Transforming Ageing at Home: Evaluating ALONE's Impact Through Enhanced Community Care

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Foreword from the CEO

Ireland is ageing – rapidly and profoundly. Within the next 5 years more than one million people in this country will be aged 65 and over. This shift presents a powerful opportunity: to reimagine how we support older people to live in the community. At ALONE, we believe that every older person should have the opportunity to age in place – safely, independently, and with dignity. Our work as part of the HSE's Enhanced Community Care (ECC) programme reflects this belief, offering a person-centred, community-based model that responds to the evolving needs of Ireland's ageing population.

This report, *Transforming Ageing at Home*, marks an important milestone. It represents a rigorous assessment of community-based care for older people in Ireland and stands as the most comprehensive evaluation of our integrated support model to date; one of only a few such in-depth evaluations of its kind conducted internationally. Through a robust mixed-methods approach – including impact surveys with 273 older people across three time points, 34 deep-dive interviews with key stakeholders, data from 640 feedback surveys from older people and referrers, and comparisons with national and international data – we have built a detailed picture of how ALONE's services are transforming lives.

The findings are compelling. Older people supported by ALONE reported notable improvements in loneliness, quality of life and personal capability, particularly those accessing our Visitation and Telephone Support & Befriending services. Beyond the individual impact, our model has helped reduce reliance on emergency services and eased pressures on GPs and other community providers; a testament to the ECC programme's vision for integrated care. These outcomes demonstrate value for money, showing that investing in community-based supports for older people delivers a meaningful return on investment; both in improved wellbeing outcomes and in reduced demand on stretched health services.

Crucially, this report amplifies the voices of a group too often overlooked: older people who are lonely, isolated, or in need of support, yet remain underrepresented in policy and planning. Their insights are at the heart of this work and are a powerful reminder of what it means to build a truly inclusive and responsive system.

We are particularly proud that this evaluation was developed and delivered in partnership with London School of Economics and Political Science. It is part of our commitment to evidence-based practice – where rigorous data and lived experience work hand in hand to shape services that matter.

As the number of people aged 65 and over continues to grow, the need for scalable, community-driven solutions has never been more urgent. We are grateful to our partners, staff, volunteers, and above all, the older people who participated in this study. Together, we are not just responding to demographic change – we are shaping a future where ageing is supported, respected, and embraced.

Seán Moynihan,
ALONE CEO

Contributors

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We would also like to thank the members of the ALONE Impact Assessment Project Steering Group for their guidance and support throughout the design and delivery of this evaluation. We are also deeply grateful to the older people, referrers, and staff members who generously gave their time and shared their experiences to inform this work. This report would not have been possible without the valuable contributions of everyone involved.

Executive Summary

- In Ireland, the population aged 65 and older has grown by 40% between 2010 and 2023, with projections indicating this group will exceed 1 million in the next five years, presenting both challenges and opportunities for social and economic policy.

- ALONE, a national organisation, plays a critical role in supporting older adults, working alongside the HSE's Enhanced Community Care (ECC) programme to deliver integrated, community-based care that promotes ageing in place and reduces hospital dependency.

- This report presents the findings from ALONE's service impact assessment, offering key insights into the effectiveness, adoption and implementation of its support model and addressing a critical gap in international research on care coordination.

- A core part of the evaluation involved 273 older people newly referred to ALONE, who completed measures of loneliness, wellbeing, capability, quality of life, and health service usage at baseline, three months, and six months. These surveys were administered by trained staff or volunteers.

- Additional data sources included semi-structured interviews with older people, referrers, and ALONE staff, annual feedback surveys, and data from ALONE's secure Management Information System (MIS).

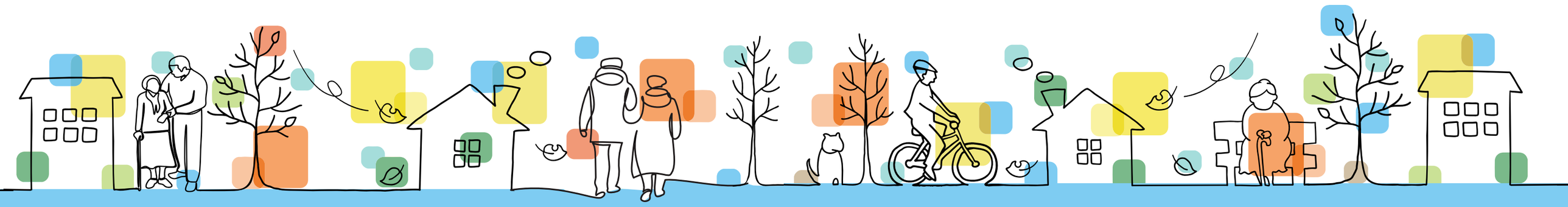
- Older people supported by ALONE experience higher loneliness, poorer quality of life, and greater use of community and acute health services compared to national populations. The voices of this vulnerable group are seldom heard, making the focus on these individuals a particularly meaningful aspect of this report.

- After six months, older people engaging with ALONE's services showed clear improvements in loneliness, quality of life, and personal capability, indicating the substantial positive impact ALONE's services may have. These benefits were especially evident among those receiving Visitation or Telephone Support & Befriending services, with enhanced relationships with staff and volunteers contributing to increased confidence and independence.

- The evaluation also indicates that ALONE's services may be contributing to reduced use of emergency and other community healthcare services, such as General Practitioners (GPs). This aligns with the ECC programme's emphasis on community-based care and highlights ALONE's person-centred and responsive approach.

- The implementation of ALONE's service model was found to be robust and responsive, with staff and stakeholders identifying areas for improvement; however, the service consistently demonstrated a strong commitment to person-centered care.

- Overall, the findings provide a strong foundation for continued investment and expansion of ALONE's integrated support model, which plays a crucial role in enhancing the lives of older people and supporting the broader healthcare system.



Who We Heard From

696
older people

- **273** in-depth impact surveys (3 time points)
- **413** feedback surveys
- **10** detailed interviews

251
stakeholders

- **14** ALONE staff interviews
- **10** external referrer interviews
- **227** referrer surveys

Those who use ALONE are more vulnerable than the broader older person population, experiencing:

- Higher loneliness
- Poorer quality of life
- Lower wellbeing
- Lower personal capability

ALONE's Impact

After 6 months with ALONE older people reported:

- Reduced loneliness
- Improved quality of life
- Higher personal capability

The strongest improvements were seen among those who received Telephone or Visitation Support & Befriending

Reducing Pressure on Health Services

Health service use dropped after 6 months with ALONE in the form of:

- Reduced visits to A&E
- Reduced A&E calls
- Reduced use of community health care services

Per-person cost reductions:

€67
saved in Emergency Department costs

€67
saved in Community Healthcare Services costs (including GPs)

What Referrers Said

78%
saw a positive impact for older people as a result of ALONE

83%
would recommend ALONE services

"I have found the service ALONE have offered to my patients to be exceptional ... It is an invaluable service that is being offered and I highly appreciate and recommend it"
– Professional Referrer

What Older People Said

70%
said ALONE met their needs

51%
said ALONE had a positive impact on their lives

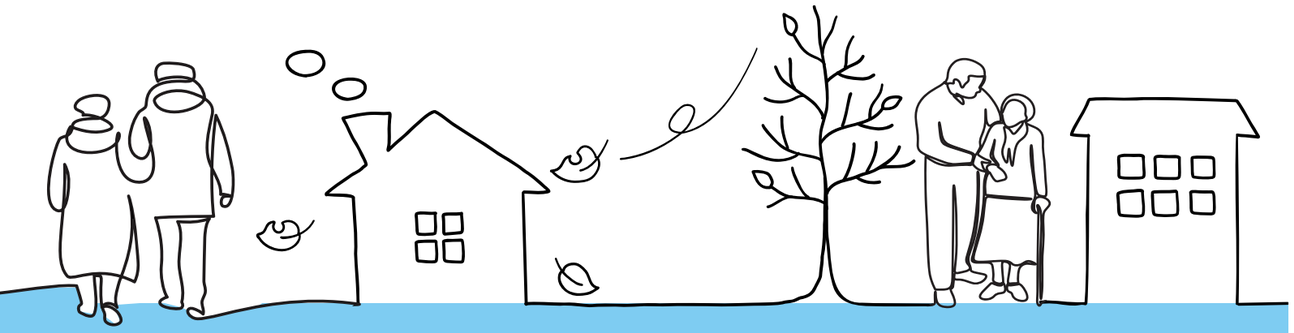
"It makes you feel important. Someone's thinking of you... a group of people, society ... cares enough about people to reach out and help them"
- Older Person

What Staff Said

Staff find meaning in ALONE's person-centred ethos and take pride in going above and beyond in support of older people

"That's the part of the job I love the most ... the satisfaction that I get then when we can support is huge"
- ALONE Staff Member

Introduction



In Ireland, the population aged 65 and older has increased by 40% between 2010 and 2023. Projections from the Department of Health indicate that this figure will exceed 1 million in the next five years and could rise to 1.94 million by 2057, presenting significant social and economic challenges - as well as opportunities[1,2].

Older adults make invaluable financial and social contributions to society through provision of care and financial support, and through community participation, volunteering, informal caregiving, and mentoring younger generations. Indeed, many are net positive contributors within their families and communities[3]. However, the fiscal and social implications of a rapidly ageing population are profound. A report published by the Department of Finance warns that, without policy reforms, rising costs related to pensions, healthcare, and long-term care could result in over €16 billion in additional annual spending[2]. The decline in home ownership also poses a significant challenge, increasing long-term pressure on the state to provide affordable and appropriate housing for an ageing population. However, investing in initiatives that promote healthy ageing can enable people to continue to live independently and make meaningful contributions to the workforce, society and their communities for longer[4].

The ability to age well is shaped by a range of physical, mental, and social factors, with chronic conditions such as cardiovascular diseases, arthritis, and untreated sensory impairments posing challenges to healthy ageing[5]. Ageing in place (where older adults live safely and independently in their own homes and communities for as long as possible) can enhance quality of life, promote autonomy, and reduce the need for institutional care which is more costly[6–8]. Additionally, the World Health Organisation (WHO) reports that community initiatives like social clubs and volunteer programmes combat isolation, promote inclusion, and reduce healthcare demands through prevention and early intervention[9]. With a rapidly ageing population and life expectancy predicted to increase in Ireland, there is a need to enable ageing in place for older people, and to ensure they have strong connections to their communities.

Ireland's policy landscape on healthy ageing is shaped by several key national strategies that collectively aim to promote integrated, community-based care and support older people to age well at home. *Sláintecare*, the government's ten-year healthcare reform programme, prioritises equal access to services and a shift away from hospital-based care towards local, person-centred supports. This vision is echoed in the *HSE National Service Plan 2025*, which focuses on integrated models of home and community-based care to support older people and reduce pressure on acute services. The *National Positive Ageing Strategy* further emphasises independence, dignity, and positive ageing. In terms of housing, the *Housing Options for Our Ageing Population* plan and *Housing for All* aim to expand suitable housing choices that allow older people to remain in their communities. Broader social policy frameworks, such as the *Roadmap for Social Inclusion* and the *Healthy Ireland Framework for Improved Health and Wellbeing*, recognise the importance of social connection and inclusion as key to healthy ageing. Collectively, these policies support the development of a more integrated system of care in Ireland.

