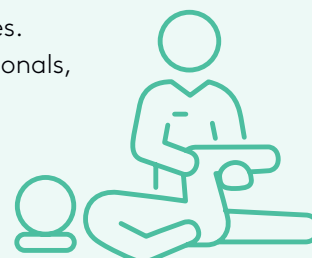
Implementation

- The Physical Activity for Health Officer (PAfHO) met with the Waterford HSE Primary Care Centre (PCC) Physiotherapy Manager to identify the activity needs of frequent physiotherapy patients advised to become active for long term health conditions.
- The PAfHO shared details of the Staying Fit for the Future – Better Balance programme, successfully implemented by HSE South Sports Partnership with the HSE and expanded to Mayo.
- The PAfHO and Physiotherapy Manager contacted HSE Cork and Cork Sports Partnership to replicate learning opportunities for Waterford fitness professionals and physiotherapists.
- A full day staff training session was provided for fitness professionals and physiotherapists, with an additional half-day session for physiotherapists.
- WSP handled fitness professional recruitment, funding, venue booking, promotional materials, participant recruitment, printing, equipment purchase, registration, evaluation, and outcome measure collation.
- Trained physiotherapists conducted outcome measurements in weeks 1 and 10 of the programme.

Outputs

- 36 adults participated in the 10 week programme: 34 females and 2 males.
- 9 professionals were trained in the programme delivery – 3 fitness professionals, 1 WSP staff member, 5 HSE physiotherapists.
- All outcome measurements improved from week 1 to week 10.

*“It was brilliant, and I practise the exercises at home”
“I’ve made improvements to my balance and I’m walking more”*



Next Steps

- Organise another Staying Fit for the Future – Better Balance training day to increase local capacity and ensure sustainability.
- Continue partnership with Waterford PCC physiotherapy team and local sports partnership colleagues to learn about developments and experiences.
- Discuss with physiotherapists the potential for measures to be developed in Waterford.

SECTION 5: Delivering Against KPIs



5.1 Introduction

A logic model for the PAFH programme was co-developed and agreed by key stakeholders, including the HSE, Sport Ireland, and the six participating LSPs). This model established the short term outcomes that served as the agreed measures of success for the pilot phase. It was agreed that progress against medium term outcome would be welcomed but not expected during a pilot. The following table presents an assessment of delivery against these outcomes and associated key performance indicators (KPIs). A RAG (Red–Amber–Green) rating has been applied to illustrate the level of progress achieved for each outcome. The RAG assessment reflects the evaluators’ professional judgement, informed by a comprehensive review of programme documentation, analysis of secondary data, and extensive qualitative consultation with stakeholders across all levels of the programme.

Clear evidence of progress against the outcome

Some evidence of progress against the outcome

Limited or no evidence of progress against the outcome



5.2 Short term Outcomes

For Partners/Stakeholders		
Increased awareness of physical activity opportunities in the community for PwCC.		Clear evidence of increased awareness amongst HCPs of the work of LSPs, the availability of PAFH and the programmes on offer.
New partnerships are established between HCPs and community-based physical activity providers.		Overall, 161 HCPs were engaged by LSPs in the PAFH programme through Advisory Groups, funded programmes, signposting, partnerships – representing a “night and day” difference from the baseline position for LSPs.
Improved working relationships between HCPs and community-based physical activity providers.		Clear evidence of strong relationships built, particularly between PAFHOS and Physiotherapy networks, Occupational therapists, Chronic Disease Hubs, Health Improvement Teams. These included the development of MOUs/SLAs in some cases.
Increased capacity to deliver physical activity programmes for PwCC within respective communities.		Across the 6 Counties, 68 tutors were recruited, trained and engaged in delivering PAFH programmes – representing increased capacity within the LSP/ community to deliver programmes.
Increased confidence amongst HCPs to/signpost to community supports.		Approximately 27% of all participants on PAFH were signposted by HCPs, this is a significant shift and is reflective of increased confidence.
Increased number and range of programmes for PwCC delivered in local communities.		253 unique programmes delivered across the 6 counties for people living with chronic conditions, or at high risk of developing chronic conditions – including a mix of tailored and adapted programmes as well as evidence-informed programming.

For the Individual PwCC

<p>Increased awareness of the benefits of, and opportunities for, physical activity.</p>		<p>Significant anecdotal and qualitative evidence gathered from participants regarding improved awareness of opportunities and benefits. 4,615 unique participants accessed programmes, indicating improvements in motivation and confidence to participate whilst strong evidence exists of participants continuing participation through PAFH programmes. Levels of physical activity increased through regular participation in programmes. The validated M1 measure shows that PAFH programmes positively increased physical activity levels among participants, with inactivity reducing by 7% and active participation increasing by 13%. While follow-up data at 3 months was limited, results align with wider LSP evidence, suggesting sustained impact beyond programme completion. Social inclusion and connection were referenced consistently by participants during case studies and qualitative feedback as the primary benefit and outcome.</p>
<p>Improvements in motivation and confidence to participate in community-based physical activity programmes.</p>		
<p>Increased levels of physical activity.</p>		
<p>Increased levels of social interaction with peers who share similar backgrounds and experiences.</p>		
<p>Increased likelihood of accessing other independent community-based physical activity opportunities.</p>		



5.3 Medium Term Outcomes

For Partners/Stakeholders		
Improved effectiveness and efficiency in signposting between HCPs and community-based physical activity providers.		Emerging evidence of improved effectiveness and efficiency through digital/system-based approaches – supported by direct client engagement by the PAFHO to uptake programmes. This however has significant resource and capacity implications and is therefore unclear as to how sustainable this can be under the current model.
Sustained capacity within the physical activity sector to develop and deliver programmes for PwCC.		Whilst 68 tutors were developed and trained, there is a clear view that demand for programmes significantly outstrips the availability. Retaining tutors also remains a key challenge for LSPs.
Reducing dependency and/or pressure on HCPs, leading to less demand on the healthcare system		The evaluation highlighted promising examples of how PAFH may help reduce pressure on HCPs.