ALONE and the Enhanced Community Care Programme

One of the key transformation programmes within *Sláintecare* is the HSE's Enhanced Community Care (ECC) programme which has the objective of moving more care into the community, closer to where people live. Specifically, the ECC programme aims to increase capacity and delivery of services such as primary care, general practice, and community-based specialist teams and reduce pressure on hospital services. The emphasis is on ageing in place through the delivery of an end-to-end care pathway that will care for people at home, prevent referrals and admissions to acute hospitals where it is safe and appropriate to do so, and enable a "home first" approach. Significant progress is being made through the ECC programme in expanding local healthcare services and reducing hospital dependency, with over 133,000 patient contacts to Community Specialist Teams in 2024, and over 7,000 unnecessary hospital admissions for frail adults avoided[10].

ALONE is a national organisation that works to create an Ireland where older people can age happily and securely at home and are strongly connected to their local communities. The organisation plays a vital role in the success of the HSE's efforts to support older adults across Ireland. ALONE's mission encompasses all older people (generally aged 60 and above) in need of their service, with a focus on improving physical, emotional, and mental wellbeing through a comprehensive range of integrated services.

A national network of staff and volunteers deliver the ALONE model across Ireland. The organisation adopts a collaborative approach, working to strengthen the broader community support sector for older people through its well-established Community Impact Network (CIN). This network plays a key role in supporting smaller community groups across Ireland by providing computerisation, training, knowledge sharing, and fostering interdisciplinary collaboration.

As an outcome-focused organisation, ALONE has deliberately developed a skilled research and evaluation team aligning with a commitment to evidence-informed practice and ongoing improvement. This report is the first in a series of evaluations that will demonstrate the impact of ALONE's work in the years ahead.

ALONE's Service Model

Support Coordination

ALONE's Support Coordination service offers help to resolve a wide range of difficulties for older people through practical support and community-based engagement. It empowers older people by devising personalised support plans to address needs related to health, finance, mobility, personal care, social connection and other emerging issues. It offers access to the range of ALONE services (such as Support & Befriending), with a particular focus on integrating social prescription and encouraging access to non-medical community supports.

Support & Befriending

ALONE's Support & Befriending service provides companionship and practical support to older people who would like or need it, either in person (*Visitation Support & Befriending)* or over the phone (*Telephone Support & Befriending).* The service provides practical support to help address everyday challenges, connects older individuals with local events and activities, and offers advice and information on health, wellbeing, and risk management.

The National Support & Referral Line (NSRL)

The NSRL creates direct access to ALONE's integrated service model. Older people, professionals, and members of the public are encouraged to free-call 0818 222 024 to access advice about ALONE services and information seven days a week from 8am – 8pm.

Assistive Technology

The mission of ALONE's Assistive Technology is to create an infrastructure to empower older people to use technology, enabling the user to manage their social connection, health, safety and security. Technology supports are fully integrated throughout all ALONE services, with staff and volunteers trained to deliver, install, and respond to technological needs as a core part of their support for older people.

ALONE's Housing

ALONE's Housing provides homes and ongoing support for older people who have housing difficulties. This includes secure tenancies with visiting supports which enable independent living.

Housing with Support

Housing with Support is a model of universal design housing with 24/7 care and support staff on site to create an alternative housing choice for those who need it and reduce the dependency on nursing homes.

Campaigning for Change

This function is designed to assist older people with challenges they face that lead to positive outcomes at individual, local, and political levels. ALONE uses insights from services and feedback from older people and volunteers to inform these campaigns.

Profile and Needs of Older People Supported by ALONE

The profile of older people supported by ALONE is described in quarterly ECC reports, all of which are publicly available via ALONE's website. In 2024, the majority (59%) of people supported across ALONE services were aged between 76 and 90 years old and 59% were female. Additionally, 79% owned their home, and around two-thirds lived alone[11]. Older people supported by ALONE typically present with multiple challenges. Nearly half of individuals supported report two or more main presenting issues, with loneliness, physical health and mobility difficulties, housing, financial difficulties and mental health problems among the most common presenting challenges. Notably, mental health emerges as a predictor for six out of seven main presenting issues, with younger individuals, non-homeowners, those experiencing loneliness, and recipients of home support, being more likely to face multiple challenges[12].

Individuals may self-refer to ALONE, be referred by a concerned family member or member of the public, or be referred by an external agency. Indeed, external agencies account for approximately two-thirds of referrals to ALONE, with most coming from HSE community services[11]. These referrals play a crucial role in identifying and assisting older adults who might encounter challenges in sourcing support independently. Volunteers also play a crucial role. In 2024, almost 44,000 older people were supported across ALONE services. Volunteer contributions were valued at up to €7.18 million, with almost 110,000 visits and 250,000 telephone calls facilitated by volunteers[11].

Evaluation Context

ALONE's published reports provide encouraging data to suggest the role the organisation plays in enhancing the wellbeing of older people across Ireland. Moreover, previous research has demonstrated the transformative impact of ALONE's Visitation Support & Befriending services in mitigating health decline, alleviating loneliness, and enhancing older people's wellbeing[13].

However, to date, a comprehensive formal evaluation has not been conducted to rigorously assess the impact of ALONE's model of support on older people's quality of life and wellbeing or on the broader healthcare system. As Ireland aims to support more older people to live independently at home, it is important to understand how this approach impacts the healthcare system. On an international level, there remains a significant lack of evidence about the overall impact of Support Coordination services[14]. In particular, there are key gaps in our understanding of who is using these types of services, what their needs are, and how these services affect their lives. Addressing these gaps would support more effective resource allocation and health service planning.

Aims and Objectives

This report aims to evaluate the impact of the ALONE Service Model in supporting ALONE's goals to help older people to age happily and securely at home. It also evaluates the model's role within the ECC programme in delivering localised care and reducing unnecessary hospital referrals and admissions. Specifically, the key objectives are:

1. To assess the effectiveness of the ALONE Service Model by determining:
    a. who the service is reaching
    b. what changes, if any, occur in an older person's wellbeing, quality of life, self-reported health, capability and loneliness following engagement with ALONE services, and
    c. what changes, if any, occur in an older person's health service utilisation patterns following engagement with ALONE and if there are any cost-savings associated with this at a health system level.
2. To explore implementation of the ALONE Service Model by examining how the model is delivered in practice.

Method

Evaluation Framework

The well-established RE-AIM PRISM framework was selected as a tool to guide this evaluation. Since its inception in 1998, the RE-AIM framework has been used over 2,400 times to plan and evaluate public health programmes[15]. It assesses interventions across five key outcomes: Reach, Effectiveness, Adoption, Implementation and Maintenance. The PRISM (Practical Robust Implementation and Sustainability Model) element adds further depth by considering how factors like programme design, setting, and the people involved influence implementation and sustainability. Applying this framework enabled an in-depth evaluation of the ALONE Service Model at both the individual and health system levels. It also supported a holistic, multi-factorial approach to understanding implementation, including identifying examples of good practice, exploring barriers to implementation, and analysing how contextual factors, such as organisational infrastructure, stakeholder engagement, and the external environment affect uptake, fidelity, and sustainability.

Table 1 depicts the specific research questions addressed in the present evaluation framed within each dimension of the RE-AIM PRISM framework. As Maintenance is typically assessed by evaluating the long-term effects of a programme on individual outcomes after a period of time (usually 6 months or more) has passed since the last intervention contact, this was not included in the current evaluation.

Table 1. *Research Questions Explored within the RE-AIM PRISM Framework*

Dimension	Description	Research Questions
Reach	**Reach** is the proportion of people who receive an intervention or service in comparison to those who are eligible for it but do not participate, whether due to a lack of awareness or a perceived lack of relevance.	• Who is ALONE providing services to? • Does the service reach all possible older people who could use it?
Effective-ness	**Effectiveness** refers to the impact that an intervention or service has on the individuals participating. In doing so, it considers all potential outcomes, whether positive or negative.	• Are the key intended benefits that support older people's ability to age at home – i.e. improved wellbeing, better quality of life, improved capability, physical health, and reduced loneliness being achieved? • Are there any unintended negative outcomes?
Adoption	**Adoption** refers to how willing the individuals or organisations responsible for delivering or referring to a programme are to initiate the programme. To facilitate adoption or utilisation of an intervention, it is essential that it is embraced by a significant proportion of agents involved in the process of service referrals.	• How willing are referral agents to participate in ALONE's Service Model within the wider setting of the Irish healthcare system?
Implement-ation	The **Implementation** dimension of RE-AIM focuses on how an intervention is delivered by staff on the ground, including consistency and fidelity to the intended approach. This dimension also incorporates considerations around **cost-effectiveness,** which is a core emphasis of the present evaluation.	• How cost-effective is the ALONE Service Model within the Irish healthcare system? • What factors influence how consistently and effectively staff deliver ALONE's services on the ground?
PRISM	**PRISM** helps explore how different layers of context affect implementation across four key domains: (a) perspectives on the intervention from both staff and recipients, (b) characteristics of the implementing organisations, staff, and recipients, (c) external environmental factors like policy and community resources, and (d) infrastructure to support implementation and long-term sustainability, such as training, roles, and monitoring systems[15,16].	• How do internal factors (e.g. organisational characteristics, staff attitudes, service user experiences) affect delivery of the ALONE Service Model? • How do external factors (e.g. national policies or political priorities) affect delivery of the ALONE Service Model?

Evaluation Design

This evaluation applied a mixed-methods approach, collecting quantitative and qualitative data between April 2024 and March 2025. All research activities were undertaken by trained ALONE staff and volunteers.

A broader project team comprising ALONE staff, older people, and volunteers provided guidance and advice to ALONE's research and evaluation department in conducting this evaluation. All survey and interview questions administered as part of the evaluation were developed with their input.

Ethical approval for this project was provided by the London School of Economics and Political Science.

It included several primary data sources:

- **Impact Surveys**. Phone-based surveys with older people, taken at baseline (pre-intervention), three months into receiving support, and six months into receiving support.
- **Older Person Interviews**. Semi-structured interviews with older people in receipt of ALONE services.
- **Older Person Feedback Surveys.** Postal or online surveys completed by older people.
- **Referrer Surveys**. Online surveys completed by ALONE referrers.
- **Referrer Interviews**. Semi-structured interviews with referrers.
- **Staff Interviews.** Semi-structured interviews with ALONE staff.

Relevant information on assessments, case notes, and service engagement were also extracted from ALONE's secure Management Information System (MIS).