For the Individual PwCC		
Sustained increase in physical activity levels.		
Improvements in physical health and well-being		Qualitative evidence through participant case studies and video interviews – shared in this evaluation report highlight significant impacts on mental health and wellbeing and social connectedness. Participants frequently report being motivated and committed to continue exercising, suggesting positive impacts on sustained participation levels. Less is known at this stage regarding increased capacity to self-manage conditions as well as sustained access to other independent physical activity opportunities, this merits further exploration in a future evaluation.
Improvements in mental health and well-being.		
Increased capacity to self-manage chronic conditions		
Increased sustained access to other independent physical activity opportunities		
Sustained sense of community and social connectedness		

Overall, the analysis of delivery against the PAFH logic model demonstrates strong and measurable progress across all short-term outcomes and emerging progress against all medium term outcomes. The evaluation found clear evidence that the programme has achieved significant advances in awareness, engagement, capacity-building, and collaboration between the health and community physical activity sectors.

At the stakeholder level, the programme has successfully established new partnerships and deepened relationships between LSPs and key components of the HSE, including Physiotherapy Networks, Occupational Therapy Teams, and Chronic Disease Hubs. The creation of formal agreements such as MOUs and SLAs in some areas provides further evidence of maturing collaboration. Importantly, HCPs are demonstrating growing confidence in referring and signposting patients to community-based programmes, with approximately 27% of participants now engaging through direct HSE referral.

At the individual level, there is strong qualitative and quantitative evidence of impact. Participants report improved motivation, confidence, and awareness of the benefits of physical activity, alongside tangible improvements in physical health, mental wellbeing, and social connectedness. The programme has also expanded the range and quality of available physical activity opportunities, with 253 unique programmes delivered and 4,615 participants engaged across the six pilot areas. While some challenges persist, particularly around sustaining tutor capacity, managing demand, and ensuring consistency in long-term behavioural change the overall direction of travel is positive.

The evidence suggests that PAFH has delivered against its agreed outcomes. These findings reinforce the programme's value as a scalable model for integrating physical activity into chronic condition management and as a key mechanism for advancing the Physical Activity Pathway in Healthcare model nationally.



SECTION 6: Analysis & Discussion



6.1 Introduction

The terms of reference for this evaluation set out five key questions against which the PAFH programme should be assessed, these key questions relate to reach, fidelity, sustainability, partnership, and relevance. This section seeks to provide answers to each of the five questions, addressing the terms of reference directly. A summary SWOT analysis for PAFH is also included in Appendix 4.

6.2 Reach

To what extent were the targeted participants reached, and to what extent were participants engaged in the programme (e.g. continuity of attendance)? What were the factors that influenced this?

PAFH was explicitly designed to reach PwCC. This targeted approach was central to the ethos and purpose of the programme. This cohort can be disengaged from physical activity and can be challenging to reach. The presence of chronic conditions can negatively impact people's ability and confidence to participate in physical activity. As outlined in Section 4, central themes of the approach taken to reach the target audience involved 'raising awareness' and 'building relationships' with key stakeholders. PAFH was very successful in reaching the target group, using a variety of methods to do so, including signposting pathways from HSE and general public relation and marketing activities. For some PAFHOS, there was also a significant amount of work done to proactively contact people, sharing information about opportunities and paving the way to participation.

Programmes were designed, tailored, and promoted to meet the needs of PwCC. This work has led to programmes which have proved very popular. Numbers are consistently high across all programmes, with some programmes regularly oversubscribed (e.g. aqua aerobics). A consistent view reported by many HSE staff was the 'increased visibility' within the healthcare space about these programmes, suggesting a heightened awareness which can contribute to increased reach among this hard-to-reach cohort.

Some initiatives are based on validated and well-established evidence-informed programmes, which have proved popular and impactful. PAFHOs and HCPs both welcomed and appreciated the multi-component nature of these programmes. Some have also been designed, developed, and delivered to address unique and specific chronic conditions. A sample of these programmes is included in Table 2.

Table 2: Sample of PAFH Programmes

Programme Name	Description	Target Audience
Prime Time of Life	A community-based physical activity programme designed to support older adults to remain active, independent, and socially connected. Sessions typically combine low-to-moderate intensity exercise with opportunities for social engagement, focusing on mobility, strength, balance, and overall wellbeing.	Older adults, particularly those who are inactive, at risk of social isolation, or experiencing age-related declines in mobility and confidence.
Strength and Balance / Better Balance	A structured programme focused on improving muscular strength, balance, and functional movement to reduce the risk of falls. Sessions are progressive, evidence-informed, and often include education on safe movement and everyday functional tasks.	Older adults and adults with reduced strength or balance, including those at risk of falls or with conditions affecting mobility.
Chair Yoga	A gentle, accessible form of yoga delivered primarily in a seated position, with optional standing elements. The programme focuses on flexibility, breathing, posture, relaxation, and stress reduction, adapting traditional yoga movements to suit varying abilities.	Adults with limited mobility, chronic conditions, or balance concerns, including older adults and those new to physical activity.
Breathe Well	A structured physical activity and breathing programme designed to support people living with respiratory conditions. Sessions combine low intensity activity, breathing techniques, and education to improve breath control, confidence, and day-to-day function.	Adults living with chronic respiratory conditions such as COPD, asthma, or long COVID, typically referred or signposted from health services.
Aqua Aerobics / Aqua Move / Aqua Aerobics for Chronic Pain & Arthritis / Aqua Move for Breast Cancer	Water-based exercise programmes delivered in a pool environment, using the properties of water to reduce joint stress while improving cardiovascular fitness, strength, and mobility. Variants are adapted to address specific health needs and recovery pathways.	Adults living with chronic pain, arthritis, post-cancer treatment (including breast cancer), or those requiring low-impact exercise due to joint or mobility limitations.
Pilates for Chronic Pain & Arthritis	A tailored Pilates programme focusing on core strength, posture, flexibility, and controlled movement. Sessions are adapted to minimise pain and support safe participation, with an emphasis on body awareness and functional movement.	Adults living with chronic pain or arthritis who require a structured, low-impact approach to improving strength and mobility.
Activator Poles for Neuro Conditions	A walking-based programme using Activator Poles to promote upright posture, balance, and coordinated movement. Sessions support safe walking patterns and functional mobility, often delivered in small, supported groups.	Adults living with neurological conditions such as Parkinson’s disease, multiple sclerosis, or post-stroke, who require additional support to engage in physical activity.