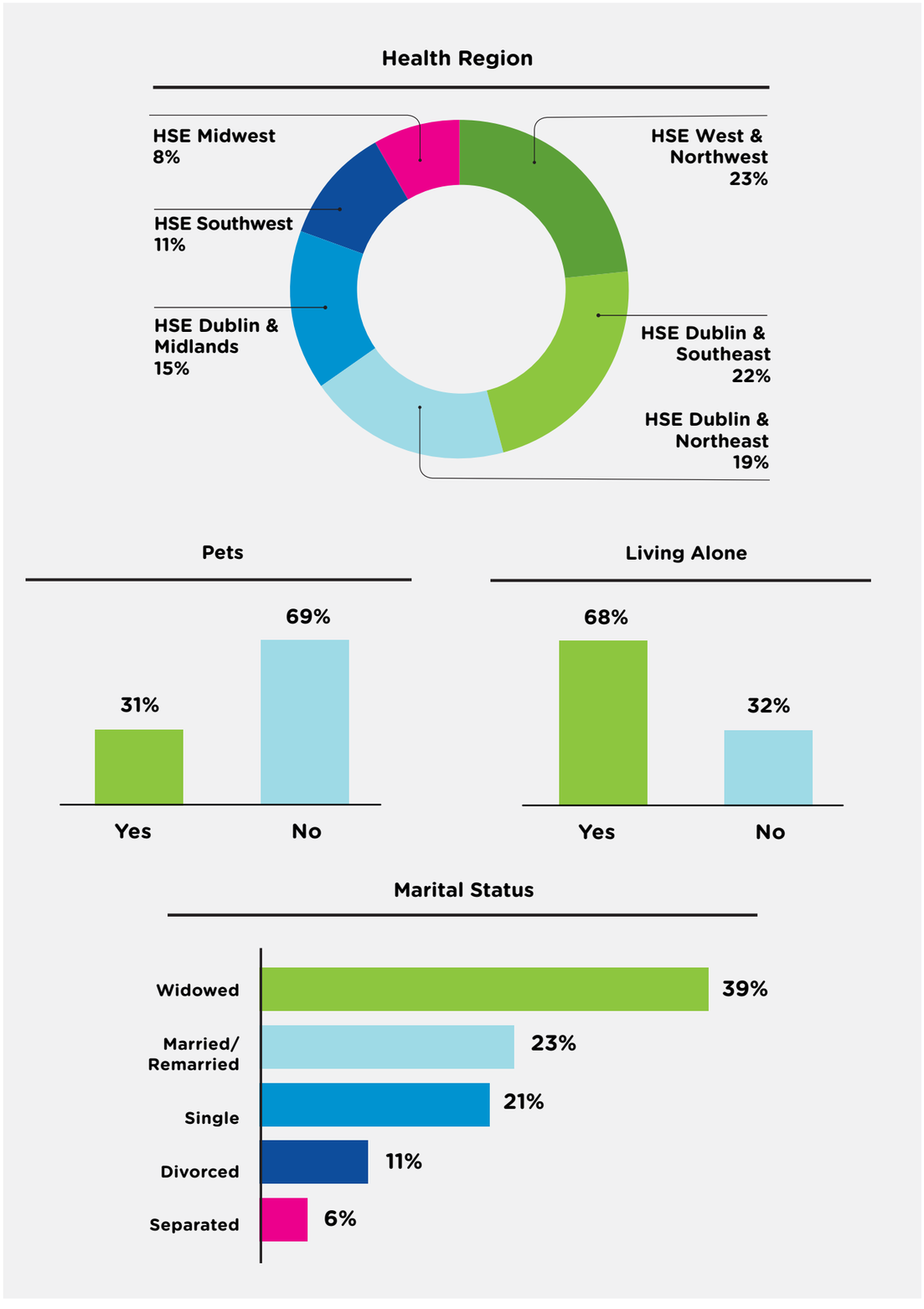
1. Impact Surveys

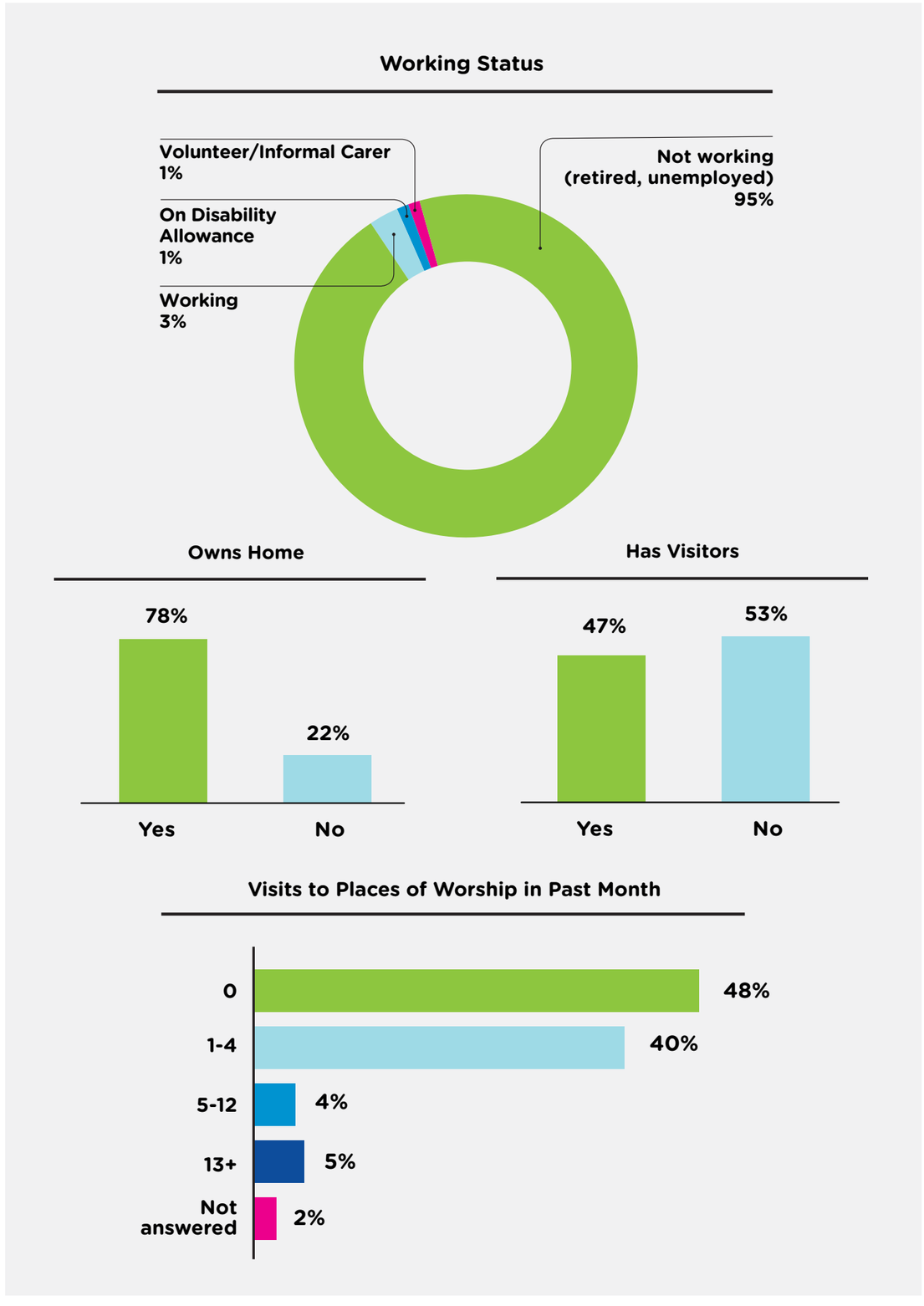
Participant Profile

The sample used for assessing the effectiveness of the ALONE Service Model was selected to be broadly representative of the population supported by ALONE, reflecting diversity across age, gender, living arrangements, and geographical regions. It comprised a total of 273 older people assessed by ALONE between April and July 2024 and was of sufficient size to robustly test meaningful trends. Participants were aged between 54 and 100 years (average age was 78 years) and nearly two-thirds (63%) were female. Almost all (98%) identified themselves as White Irish.

As the figure on the following page shows, participants were from across all six HSE health regions, about one-third owned a pet, the majority were widowed, and over two-thirds (68%) reported living alone. Additionally, 78% owned their own home, and a large majority were not working (95%). As regards connection with others, over half (53%) did not have any regular visitors and 48% did not regularly visit any places of worship.

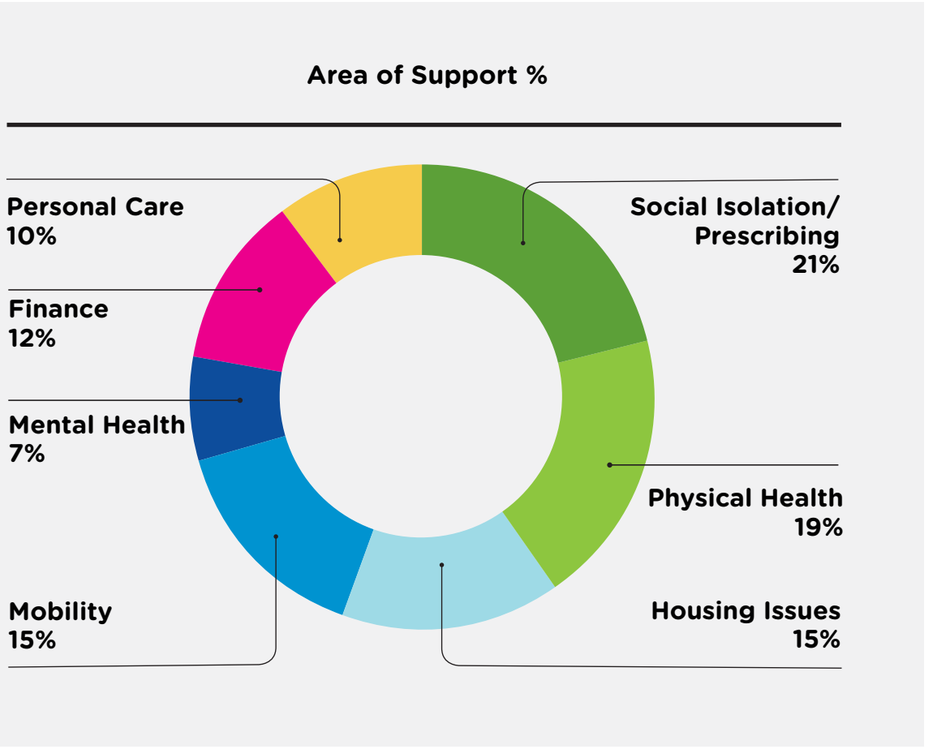
Figure 1. *Impact Survey Participant Characteristics (N = 273)*





All participants underwent a comprehensive assessment by an ALONE Support Coordinator. The most common areas in which older people required support are displayed in the figure below. As this shows, social isolation, physical health and housing issues were most prevalent.

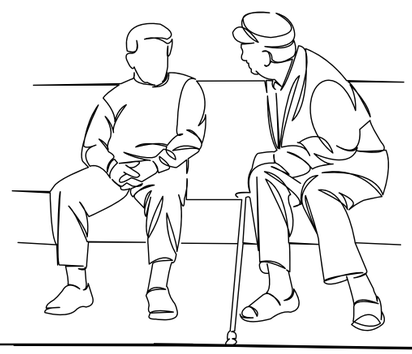
Figure 2. *Areas of Support Required by Participants*



These assessments resulted in the provision of 801 targeted supports for participants, the most common of which are outlined in **Table 2**.