Programme Name	Description	Target Audience
Phase 4 Cardiac Rehabilitation	A supervised, community-based exercise programme designed as a progression from clinical cardiac rehabilitation. Sessions focus on improving cardiovascular fitness, confidence, and long-term self-management through structured, safe physical activity.	Adults who have completed Phase 3 cardiac rehabilitation and are medically cleared to continue physical activity in a community setting.
Falls Prevention	A targeted programme combining strength, balance, and education to reduce falls risk. Sessions may include functional exercises, confidence-building, and advice on safe movement in everyday environments.	Older adults and adults identified as at risk of falls, including those with previous falls or reduced confidence in mobility.
Walking Programmes (Walk and Talk)	Low-threshold, community walking programmes that combine physical activity with social interaction. Walks are typically graded, inclusive, and supported, encouraging regular participation and progression over time.	Adults who are inactive, socially isolated, or living with long-term conditions, including those who may be transitioning into more structured physical activity.
Outdoor Mobility	An outdoor-based programme focused on improving confidence, balance, and functional movement in real-world environments. Activities may include walking on varied terrain, negotiating obstacles, and building skills for everyday outdoor mobility.	

It should be noted that PAFHOs also identified constraints on delivering more programmes, including the availability of competent exercise tutors, limited budgets, administrative pressures, and the availability of suitable venues.

Keeping people engaged in physical activity is always a challenge, but PAFH programmes appear to have had high levels of retention. This can be attributed to programmes that catered to needs, the professionalism of exercise instructors, and the supportive environment, all of which were reported by many participants.

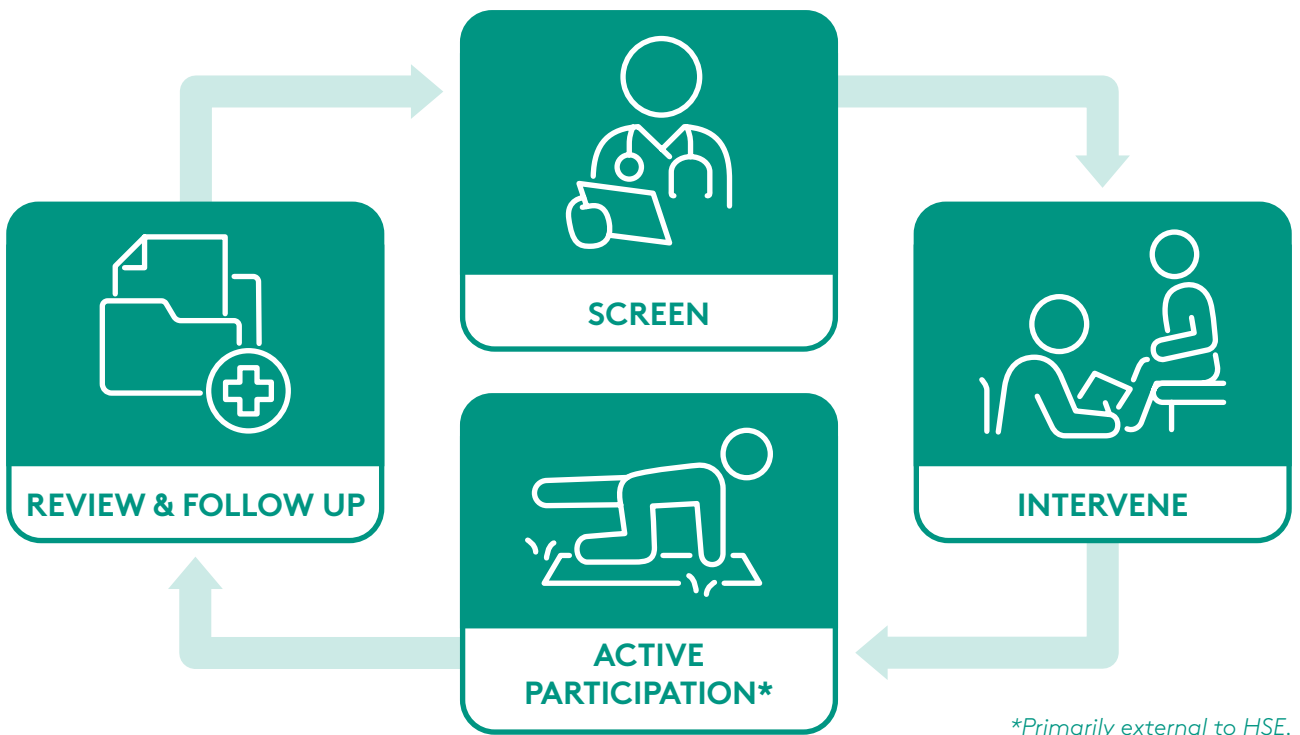
Accessibility was also a contributing factor to achieving the high number of participants. This included delivering programmes within the community, utilising open, shared, and inclusive spaces such as community centres, leisure centres, and public buildings. The size, scale and rurality of many counties also presented challenges in having accessible programmes. Affordability was also important, with the programmes significantly discounted and, in some cases, free at the point of access for those who had either a medical card, a long-term illness, or a GP Visit Card.

6.3 Fidelity

Did the PAFH programmes operate by agreed objectives? What were the factors that influenced this?

PAFH remained strongly aligned with its objectives and intended outcomes. However, there was sufficient flexibility and autonomy within each area to deliver the programme in a way which reflected local needs. This meant that there was no consistent uniform approach, with each LSP keen to have control over how PAFH was delivered locally.

A significant focus of the work was to develop pathways between HSE and LSPs, and all PAFHOs invested considerable time, effort and resources into developing this collaborative approach. Pathways have now formed and continue to strengthen, facilitating the flow of PwCC into community-based physical activity opportunities. This supports a key drive from HSE to embed the Physical Activity Pathway for Healthcare model in primary and secondary care and to move towards more exercise and physical activity in the community.



Steps integral to implementation of MECC within Health Services

Figure 4: Physical Activity Pathway in Healthcare (PAFH)

The programmes delivered across all six LSPs varied in the earlier stages. However, evidence suggests that a more consistent suite of programmes evolved over time, with a shift towards using more evidence-informed programmes. These programmes have straddled prevention, early intervention, and ongoing management of chronic conditions, which has been welcomed by the HSE and participants alike.

PAFH has been developed across six distinct areas within the pilot, this has helped with knowledge transfer and exchange of learning across multiple regions, resulting in an emerging model that can be used to scale the programme nationally. There is strong evidence to support the positive contribution of collaboration and learning across all PAFHOs, LSPs and HSE areas. This has helped develop a more effective programme and acts as proof of concept for broader implementation and policy decisions.

6.4 Sustainability/Longevity

Was sustainability/longevity built into the way the PAFH programmes engaged with targeted individuals and organisations? What were the factors that influenced this?

PAFH recognised key limitations in capacity from the outset and worked to ensure that a parallel process of upskilling exercise tutors in this specific area was implemented. Training programmes were rolled out and accessed by exercise tutors to build capacity across the sector, which could help contribute to sustainable programmes. The work done in the pilot has contributed to a complementary project led by key multi-sectoral stakeholders to develop a new Competency, Qualification, and Accreditation Framework for Long Term Conditions Exercise Instructors.

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Tutors trained or upskilled to deliver physical activity programmes to PwCC across the pilot.

Table 3: Examples of Training by Exercise Tutors Supported by PAFH

Examples of Training Undertaken by Exercise Tutors

- NCEF Tutor Training Workshop on Chronic Conditions
- Prime Time of Life
- PSI Falls Prevention
- Training with British Association for Cardiovascular Prevention and Rehabilitation
- ComEx Pain Training
- Staying fit for the Future Better Balance programme

Programmes have evolved and have been refined continuously throughout the project's lifetime. There are examples of where programmes piloted in public leisure centres have then become part of the mainstream programming, or where experienced exercise instructors have developed provision as a result of the pilot. This cascading effect is a positive example of how these targeted programmes can become more commonplace and sustainable in the long term.

HSE staff were positive in their appraisal of programmes offered through PAFH, and reinforced that their confidence in the programme had grown over time. 'Consistent', 'reliable', 'accessible' and 'high quality' were terms regularly used by HCPs in their feedback about PAFH.

As outlined previously, relationship building between PAFHOs and HSE staff has been a central pillar and core to its success. HSE staff identify the 'person' in the PAFHO role as the 'go-to' person. This is positive, but it also brings its challenges and limitations, particularly if there is a change in personnel, in terms of affecting longer-term systemic change.

Sustainability/longevity is also dependent on how effective signposting pathways are. Whilst there is evidence that this has improved (see Section 4), it is not clear if there are always transparent and efficient processes in place to maximise signposting opportunities. Only in some situations have PAFHOs been given consent to access contact details for patients who HSE staff feel might be suitable for physical activity opportunities. This allows PAFHOs to make direct contact with patients, share appropriate and real-time information, and encourage uptake of new opportunities all of which are shown in evidence as increasing participant engagement levels. This is an approach that is favoured by HCPs and is supported by research

to deliver better and longer-term outcomes. The sharing of patient information, where it occurs, must comply with GDPR protocols. Where this is not in place, HSE staff reported that they were often not fully capable of sharing accurate information and the signposting process only involved exchanging contact details for the PAFHO/LSP.

A key challenge appears to be transitioning individuals onto more generic physical activity programmes after completing these tailored, targeted programmes. Anecdotally, there is a general view that people often find taking that next step more challenging and they tend to want to reengage in programmes with the PAFHOs. This reduces availability on subsequent programmes for new participants, which creates a resourcing challenge given the ever-increasing demand from within the target group. PAFHOs and exercise tutors both play a role in supporting participants in taking that next step, linking people into other mainstream LSP activities or local leisure services programmes.

It should be noted that LSPs recognise the potential for further expansion of PAFH, but Coordinators were consistent in their views that there needed to be consideration to adequately resourcing the programme.



6.5 Partnership/Stakeholder Engagement

How well were the targeted organisations and partners engaged (e.g. HSE, Community Workers, and Charity Organisations)? What were the factors that influenced this?

Stakeholder engagement was central to the success of PAFH, evidenced in the 'building relationships' and 'instilling confidence' phases of the model outlined in Section 4. PAFHOs have worked hard to build and strengthen relationships with key parts of the health sector. Notably, this included parts of the industry that LSPs had never directly engaged with, such as Primary Care Teams and Chronic Disease Hubs. This work was time-consuming and resource-intensive, but critical. It helped build trust and confidence in the offering provided and increased the likelihood of HCPs' signposting clients into physical activity programmes.

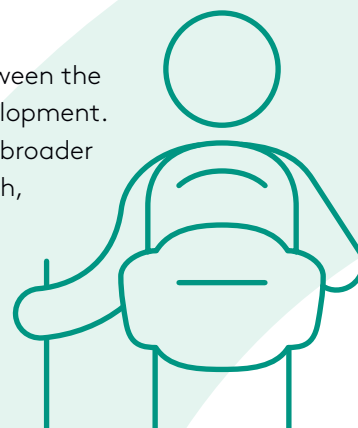
161
HCPs engaged through advisory groups, networks, signposting, and partnership across the pilot.

LSP Coordinators noted a stark difference in the level and quality of relationships with HSE because of PAFH, with one citing it as 'night and day' when describing the change. There are now practical examples of collaborative working and more effective pathways in place, which are improving outcomes for PwCC and which will, through time, help reduce pressures on the health service.