Table 2. *Most Frequent Targeted Supports Provided to Participants*

Intervention Type	N
ALONE Visitation Support & Befriending	121
Social Prescribing - Local Community Groups/Events	96
ALONE Telephone Support & Befriending	64
Technology for Physical Health/Mobility	55
Mobility Fixtures/Aids/Furniture	54
Utilities	52
Home Repairs Internal/External	50
Benefits/Entitlements	35
Housing Adaptations	34
Cleaning/Decluttering	29
Anxiety/Depression/Mental Health	28
Nutrition	26



Procedure

All individuals who were referred to ALONE and completed an assessment with an ALONE staff member between April and July 2024, did not have a cognitive impairment/significant memory issue, and were not ALONE tenants (this cohort were part of an evaluation carried out separately relating to housing services) were invited to participate (n = 527). Those who consented were contacted by an ALONE staff member or volunteer by telephone on three occasions: at the beginning of their engagement with ALONE services (Time 1; baseline), three months (Time 2), and six months later (Time 3).

Overall, 273 surveys were completed at Time 1 (four participants did not fully complete all measures and chose not to continue). From this group, 212 participants fully completed the survey at Time 2 and 182 people completed the survey at Time 3.

At each stage of data collection, five vouchers were randomly assigned to individuals who had completed the surveys. A detailed risk protocol was created for the project to protect the safety and wellbeing of all participants, and to ensure that any requests for additional support from ALONE were referred to service staff.

Measures

At Time 1 participants were asked to provide some demographic and contextual information (e.g. age, marital status, working status, health conditions). At Times 2 and Time 3, participants were asked if there were any changes in their personal circumstances which they felt might impact their health and wellbeing. At all three time points participants answered questions about their utilisation of primary and acute health services in the previous three months and completed several short questionnaires outlined in **Table 3**.

Table 3. *Standardised Measures used in ALONE Services Impact Assessment*

Dimension	Measure	Description	Number of items	Range
Loneliness	ULS-3[17]	Measures loneliness by focusing on an individual's emotional experience of loneliness and social relationships.	3	3-9
Mental Wellbeing	Shortened Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)[18]	Assesses the mental wellbeing of individuals. Includes items focused on positive psychological functioning, measuring aspects such as happiness, life satisfaction, and social connection.	7	7-35
Capability	ICECAP-O[19]	A capability-based measure of general quality of life of older people. It looks at whether older people have the freedom and ability to live a life they value – in terms of factors such as social attachments, security, role within the community, and independence.	5	0-1
Quality Of Life	EQ-5D-3L[20]	Uses utility scores to assess health-related quality of life across five dimensions (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) each with three levels of severity.	5	-0.594 - 1
Self-Reported Health	EQ-5D-3L-VAS	A visual analogue scale for individuals to rate health.	1	0-100

Analysis

All data were analysed using SPSS. The primary analyses were conducted for all participants who provided information at baseline, even if they did not fully complete information at Times 2 and 3. In this case the values of missing data were estimated using an approach called imputation. As previous research has demonstrated the positive impact of ALONE's Visitation Support & Befriending services on older people's wellbeing, subgroup analysis were conducted for those who specifically received active Visitation or Telephone Support & Befriending during the intervention period (n=68).

Secondary analysis was conducted using available data only; that is, only for participants who provided information at all three time points. The aim was to identify whether there were statistically significant changes in outcomes and cost data between different time points and over the full six-month evaluation period. The information on unit cost data for non-acute community-based health services and hospital-based health services was obtained from published unit cost estimates by Smith et al. (2021)[21], publicly available HSE hospital charges[22], and a 2023 Parliamentary Question response from the HSE[23].

The exact statistical method used for analysis depended on the nature of the data. The primary statistical approach used was repeated measures analysis of variance. This is commonly used to look at changes in data for the same person over three or more time periods where data are normally distributed. An alternative approach using techniques called the Friedman test and Bonferroni adjusted Wilcoxon signed rank tests were used for non-normally distributed data.

For data on changes in resource use and costs, as well as changes in quality of life, a statistical approach known as bootstrapping was used which randomly resampled data 1,000 times to determine whether there were significant changes.

2. Older Person Interviews

Participant Profile

Interviewees were 10 older people (50% female) who were actively receiving Support & Befriending services from ALONE as of April 2024 and were not completing impact surveys. Of this group, 60% were living in an urban setting and 40% were living in a rural setting. The majority had been receiving support from ALONE for between 9 and 24 months, with only one individual indicating they had been receiving support from ALONE for an extended period (10+ years).

Procedure

The inclusion criteria (informed consent, length of contact with ALONE > 6 months, living at home, no cognitive impairment and ability to participate in an in-person interview in English) were applied to ALONE's MIS to generate a list of eligible 348 individuals. These were geographically stratified based on Ireland's six Health Regions and a random selection of 17 eligible participants was generated. 10 interviews were ultimately conducted (7 in-person and 3 over the phone).

Interview Questions

Semi-structured interview guides were designed within the RE-AIM PRISM framework to obtain a deeper understanding of older people's lived experiences with ALONE, how effective they found the service, as well as the acceptability of the processes they went through to get support from ALONE. Topic guides were used flexibly to enable a natural flow in each conversation and allow for follow-up questions.

Analysis

Interviews were recorded and transcribed verbatim, then anonymised and thematically analysed using qualitative analysis software (MAXQDA). Thematic coding was guided by the key interview questions and structured using the RE-AIM PRISM framework.

3. Older Person Feedback Surveys

Participant Profile

A total of 413 older people (57% female) across all 26 counties in Ireland completed the survey (a response rate of 13%). Most participants were aged 71-85 (55%), although a significant number of those aged 85+ (*n* = 66; 16%) also took part. These figures broadly align to the general population of older people supported by ALONE services.

Procedure

In June 2024, a brief survey was distributed to a sample of older people who met specific inclusion criteria; that is, they had completed an assessment with ALONE, were active in the service within the previous 6 months, were not an ALONE tenant, and were not already taking part in the impact survey. Participation was invited through three methods:

i. All older people with an e-mail address on ALONE'S database (*n* = 587) were invited to participate by e-mail

ii. All older people who had received a SMS from ALONE's Communications and Fundraising team in the previous year (who had not already received an email invite) were invited to participate by SMS (*n* = 1,624)

iii. A random sample of 1,000 older people who did not fall into the SMS or email categories were contacted by post.

Where older people reached out by phone, text, or e-mail to request a paper copy of a survey, this was sent. Where necessary, ALONE staff also supported some individuals in completing the survey.

Survey Questions

The survey included 36 questions (a mix of closed and open-ended) covering details of service received and desired, information on accessing community services, satisfaction and experience with ALONE, recommendations for improvement and perceived impact of support.

Analysis

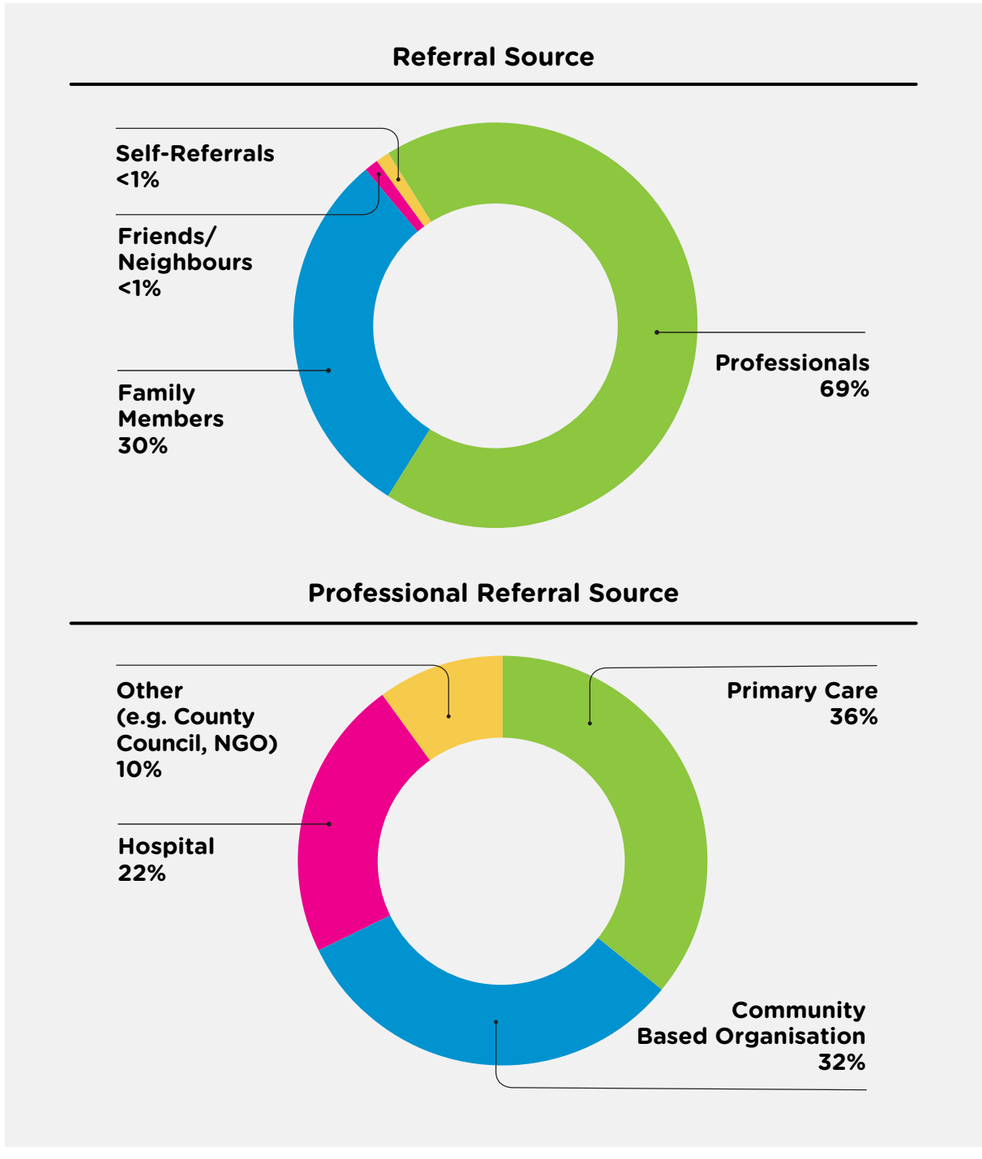
Descriptive analysis was conducted using SPSS, while Microsoft Excel was used to code qualitative responses to open-ended questions.

4. Referrer Surveys

Participant Profile

Participants were 227 individuals who had made at least one referral to ALONE between April 2022 and May 2024. Participants were from all 26 counties, with the majority from Dublin (20%), Cork (14%) and Donegal (12%). Most respondents (54%) reported that they had referred five or less people to ALONE in the past, with 14% reporting that they had referred more than ten individuals. Referral sources are detailed in **Figure 3**.

Figure 3. *Referrer Survey - Referral Sources*



Procedure

The survey was conducted online using Microsoft Forms. It was sent in June 2024 to 1,629 referrers who had made a referral to ALONE in the previous six months. One follow-up reminder email was sent, and 227 responses were received (14% response rate).

Survey Questions

The survey consisted of 11 questions (3 open ended and 8 closed questions). Questions focused on referrer profiles, awareness and satisfaction with the referral process, challenges faced, perceived outcomes for older people, and suggestions for improvement.

Analysis

Descriptive analysis was conducted using SPSS, while Microsoft Excel was used to code qualitative responses to open-ended questions.

5. Referrer Interviews

Participant Profile

Participants were 10 individuals who had referred to ALONE at least once between April 2022 and May 2024. Seven were professional referrals, two were family members, and one was a friend/neighbour. Most referrers had referred 1-5 people to ALONE, although two hospital-based professionals referred more than 10 people and one had referred 6-10. The referrers who took part in interviews came from seven different counties, providing some geographic differentiation.