The appetite within parts of the HSE to engage with the pilot varied across some counties and even within specific clinical areas. Some clinical professionals were enthusiastic and passionate about the role these community-based programmes have and could play. Others were perhaps more passive. Whilst they noted the presence of PAFH Programmes, it is unclear if they were as proactive in encouraging signposting pathways. Embedding signposting to physical activity opportunities as part of routine clinical care will take time. This reinforces the importance of clear policy direction championing this approach, and positive, strategic leadership within the HSE. Some HSE staff also reported that they needed to be more 'outward looking' beyond the statutory health service and have more confidence in non-clinical programmes as a key part of the solution to achieve systemic change.

An important point raised by several stakeholders was the significant change and challenges faced within the HSE. HSE has undergone significant restructuring, with changes in staffing and new infrastructure (e.g. Chronic Disease Hubs). This is all happening at the same time that PAFH is rolling out, creating in itself some additional challenges and complexities which have to be navigated by stakeholders. Whilst there was a focus on key parts of the HSE as outlined above, stakeholder engagement also extended to considerable work undertaken with patient support organisations. PAFHOs interfaced with many organisations operating across the target areas that support people with a range of chronic conditions (e.g., Irish Heart Foundation, Arthritis Ireland, Diabetes Ireland etc.).

There has been much focus and attention on encouraging collaboration between the pilot organisations and capturing learning to inform and shape broader development. This evaluation also recognises the vast contribution of PAFHOs' time to this broader mission. Notable contributions have been made to local and regional research, symposiums, conferences and initiatives by all PAFHOs.



6.6 Relevance/Impact

Level of perceived relevance and impact of the Sport Ireland PAFH Programme by the participants and partners. What were the factors that influenced this?

In assessing PAFH relevance, the central consideration was the perceived level and significance of impact of PAFH by participants and partners. This is summarised in Table 4.

Table 4: National and Local Objectives for PAFH

Stakeholder	Relevance/Impact
Participants	<ul style="list-style-type: none"> • Greater availability of tailored physical activity programmes catered to needs • Improved accessibility and removal of barriers to physical activity opportunities • Improvements in physical health • Improvements in mental health and wellbeing • Improvements in the management of existing chronic conditions • Reduced likelihood of developing chronic conditions • Reduced social isolation
LSPs	<ul style="list-style-type: none"> • Improved capacity with a dedicated staffing resource focused on this critical area • Complemented and added value to programmes that had been in development for PwCC • New evidence-informed programmes developed/delivered • Greater reach and engagement with PwCC • Greater recognition, understanding and appreciation for the work of LSPs within HSE • Improved confidence within LSPs to develop this area of work
HSE	<ul style="list-style-type: none"> • Pathways to signpost PwCC to physical activity opportunities (Tier 3 of the Physical Activity for Health Model) • Clear step-down evidence-informed programmes from existing clinical programmes • Helps de-medicalise exercise in a non-clinical setting • Complements work of HSE and other core initiatives (e.g. Make Every Contact Count) • Keeping people healthy and away from clinical settings, alleviating pressures on the healthcare system
Other HCPs (e.g. Patient Support Organisations)	<ul style="list-style-type: none"> • Opportunities for their target groups to access and benefit from physical activity opportunities
Exercise Tutors/ Professionals	<ul style="list-style-type: none"> • Training and upskilling opportunities • Improved confidence to engage and support PWCC. • Employment/work opportunities • Access to new target group

SECTION 7: Conclusion & Recommendations



7.1 Introduction

The evaluation of the PAFH pilot highlights the development of a structured and practical model for connecting HCPs and community-based physical activity. Delivered through collaboration between Sport Ireland, the HSE, and six LSPs, the programme has evolved steadily, demonstrating how coordinated approaches can help PwCC to become more active and supported in their communities. The following conclusion summarises the key findings through the lens of the six-stage PAFH model, outlining progress made, lessons learned, and considerations for how the programme might continue to develop and grow through a series of recommendations.



7.2 Summary of findings



STAGE 1

Raising Awareness

At the foundation of the PAFH model was the extensive effort to raise awareness of the role that LSPs can play in supporting PwCC. This required persistent engagement and clear communication. The awareness-building phase was resource-intensive, but it laid essential groundwork for collaboration. It also coincided with a period of significant restructuring within the HSE, adding complexity to stakeholder engagement and communication efforts. Nevertheless, PAFHOs successfully positioned the programme within the wider health and wellbeing landscape, leveraging consistent messaging and locally tailored outreach to establish credibility across health networks.



STAGE 2

Building Relationships

The relationships forged between LSPs and HSE have become one of the programme's most significant achievements. These partnerships did not emerge quickly and require ongoing, consistent and focused engagement to build and maintain mutual trust and understanding. The process has been highly relational, requiring both leadership and persistence. Strong interpersonal connections now underpin collaboration at the local level, but there remains a need to formalise these relationships through Memoranda of Understanding (MOUs) and Service Level Agreements (SLAs) to ensure sustainability beyond individual personnel. The shared learning and collaboration between the six pilot LSPs further strengthened this stage, providing opportunities for knowledge exchange, joint training, and the sharing of ideas that added value to the pilot.



STAGE 3

Instilling Confidence

Over time, confidence has grown among HCPs in signposting patients to community-based programmes. This has been achieved through quality assurance, upskilling of tutors, introduction of evidence-informed programmes, shared evidence of impact, and the professionalism of the PAFHO role. HSE staff now demonstrate greater awareness and confidence in the LSPs and their exercise tutors, reflected in the marked increase in referrals, with approximately 27% of participants joining programmes via health service signposting. However, challenges remain. Effective feedback loops between HSE and LSPs are not always in place, meaning HCPs are not always aware of whether their referrals result in participation. Strengthening these mechanisms will reinforce the value of signposting and help maintain confidence in the process.



STAGE 4 Signposting

The signposting stage represents a critical turning point in the PAFH cycle. Processes are now considerably more robust and consistent than prior to the pilot, but efficiency varies across areas. Evidence suggests that when patients consent to having their contact details shared directly with LSPs, PAFHOs are far more successful in facilitating participation than when patients are simply handed information. While this person-centred approach is proven to yield better outcomes, it is also labour-intensive and unlikely to be scalable within current resource levels. Future iterations should explore digital or technological solutions that can improve efficiency as well as those that offer personalisation and human interaction. Establishing structured feedback loops between PAFHOs and referring HCPs would also enhance transparency, encourage continued engagement from HCPs, and strengthen the sustainability of signposting pathways.



STAGE 5 Programme Access

The PAFH pilot has led to the delivery of a diverse and high-quality suite of physical activity programmes that are safe, inclusive, and relevant to people living with chronic conditions. The approach has been organic and adaptive, evolving in response to learning, demand, and resource constraints. Over two years, 253 programmes were delivered by 68 trained tutors, demonstrating the success of targeted capacity building within the community. This investment in tutor development has laid a foundation for long-term sustainability, though retention of tutors and limited resources remain pressing challenges. Demand now significantly exceeds supply in many areas, underscoring the need for additional investment to scale provision. Consistency in branding, marketing, and messaging while allowing for local context would also strengthen public recognition of PAFH and reinforce its credibility both locally and nationally.



STAGE 6 Participant Outcomes

Ultimately, the impact of PAFH is reflected in the experiences and outcomes of participants. The programme has increased physical activity participation among PwCC Participants consistently report improved physical health, mental wellbeing, and social connection. The sense of belonging fostered within these programmes has been as valuable as the physical benefits themselves according to participants. LSPs, too, have gained confidence and capacity, while the HSE recognises the programme's potential to reduce pressures on the healthcare system through prevention. Looking ahead, a national rollout of PAFH would be widely supported, though stakeholders caution that new areas will require time, capacity-building, and careful groundwork to replicate the success achieved in the pilot counties.

7.3 Conclusion

The evaluation of the PAFH pilot highlights the development of a structured and practical model for connecting HCPs and community-based physical activity. Delivered through collaboration between Sport Ireland, the HSE, and six LSPs, the programme has evolved steadily, demonstrating how coordinated approaches can help PwCC to become more active and supported in their communities. The following conclusion summarises the key findings through the lens of the six-stage PAFH model, outlining progress made, lessons learned, and considerations for how the programme might continue to develop and grow through a series of recommendations.

7.4 Recommendations

The following recommendations are grounded in the evaluation's findings.

Recommendation 1: Model/Framework

The evaluation has identified an emerging six stage PAFH model. Partners should consider adopting this flexible but structured six stage framework to guide the delivery of PAFH across all LSPs. This framework should act as a reference point for onboarding new staff and partners, especially in areas without existing relationships. Such a framework would support consistency in delivery, aid scalability, and protect the identity and ethos of PAFH as it evolves nationally.

Recommendation 2: Branding

Having the exact same branding for all programmes across every area seems unlikely. Still, it may be helpful to have a unified overarching brand which easily identifies these physical activity opportunities as being developed specifically for PwCC and being of sufficient quality and standard given their connection to the LSP network – assisting to build confidence amongst HCPs nationally that can trickle down locally. A co-designed approach engaging PAFHOs, LSPs, HSE staff, and participants—should inform branding decisions to ensure language remains inclusive, empowering, and non-clinical.

Recommendation 3: Signposting

Investment is needed to modernise signposting processes by:

- Exploring secure and GDPR-compliant digital signposting systems that enable seamless information sharing between HSE professionals and LSPs (such as the model used in Limerick).
- Promoting direct, proactive follow-up by PAFHOs, where appropriate, to improve participant engagement and reduce drop-out – ensuring appropriate resources are in place.
- Sharing learning from LSPs that have already developed effective tech-enabled signposting models (e.g. Limerick)
- System-level improvements should be aligned with national e-health initiatives and the evolving Physical Activity Pathway in Healthcare Model.
- Embedding an effective, yet proportionate feedback loop, enabling HCPs to understand who has taken up referrals & to help inform effectiveness on an ongoing basis.

This would facilitate the transfer of clients' information from the HSE to PAFHOs, allowing for follow-up and increasing the likelihood of uptake in physical activity opportunities for the target group.

Recommendation 4: Formalising Relationships

To mitigate reliance on personal relationships and ensure sustainable partnerships and relationships are developed, it is recommended that:

- Service Level Agreements (SLAs) or Memoranda of Understanding (MOUs) should be developed between LSPs and relevant HSE departments.
- These agreements should clearly define roles, responsibilities, shared outcomes, and mechanisms for review.
- Formal agreements should also encourage co-investment, co-design, and joint monitoring of local delivery.

This will help to sustain and embed collaboration and protect progress through personnel changes.

Recommendation 5: Strengthen Administrative and Data Management Capacity

This recommendation recognises that administrative capacity plays an important role in supporting participation, that timely and personal follow-up with participants is a key enabler in converting referrals into sustained engagement, and that improved systems and data infrastructure are essential to enhance delivery quality, sustainability, and confidence in evaluation evidence. Future iterations of PAFH should consider within their budget, appropriate resources for administrative support and digital system implementation, specifically to ensure:

- A)** Existing M1 data collection protocols are well established, widely promoted, and underpinned by international best practice; however, their consistent application within PAFH is constrained by limited administrative capacity within LSPs for post programme and 3 month follow up. This could be enhanced by introducing administrative capacity (shared across LSPs) and/or by sourcing appropriate digital infrastructure to enhance data collection.
- B)** Additional administrative capacity would have an added benefit of enabling further human interaction in follow up to signposting from HCPs, which appears to be correlated with increasing participation in programmes.
- C)** Appropriate digital infrastructure/systems may also enable improvements in referral tracking, participant management, and outcome reporting, aligned with existing M1 protocols.
- D)** Qualitative insights, including case studies and participant feedback, remain vital for capturing lived experiences and should continue to complement quantitative data. The collection of this data could also be supported by enhanced administrative resource.