Procedure

Referrers who took part in the referrer survey were invited to provide their contact details if they were open to being interviewed by a member of the project team. These individuals were stratified by referrer type (primary care professionals; community-based organisations; hospital staff; and family/friends) and 14 individuals were randomly selected and invited to participate. Ten interviews were conducted between July and September 2024 over Microsoft Teams.

Interview Questions

Structured interview guides were designed within the RE-AIM PRISM framework to obtain a deeper understanding of the experience each person had with the referral process. Guides were used flexibly with questions exploring engagement with ALONE, awareness of its services, experiences of referral, perceived impact on older people, and suggestions for improvement.

Analysis

Transcribed interviews were thematically analysed using qualitative analysis software, within a coding framework guided by key interview questions and structured using the RE-AIM PRISM framework.

6. Staff Interviews

Participant Profile

Participants were 14 staff members working in ALONE. Participants were stratified across geographic service locations and came from a variety of roles including Support Coordinators, Volunteer Support Officers, Service Managers, NSRL staff and members of the ALONE leadership team.

Procedure

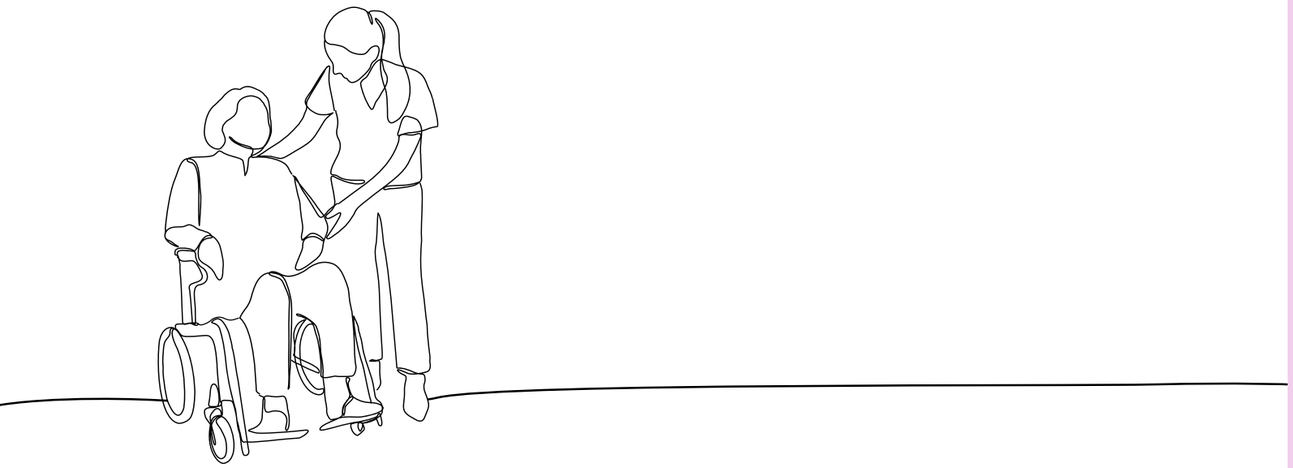
The Human Resources department at ALONE randomly selected 15 eligible staff members (in role for at least six months and not participating in any disciplinary or grievance investigations). A member of the project team invited these individuals to participate, and those who agreed were interviewed via Microsoft Teams between February and March 2025.

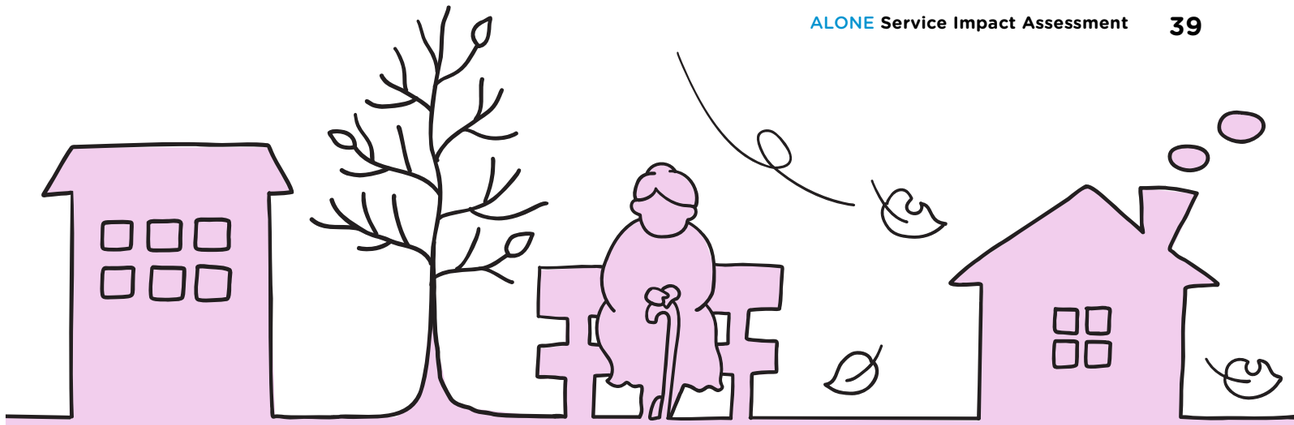
Interview Questions

Semi-structured interview guides were designed within the RE-AIM PRISM framework to explore implementation of the ALONE Service Model and how contextual factors affect its uptake, fidelity, and sustainability. Guides were used flexibly with questions covering role responsibilities, service reach and adoption, implementation of the ALONE model, internal supporting structures, perceived effectiveness, and views on sustainability.

Analysis

Transcribed interviews were thematically analysed using qualitative analysis software, within a coding framework guided by key interview questions, and structured using the RE-AIM PRISM framework.





Results

Objective 1. Evaluating the Impact of ALONE's Services on Older People

1a. Service Reach

As the table below shows, based on the latest Census data, ALONE services reached almost 2% of the total population of older people in Ireland in 2024.

Table 4. *Service Reach – ALONE 2024*

	HSE Dublin & Northeast	HSE Dublin & Midlands	HSE Dublin & Southeast	HSE Southwest	HSE Midwest	HSE West & Northwest	Total
Total population	1,187,082	1,077,639	971,093	740,614	413,059	759,652	5,149,139
Number of older people	332,383	282,341	286,472	239,959	134,657	259,801	1,535,614
Number of individuals supported by ALONE*	4,655	4,341	3,906	3,618	1,717	5,240	24,294

Source: ALONE End of Year ECC Report, 2024[11]. Note: Health region data were not available for some callers to ALONE's NSRL

The 273 individuals who completed surveys at Time 1 highlighted the typically complex and multi-faceted health challenges faced by older people receiving ALONE services. The vast majority (96%) reported taking daily medications and over two-thirds (70%) reported having more than one health condition (see **Figure 4**). Participants reported having a total of 654 conditions across over 20 different categories. The most common categories reported were high/low cholesterol (18%), cardiovascular issues (13%) and chronic pain (12%).

Figure 4. *Number of Conditions Reported by Participants (N = 273)*

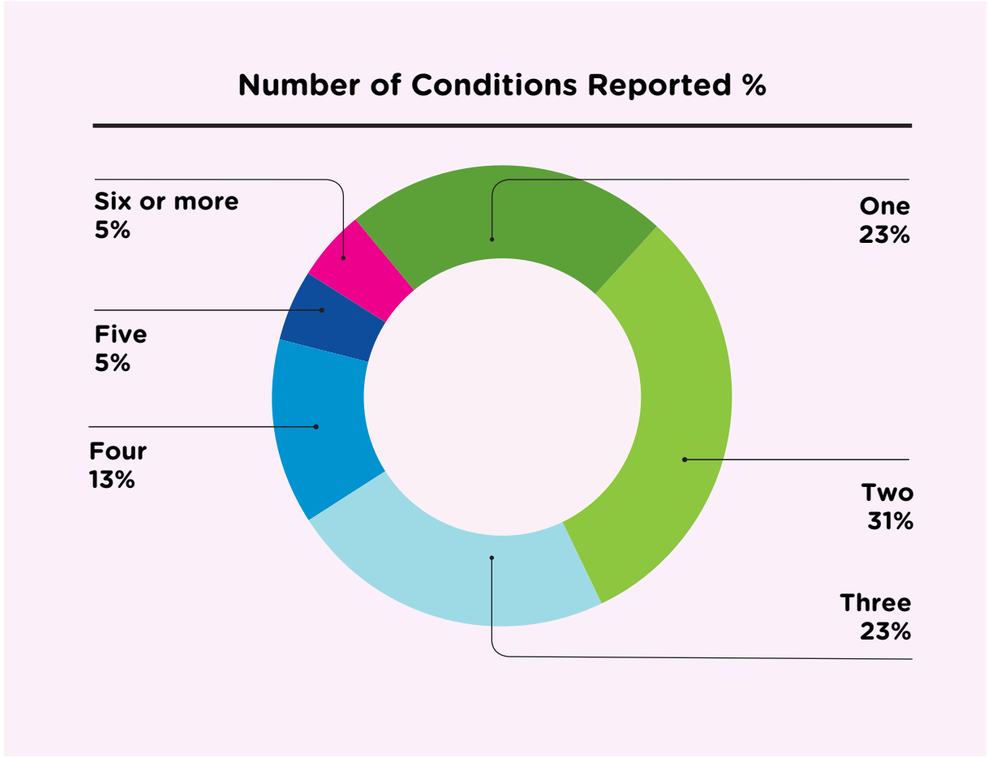


Table 5 on the following page shows the average levels of loneliness, wellbeing, self-reported health and primary care/acute service use for participants at Time 1. As this indicates, participants generally experienced higher levels of loneliness and lower levels of capability, quality of life, and self-reported health compared to older adults in the general population. While wellbeing scores were lower than those observed in some Scandinavian countries, they were broadly comparable to levels reported by older men and women in the UK. Additionally, participants reported more frequent visits to general practitioners, greater use of emergency services, and higher rates of hospital admissions.