These actions would a) increase participation on programmes (resulting from human follow up), increase the amount of complete (including 3 month follow up) M1 datasets, support an effective feedback loop through participant referral tracking as well as continue to capture important qualitative information from participants, thereby enhancing the overall quality and reliability of evaluation evidence.

Recommendation 6: Shared Learning

Peer learning has been a major strength of the pilot. To maintain this national and sub-regional peer network of PAFHOs should be continued and resourced. In addition, and where possible, connections should be fostered to facilitate ongoing collaboration between PAFHOs, LSP Coordinators, HSE partners, and tutors through site visits, training and opportunities for shared learning.

Recommendation 7: Alignment to National Plans

Any national rollout of PAFH must make the strategic links to recommendations proposed by the Physical Activity Pathways in Healthcare Model Advisory Group¹ (e.g. Recommendation 8, Exercise Referral Schemes) and maximises opportunities for a whole systems approach.

¹ [Physical Activity Pathways in Healthcare Model](#)

APPENDICES



Appendix 1: Logic Model

Context and Assumptions

One in two Irish people over the age of 50 has at least one long-term, chronic condition².

The level of multi-morbidity is increasing, with 18% of adults over 50 having two or more chronic conditions. It is estimated that within the next decade, the number of adults with chronic diseases will increase by around 40%, with most conditions affecting those in the older age groups³.

Individuals with chronic conditions face barriers to accessing community-based physical activity programmes tailored to their needs.

A lack of formalised collaboration between health services and LSPs hinders effective signposting to physical activity opportunities.

Sport and physical activity practitioners often lack specialised training to work with individuals with chronic conditions.

HCPs are often unaware of available/suitable community physical activity programmes, leading to missed signposting opportunities for patients with chronic conditions.

PwCC struggle to maintain physical activity independently after completing structured programmes due to a lack of ongoing support.

Clinical treatment of PwCC places extreme pressure on HSE resources.



² [Physical Activity for People with Chronic Conditions](#)

³ [National Risk Assessment 2018](#)

Table 5: Physical Activity for Health logic model

Inputs

1. Funding from Healthy Ireland/Sport Ireland.
2. LSP resources and time.
3. 6 PAFHOs employed within 6 LSPs/LAs.
4. National PAFH Working Group time and resources to ensure the collaboration and participation of all six individual LSPs/LAs.

Activities

1. Relationship building between PAFHOs and HCPs to enhance collaboration meetings, presentations, invitations to HSE events, sharing information, co-design of programmes, etc.
2. New or existing Advisory Groups comprising multi-sectoral stakeholders are used in each area to guide and support the development and delivery of the PAFH Programme.
3. Establishment of signposting and/or referral pathways between HCPs and community-based physical activity programmes delivered by LSPs.
4. Upskilling of physical activity tutors to better equip them with the knowledge and skills to deliver physical activity programmes for people with PWCC.
5. Upskilled Physical Activity Tutors are procured to deliver tailored physical activity programmes for PwCC.
6. Programmes are developed and delivered for PwCC, which include:
 - a. Evidence-informed programmes tailored for PwCC;
 - b. New programmes, developed by PAFHOs for PwCC;
 - c. Promotion of existing LSP and other programmes to PwCC.
7. National PAFH Working Group Meetings are held quarterly to encourage collaboration, cross-cutting opportunities, and shared learning.

Outputs

A network of relevant professionals is identified in each County that can connect PwCC to physical activity programmes.

Formalised and/or structured signposting systems are in place between HCPs and community-based physical activity programmes delivered by LSPs (Tier 3 of PAPH Model).

Additional funding and/or resources are secured to enable physical activity programmes for PwCC.

A network of qualified physical activity tutors who can deliver physical activity programmes for PwCC is established in each County.

High-quality physical activity programmes are delivered in local communities.

PwCC participate in physical activity programmes in community settings.

Short Term Outcomes

For Partners/Stakeholders:

- Increased awareness of physical activity opportunities in the community for PwCC.
- New partnerships are established between HCPs and community-based physical activity providers.
- Improved working relationships between HCPs and community-based physical activity providers.
- Increased capacity to deliver physical activity programmes for PwCC within respective communities.
- Increased confidence amongst HCPs to refer/signpost to community supports.
- Increased number and range of programmes for PwCC delivered in local communities.

For the Individual PwCC:

- Increased awareness of the benefits of, and opportunities for, physical activity.
- Improvements in motivation and confidence to participate in community-based physical activity programmes.
- Increased levels of physical activity.
- Increased levels of social interaction with peers who share similar backgrounds and experiences.
- Increased likelihood of accessing other independent community-based physical activity opportunities.

Medium – Long Term Outcomes

For Partners/Stakeholders:

- Improved effectiveness and efficiency in signposting between HCPs and community-based physical activity providers.
- Sustained capacity within the sport and physical activity sector to develop and deliver programmes for PwCC.
- Reducing dependency and/or pressure on HCPs, leading to less demand on the healthcare system.

For the Individual PwCC:

- Sustained increase in physical activity levels.
- Improvements in physical health and well-being.
- Improvements in mental health and well-being.
- Increased capacity to self-manage chronic conditions.
- Increased sustained access to other independent physical activity opportunities.
- Sustained sense of community and social connectedness.

Long Term Impact

- More PwCC are more active, more often.
- Improved population health and wellbeing.
- Reduced prevalence of chronic disease in the population.



Appendix 2: Key Objectives Physical Activity for Health

The PAFH Pilot contained several key objectives⁴ at both national and local (County Level), as outlined below.

Table 6: National and Local Objectives for PAFH

National Level Objectives

- Develop and formalise the working relationship between the PAFHOs, the LSPs and the HSE.
- To accept appropriate signposting from health service initiatives while facilitating the enrolment in subsidised LSP or partner programmes for recreational physical activity.
- To coordinate and quality assure the delivery of a suite of structured physical activity programmes for PwCC that encompass the following features:
 - Designed by the LSPs in collaboration with HCPs;
 - Includes follow-up 3-month post-programme completion;
 - For PwCC or long-term health conditions;
 - Focuses on building participants' skills and confidence in engaging with and maintaining recreational physical activity participation independently.
- To strengthen and develop the working relationship between the LSPs and stakeholders, including local HCPs.
- Identifying training and educational needs of sport and physical activity practitioners in physical activity for PwCC.
- Through active communication, engagement, and partnership, healthcare practitioners' awareness of physical activity/recreational sport opportunities can be increased, and service users can be signposted to.

Local Level Objectives

- To improve pathways for people living with chronic conditions to engage in community physical activity programmes.
- For PAFHOs to bridge the gap in physical activity participation for PwCC who have benefited from the available healthcare system supports but are not yet able to participate in community programmes offered by LSPs.
- To ensure that those who require additional support are facilitated within these PAFH programmes until they are ready to engage in community-based physical activity.

⁴ Taken from Sport Ireland's Request for Quotation (RfQ)

Appendix 3: Short, medium and long term outcomes

In delivering the national and local level objectives, it was assumed that PAFH would deliver on the following short, medium and long term outcomes.

Table 7: Short, Medium and Long Term Outcomes of PAFH

Short Term Outcomes (within the timeframe of the pilot)

For the Individual PwCC:

- Increased awareness of the benefits of, and opportunities for, physical activity.
- Improvements in motivation and confidence to participate in community-based physical activity programmes.
- Increased levels of physical activity.
- Increased levels of social interaction with peers who share similar backgrounds and experiences.
- Increased likelihood of accessing other independent community-based physical activity opportunities.

For Partners/Stakeholders:

- Increased awareness of physical activity opportunities in the community for PwCC.
- New partnerships are established between HCPs and community-based physical activity providers.
- Improved working relationships between HCPs and community-based physical activity providers.
- Increased capacity to deliver physical activity programmes for PwCC within respective communities.
- Increased confidence amongst HCPs to refer/signpost to community supports.
- Increased number and range of programmes for people with PwCC delivered in local communities.

Medium - Long Term Outcomes (beyond the pilot)

For the Individual PwCC:

- Sustained increase in physical activity levels.
- Improvements in physical health and wellbeing.
- Improvements in mental health and wellbeing.
- Increased capacity to self-manage chronic conditions.
- Increased sustained access to other independent physical activity opportunities.
- Sustained sense of community and social connectedness.

For Partners/Stakeholders:

- Improved effectiveness and efficiency in signposting between HCPs and community-based physical activity providers.
- Sustained capacity within the sport and physical activity sector to develop and deliver programmes for PwCC.
- Reducing dependency and/or pressure on HCPs, leading to less demand on the healthcare system.

Long Term Impact

- More PwCC are more active, more often
- Improved population health and wellbeing
- Reduced prevalence of chronic disease in the population

Appendix 4: SWOT Analysis of PAFH Programme

S

STRENGTHS

- Clearly defined purpose and focus.
- Sufficient autonomy to develop in response to local need/ structures.
- Dedicated staffing resource to champion and lead on physical activity opportunities for PwCC.
- Increased availability and accessibility of physical activity programmes designed specifically to cater to needs of PwCC.
- Capacity built with exercise tutors to meet demand.
- High levels of engagement with HSE, leading to strengthening of relationships.
- More effective and efficient signposting pathways in place.
- Implementation of a multi-sectoral systems-based approach.



W

WEAKNESSES

- Lack of consistent data on physical activity levels and impact, making it difficult to objectively measure participant progress and outcomes at scale.
- Constraints in resources make meeting identified needs and demand very difficult.
- Systems based change is challenging work and requires a significant investment of time and resources.



O

OPPORTUNITIES

- Further expansion of programme designed and delivered specifically for PwCC.
- More evidence-informed programmes developed.
- Expand engagement to other parts of the HSE, including GPs
- Development of some consistent branding to distinguish programmes as suitable for PwCC.
- More sophisticated signposting processes which improve efficiency and effectiveness.
- Transfer of validated and tested model to new areas.



T

THREATS

- High dependency on personal relationships with PAFHOs built up through time, so any change in staff could impact negatively on collaborative working.
- Programmes need to be long term (3 Years +) to achieve the desired effect.
- Lack of funding to support expansion of PAFH nationally.
- Insufficient resources to meet demand could frustrate participants and practitioners.



Appendix 5: Report Objectives

The Terms of Reference for the evaluation included:

- A)** The implementation of a formative phase of evaluation to develop a logic model, evaluation framework, and data collection process for PAFH. The developed logic model is included in Appendix 1.
- B)** The delivery of a process element of the evaluation to understand how the PAFH programmes were developed and implemented across different LSPs by answering the following questions:
- i) **Reach:** To what extent were the targeted participants reached, and to what degree were participants engaged in the programme (e.g. continuity of attendance)? What were the factors that influenced this?
 - ii) **Fidelity:** Did the PAFH programmes operate in accordance with the agreed objectives? What were the factors that influenced this?
 - iii) **Sustainability/Longevity:** Was sustainability/longevity built into the way the PAFH programmes engaged with targeted individuals and organisations? What were the factors that influenced this?
 - iv) **Partnership/Stakeholder engagement:** How well were the targeted organisations and partners engaged (e.g. HSE, Community workers, Charity organisations)? What were the factors that influenced this?
 - v) **Relevance/Impact:** Level of perceived relevance and impact of the PAFH programme by the participants and partners. What were the factors that influenced this?
- C)** The delivery of an outcomes element of the evaluation to assess the extent to which the following objectives, their corresponding outputs and outcomes have been achieved:
- i) Did the programme influence beliefs and attitudes of people with PwCC towards engagement in physical activity? To what degree was this successfully achieved?
 - ii) Did the programme create opportunities to assist PwCC engage in regular physical activity and find a pathway to community physical activity programmes? To what degree was this successfully achieved?
 - iii) Did the programme work in partnership with key local stakeholders in adopting a systems-based approach that implements coordinated actions within and across systems in sport, health, and local authorities to increase physical activity and address sedentary behaviour for PwCC? To what degree was this successfully achieved?



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