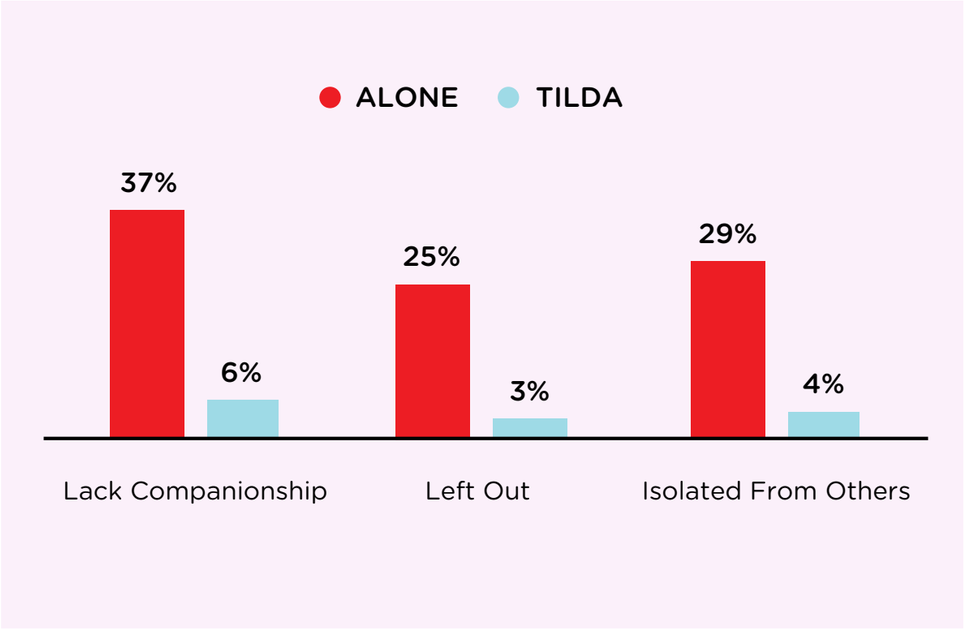
Table 5. Average Baseline Scores Compared to National and International Studies

Dimension	Measure	ALONE M (SD)	National M (SD)	International M (SD)
Loneliness	ULS-3	5.65 (2.1)	4.7 [24] 4.0 [25]	3.89 US [25]
Mental Wellbeing	SWEMWBS	23.7 (4.4)	Comparative data unavailable	23.59 – 24.26 UK [26] 27.4 Denmark [27] 26.8 Iceland [27]
Capability	ICECAP-O	0.68 (0.22)	Comparative data unavailable	0.83 UK* [28] 0.84 Australia [28]
Quality of Life	EQ-5D-5L	0.32 (0.42)	Comparative data unavailable	0.75 Europe [29]
Self-Reported Health	EQ5D-VAS	59.91 (22.7)	74+ for aged 55 & above [30]	71.2 Europe [31]
Health Service Use	GP Consultations per year	8.96	4.34 [32] 3.9 [33]	3.8 Sweden [34]
	A&E visits per year	1.92	0.27 [33]	0.43 US [35] 0.5 Sweden [34]
	Planned hospital admissions per year	1.36	0.28 [33]	0.3 Sweden [34]
	Unplanned hospital admissions per year	2.24		

As **Figure 5** shows, compared to data collected as part of the national Irish Longitudinal Study on Ageing (TILDA[1]), older people referred to ALONE were far more likely to often feel they lack companionship, feel left out, and isolated from others.

1 The authors of the TILDA study extracted the data from Wave 6 and provided it to ALONE for the purposes of this report.

Figure 5. Self-Reported Loneliness (%) for ALONE Participants Compared to Older Person National Average



Perception of Reach of ALONE Services

Overall, ALONE staff members felt that their work effectively reaches the older individuals who engage with their services. Several people noted that the organisation has grown and expanded significantly in the last number of years, with a growth in staff and volunteers throughout the country.

"I think with Support Coordinators in pretty much all of the areas... it's very well covered ... they are actually going out to the person's house and carrying out that assessment, and they're seeing a face"
- ALONE Staff Member

Improving Awareness and Understanding

Interviews with older people, referrers and staff indicated that while ALONE services effectively reach many older people, some of the most vulnerable and isolated - especially those not connected to formal support networks or community services - may remain unidentified.

"I suppose there's a lot of older people that don't reach our services.... If the professional isn't aware of them or if they don't go to the GP very frequently and if a professional isn't making that referral on their behalf, chances are they're not going to make a referral on their own behalf"
- ALONE Staff Member

Staff recognised that while ALONE's name recognition and service reach have grown - supported by increased staffing, a nationwide presence, and the introduction of the NSRL - further work is needed to strengthen awareness across the country.

Some staff members noted gaps in public understanding of ALONE's full range of services, with many only associating it with Visitation Support & Befriending. One professional referrer noted that only two or three out of ten patients they see were familiar with the organisation, necessitating detailed explanation of services. This was supported by the finding that some older people interviewed were unaware of the full range of ALONE services.

"They're not aware because Visitation Support & Befriending is only a small part of what ALONE offer; they have so many things they provide. And the older person they'll be surprised, you know, a lot of people think that it is only visitation"
- ALONE Staff Member

Consent and Engagement

Both older people and referrers highlighted challenges in encouraging older people to engage with ALONE, particularly in rural areas where pride, stigma, and a lack of local outreach were barriers. Referrers frequently encountered resistance from older individuals wishing to maintain their independence or who did not perceive themselves as needing help.

Obtaining consent was also noted as especially difficult when working with individuals with dementia or cognitive impairments.

"It can be difficult to get a dementia client to consent to something with a stranger over the phone"
– Professional Referrer

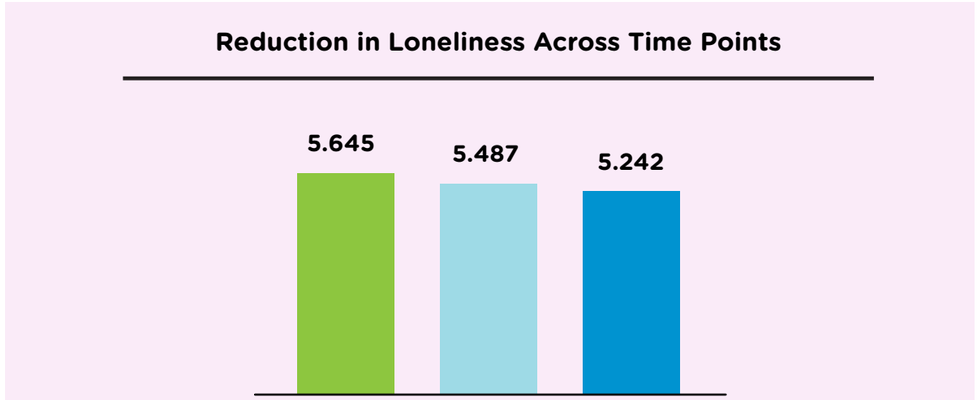
1b. Service Effectiveness

Quantitative Findings

Loneliness

The figure below shows that levels of loneliness reduced between baseline and three months, and between three and six months. This suggests that greater reductions in loneliness may be associated with longer duration of time engaged with ALONE services.

Figure 6. *Reduction in Loneliness Across Time Points*



Using repeated measures analysis of variance loneliness scores reduced statistically significantly over the 6 months, $F(2, 544) = 8.985$, $p = <0.001$. The mean reduction in loneliness between Time 1 and Time 3 as well as between Time 2 and 3 was statistically significant: mean reduction -0.403 (-0.639, -0.167) $p = <0.001$ and -0.245 (-0.482, -0.009) $p = 0.039$ respectively. There were no significant changes in loneliness between Time 1 and Time 2.

Table 6. *Pairwise Comparisons of Changes in Loneliness*

(I) Time	(J) Time	Mean Difference (I-J)	Std. Error	Sig.[b]	95% Confidence Interval for Difference[b]	
					Lower Bound	Upper Bound
1	2	.158	.091	.256	-.062	.377
	3	.403*	.098	<.001	.167	.639
3	1	-.403*	.098	<.001	-.639	-.167
	2	-.245*	.098	.039	-.482	-.009

Based on estimated marginal means. *The mean difference is significant at the .05 level. b. Adjustment for multiple comparisons: Bonferroni.

Subgroup analysis of participants in active receipt of Telephone or Visitation Support & Befriending also showed reduced loneliness between Time 1 and Time 3, $F(2, 66) = 4.95$, p=0.01, with a marginally greater mean reduction of -0.735.

Wellbeing

As the table below shows, there was little change in mean wellbeing scores at the three time points.

Table 7. *Mean SWEMWBS Scores at the Three Timepoints*

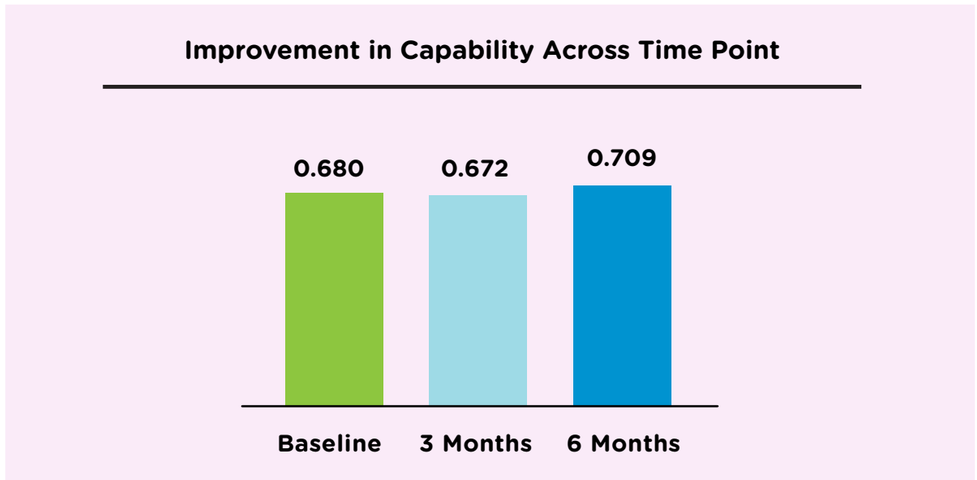
Time Period	N	Mean value	Std. Dev	Min	Max	Percentiles		
						25th	50th	75th
Baseline	273	23.659	4.363	12.40	35.00	20.73	24.11	26.53
3 months	273	23.734	4.224	13.33	35.00	20.73	23.21	26.02
6 months	273	23.680	4.092	14.08	35.00	20.73	24.11	26.02

Repeated measures analysis of variance indicated that there was no statistically significant difference in wellbeing scores over time, $F(2, 544) = 0.068$, $p = 0.935$. These results did not change when looking at the subgroup in active receipt of Support & Befriending services.

Capability

The figure below shows capability scores at the three time points. As this shows, capability scores improved at six months compared to baseline.

Figure 7. *Improvement in Capability Across Time Points*



Using repeated measures analysis of variance, capability scores improved statistically significantly over the six months, $F(1.893, 511) = 6.799$, $p = 0.002$.

The mean increase in capability between Time 2 and Time 3, as well as between Time 1 and 3, was statistically significant: mean difference 0.037 (0.014, 0.060) $p < 0.001$ and 0.029 (0.003, 0.055) $p = 0.022$ respectively. The magnitude of improvement is mainly between 3 month and 6 month follow up, suggesting that greater levels of improvement in capability may be associated with longer duration of time engaged with ALONE Services.

Table 8. *Pairwise Comparisons of Changes in Capability*

(I) Time	(J) Time	Mean Difference (I-J)	Std. Error	Sig.[b]	95% Confidence Interval for Difference[b]	
					Lower Bound	Upper Bound
1	2	0.008	0.012	1.000	-0.020	0.036
	3	-0.029*	0.011	0.022	-0.055	-0.003
3	1	0.029*	0.011	0.022	0.003	0.055
	2	0.037	0.009	<0.001	0.014	0.060

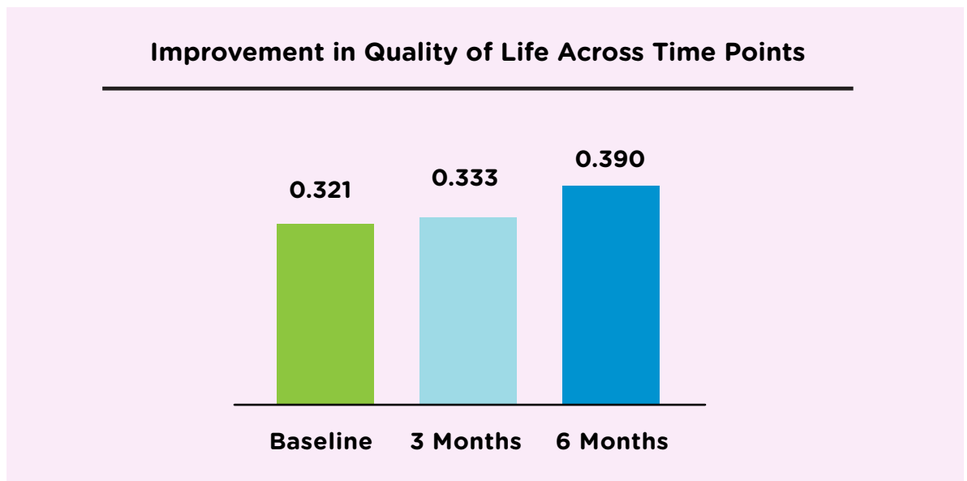
Based on estimated marginal means. *The mean difference is significant at the .05 level. b. Adjustment for multiple comparisons: Bonferroni.

Of note, participants in active receipt of Telephone or Visitation Support & Befriending (n=68) had greater marginal improvement in capability, $F(2, 66) = 6.075$, $p = 0.004$, with a mean increase of 0.067 capability points.

Quality of Life

The figure below shows that mean utility values for quality of life at the three time points improved between baseline and six months.

Figure 8. *Improvement in Quality of Life Across Time Points*



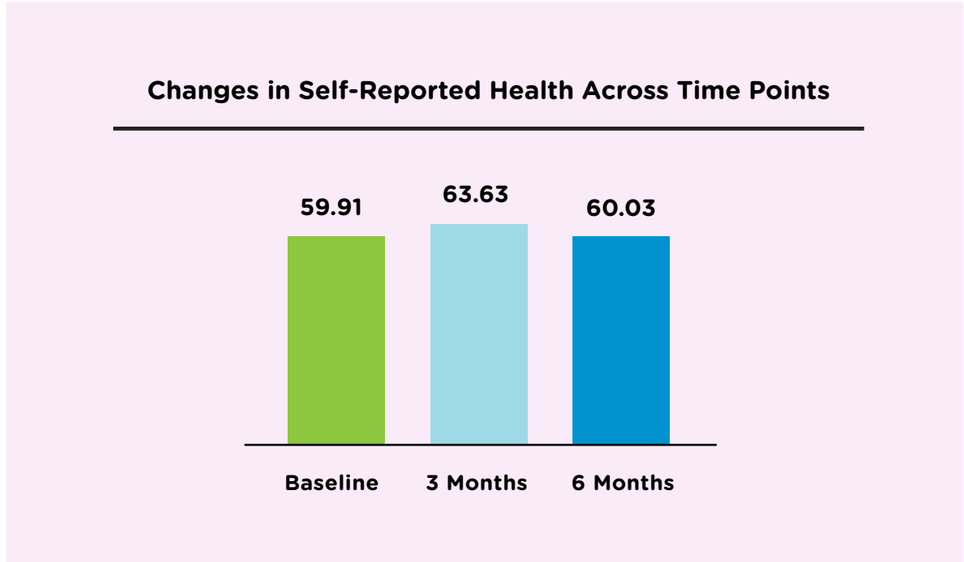
Changes in scores were examined with accelerated bootstrapping to approximate normally distributed datasets. There were no significant differences in quality of life scores between baseline and 3 months, but the increase in scores between baseline and 6 months is significant (mean difference 0.069, 0.029 – 0.109, $p < 0.001$). This is a small effect (Cohen's d = 0.198). The mean increase in quality of life scores between 3 and 6 months is also significant (mean difference 0.058, 0.024 – 0.090, $p = 0.003$). This is a small effect (Cohen's d = 0.204). This suggests that greater levels of improvement in quality of life may be associated with longer duration of time engaged with ALONE Services.

For the subsample of older people in active receipt of Telephone or Visitation Support & Befriending the mean improvement in quality of life between baseline and 6 months is also significant (mean difference 0.17, 0.074 – 0.269, $p = 0.002$). This is a small to medium size effect (Cohen's d = 0.394).

Self-Reported Health

The figure below shows mean self-reported health scores at the three time points.

Figure 9. *Changes in Self-Reported Health Across Time Points*



Using a repeated measures analysis of variance there were statistically significant changes in self-reported health, $F(1.949, 530.137) = 6.640$, $p = 0.002$; Greenhouse-Geisser adjustment. The mean increase in self-reported health between Time 1 and 2 was statistically significant, (mean difference 3.718 (1.026, 6.410), $p = 0.003$). However, the reduction in self-reported health between Time 2 and Time 3 was also significant (mean difference -3.593 (-6.254, -0.932), $p = 0.004$). From Time 1 to 3 there was no significant difference in self-reported health.

Table 9. *Pairwise Comparisons of Changes in Self-Rated Health Scores*

(I) Time	(J) Time	Mean Difference (I-J)	Std. Error	Sig.[b]	95% Confidence Interval for Difference[b]	
					Lower Bound	Upper Bound
1	2	-3.718*	1.118	.003	-6.410	-1.026
	3	-.125	1.249	1.000	-3.133	2.884
3	1	.125	1.249	1.000	-2.884	3.133
	2	-3.593*	1.105	.004	-6.254	-.932

Based on estimated marginal means. *The mean difference is significant at the .05 level. b. Adjustment for multiple comparisons: Bonferroni.

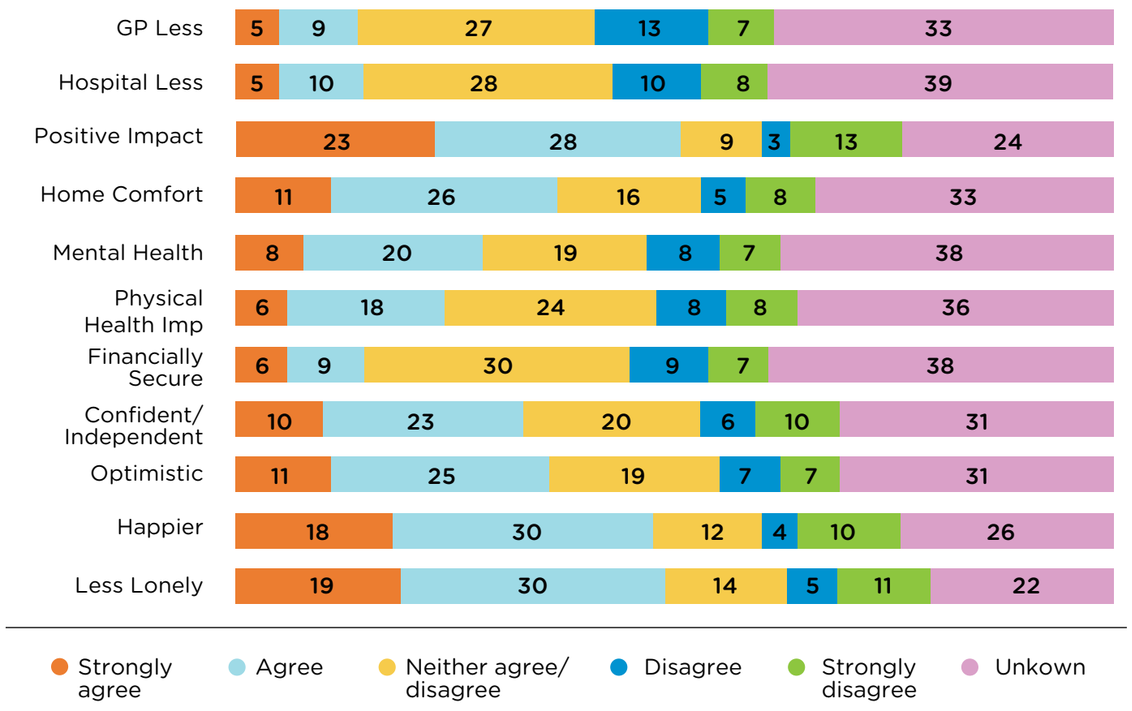
Stakeholder Perspectives

Looking to the feedback survey, most older people (70%) reported that the service provided by ALONE met their needs, with around half of respondents reporting an improvement in mood and a reduction in loneliness as a result of receiving support from ALONE.

"When the day is long and silent it is always nice with a phone call and an interesting talk to stimulate you intellectually" - Older Person

Approximately one-third of the participants reported heightened optimism, enhanced confidence and independence, and a more comfortable living environment. Moreover, 15% indicated an enhancement in their financial stability and/or a reduction in the reliance on hospital and GP services following engagement with ALONE (see **Figure 10** for full breakdown).

Figure 10. *Self-Reported Perceived Impact of ALONE Services (%)*



From a referrer perspective, 62% of referrers noticed positive changes or improvements in the older people they referred to ALONE. Moreover, 78% felt ALONE services had a positive impact on the lives of older people and 83% would recommend them to others.

Qualitative Findings

Many older people who were interviewed reported that support from ALONE had a significant positive impact on their quality of life, especially through alleviating loneliness and isolation.

> *"I live alone, and I appreciate my weekly phone calls from ALONE. The callers are always friendly and interesting, and they make me feel better" - Older Person*

Interviewees reported that the regular interaction offers meaningful social connection and helps structure daily life with many participants sharing how much of a difference the support makes. Strong bonds often form between older people and volunteers, with some even considering them part of their extended family and repeatedly highlighting the value of regular conversation in improving their mental health.

> *It makes a difference, I'm not that kind of a needy person, not really, but I look forward to the visits. She's a lovely girl, and we get on very well" - Older Person*

This sentiment was echoed by those who noted that even initiating the referral process could bring a sense of hope to those feeling isolated.

> *"The older people I've referred have expressed their gratitude. They feel less isolated and more connected to the community" - Professional Referrer*

ALONE staff also spoke about how they observed older people gain confidence once engaged with ALONE services.

> *"People gaining an awful lot of confidence back ... actually just saying, I'm having a problem with this to a Support Coordinator... so confidence comes back straight away" - ALONE Staff Member*

Value of Types of Support

Referrers observed how practical support (e.g. form completion, technology use, household tasks) enables older people to maintain independence at home. Older people valued practical assistance, which helped them feel remembered, cared for, and empowered, especially following hospital stays or during challenging periods.

> *"It makes you feel important. Someone's thinking of you... a group of people, society ...cares enough about people to reach out and help them" - Older Person*

Many older people highlighted the importance of support during Christmas, while ALONE staff also noted technology as another key form of support.

> *"There was one lady and she was ... able to see her grandkids on a regular basis through the Alexa. All she had to do was say Alexa call ... her daughter... She didn't have to move.. I think it blew their minds that stuff like that was even available" - ALONE Staff Member*

Desire for More Support

While volunteer visits and calls were appreciated, some older people expressed a desire for more frequent support.

> *"I see absolutely nobody for the whole week. I go to town on a Thursday, I get my pension... I might have a chat in the street. That's it, come home, back to the same thing ... when you're on your own, your head goes into yourself" - Older Person*

Older people also expressed how much they enjoyed simply getting out of the house when it was possible.

> *"Yes, it is lovely, because I really get out... like that for a cup of coffee. The lady that comes now, she's very, very good, you know" - Older Person*

1c. Health Service Resource Utilisation and Cost Analysis

Table 10 on the following page displays the average health service of participants use over the three time periods. As this shows, contact with GPs is high among older people at all three time points, while there is lower use of other community services. Notably, this shows emergency calls and visits, and use of community healthcare services were significantly lower at 6 months. This means there may be an association between receiving ALONE services and reductions in the use of these healthcare services. There was also a significant reduction in GP contacts at 3 months.

Table 11 shows total mean costs for different types of health service use across the three time periods, while changes in mean costs between the three time periods are shown in **Table 12**. Using a parametric bootstrapping approach, total costs at both the 3-month (-€729) and 6-month (-€741) follow-ups are lower compared to baseline; however, these reductions are not statistically significant and are primarily attributed to a decrease in planned hospital admissions.

However, as **Table 12** shows, the costs of all community related services (including GP contacts) are significantly lower at 6 months, mean difference €67 (95% CI €22 – €122) p = 0.023. The costs of visits to hospital emergency departments were also significantly lower at 6 months, mean difference €67 (95% CI €30 – €109), p = 0.010.

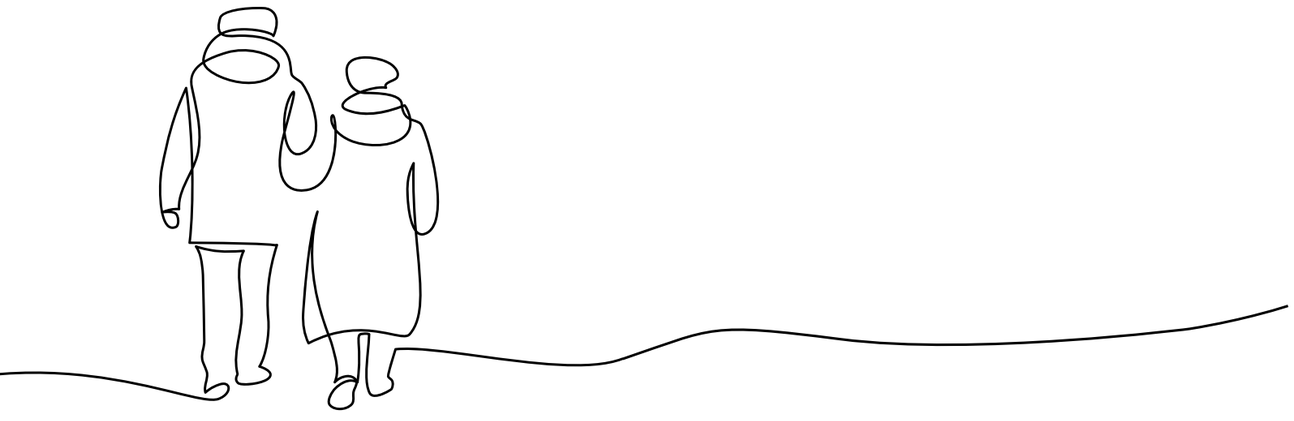


Table 10. *Changes in Health Care Service Use Between Baseline and 6 Months*

Service	Mean 1	Mean 2	Mean 3	Mean Difference 2-1	p	Mean Difference 3-2	p	Mean Difference 3-1	p
GP (Consultations)	2.24	1.92	2.08	-0.32	0.021*	0.16	0.226	-0.16	0.261
Community Healthcare Services[1]	0.46	0.28	0.14	-0.18	0.103	0.14	0.002**	-0.32	0.009**
Calling A&E	0.32	0.20	0.23	-0.12	0.004**	0.03	0.312	-0.09	0.021*
Visiting Emergency Dept	0.48	0.27	0.28	-0.21	0.011*	0.01	0.731	-0.19	0.009**
Outpatient Visit	1.10	1.01	1.22	-0.08	0.582	0.20	0.611	0.12	0.710
Planned Admissions	0.34	0.20	0.13	-0.14	0.032*	-0.07	0.226	-0.21	0.011*
Planned Nights	0.91	0.49	0.48	-0.41	0.408	-0.02	0.902	-0.43	0.395
Unplanned Admissions	0.35	0.29	0.27	-0.07	0.186	-0.02	0.696	-0.08	0.161
Unplanned Nights	2.45	2.37	2.36	-0.08	0.883	-0.02	0.972	-0.10	0.883

[1] Refers to general community healthcare service utilisation where the type (e.g. physiotherapist, occupational therapist, optician etc) was unspecified by the respondent

* difference is significant at p < .05

** difference is significant at p < .01

Table 11. Health Service Costs

	N	Min	Max	Mean	Std. Deviation
Baseline					
Community	273	€0	€4,732	€281	422
Hospital Emergency Department	273	€0	€4,154	€165	438
Hospital Outpatient	273	€0	€2,381	€217	334
Planned Hospital Stay	273	€0	€107,550	€1,086	7,133
Unplanned Hospital Stay	273	€0	€66,920	€2,928	9,612
Total Cost	273	€0	€107,550	€4,678	11,810
3 Months					
Community	273	€0	€1,346	€226	260
Hospital Emergency Department	273	€0	€4,154	€94	321
Hospital Outpatient	273	€0	€4,762	€201	418
Planned Hospital Stay	273	€0	€33,460	€591	3,074
Unplanned Hospital Stay	273	€0	€72,895	€2,836	9,620
Total Cost	273	€0	€72,955	€3,949	10,135
6 months					
Community	273	€0	€1,651	€214	253
Hospital Emergency Department	273	€0	€4,154	€98	323
Hospital Outpatient	273	€0	€21,826	€241	1,347
Planned Hospital Stay	273	€0	€33,460	€569	3,294
Unplanned Hospital Stay	273	€0	€100,380	€2,815	10,174
Total Cost	273	€0	€101,943	€3,937	10,784

Table 12. Changes in Health Care Costs Between Baseline and 6 Months

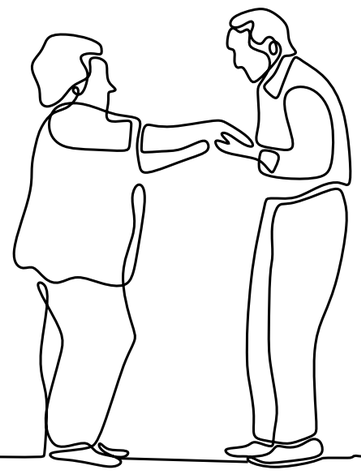
Service	Mean 1	Mean 2	Mean 3	Mean Difference 2-1	P	Mean Difference 3-2	P	Mean Difference 3-1	P
Community	€281	€226	€214	-€55	0.041*	-€12	0.396	-€67	0.023*
Emergency Dept	€165	€94	€98	-€71	0.011*	€4	0.697	-€67	0.010**
Planned Hospital Visits	€217	€201	€241	-€16	0.569	-€22	0.610	€24	0.698
All Outpatient	€382	€295	€339	-€87	0.013*	€43	0.589	-€43	0.626
Planned Hospital Stays	€1086	€591	€569	-€495	0.395	-€22	0.905	-€517	0.372
Unplanned Hospital Stays	€2,928	€2,836	€2,815	-€92	0.872	-€22	0.968	-€114	0.892
All Inpatient	€4,014	€3,427	€3,384	-€587	0.441	-€44	0.933	-€630	0.478
All Costs	€4,678	€3,949	€3,937	-€729	0.339	-€12	0.990	-€741	0.385

*difference is significant at $p < .05$

**difference is significant at $p = .01$

A generalised linear regression model with gamma family and log link function was used to examine potential factors that influenced total costs incurred between baseline and six month follow up. The model considered the impact of baseline costs, whether individuals were or were not active with Telephone and/or Visitation Support & Befriending services, lived alone and owned their own homes. It also looked at age and gender. In building the model, baseline capability and wellbeing scores were also examined, but these were not significant and to be parsimonious were not included in the best fit model. The model with best fit found several factors to be associated with these costs.

Analysis showed that being male and having poorer quality of life at baseline were significantly associated with higher expected health service utilisation costs at 6 months ($p = 0.006$ and $p < 0.001$ respectively). In contrast, higher levels of loneliness at baseline were associated with lower costs at six months ($p < 0.001$).



Objective 2. Exploring Implementation of the ALONE Service Model

2a. Adoption

Strong Referrer Engagement

Referrer surveys and interviews revealed strong engagement with ALONE's service model, with high levels of satisfaction and a clear intention to continue referring. Most referrers found the process easy (90%), were satisfied overall (88%), and intended to keep referring (87%), citing the organisation's effectiveness in addressing social isolation and supporting older people's independence.

ALONE's integration within the wider healthcare system was seen as valuable, and the professionalism and compassion of staff were consistently praised. The majority expressed appreciation for the service, with 83% recommending ALONE to others.

"I have found the service ALONE have offered to my patients to be exceptional. I am always recommending ALONE to colleagues. It is also great to have such a timely response to any referrals I have sent in. I think it is an invaluable service that is being offered and highly appreciate and recommend it" – Professional Referrer

A Need for Increased Awareness

Looking to referrer surveys, while 80% of respondents felt fully informed about ALONE services, only 60% agreed that there is good awareness of ALONE amongst other stakeholders. Similarly, ALONE staff perceived that often referrers lack a comprehensive understanding of what ALONE offers.

"We had a representative from ALONE come to one of our meetings... to kind of give us a low down of exactly what this is, what services you offer, how to refer, and everything like that. So definitely since that meeting, I've referred a lot more people than I would have done previously" – Professional Referrer

Referral Process Challenges

Some referrers identified opportunities to improve communication and consistency in the referral process, including clearer follow-up practices, timely updates, and confirmation emails to support better continuity of care.

2b. Implementation

Several factors were described as contributing to the successful rollout of ALONE services, as outlined below.

Volunteer Preparedness and Engagement

Volunteers were identified as playing a vital role in ALONE's work and contributing significantly to the organisation's success. Their flexibility and commitment were widely praised, with many volunteers reporting a deep sense of purpose and personal growth.

> *"There's really no estimation on the value of volunteers because we simply would not have a telephone service without them" - ALONE Staff Member*

Appropriate volunteer matching emerged as critical to ensuring preparedness. Aligning volunteers' availability, experience, and resilience with the needs of older people was seen to enhance service consistency and volunteer satisfaction.

> *"I do the checks. I put my information in the system where I'd say look, a really experienced volunteer who has a lot of experience, maybe with dementia, what type of older person they would be suited to be matched with. Or if they're a young or first-time volunteer, I would put down they should be matched with someone low risk initially" - ALONE Staff Member*

Staff noted that inconsistent availability was a key challenge of relying heavily on volunteers, who typically contributed one to four hours per week, primarily through social interactions, and highlighted the need for greater recognition of their contributions and sufficient support.

Person-centred Support

ALONE staff consistently emphasised the importance of a person-centred, adaptable approach to delivering meaningful support. Staff shared practical examples of tailoring communication and engagement to meet individual needs, often going beyond their formal roles out of a strong sense of care for the older people and volunteers they support. Maintaining the human element - through compassionate communication, emotional safety, and the principle of "do no harm" - was viewed as crucial to upholding service quality and ALONE's ethos.

> *"So, it was nice just to kind of get her just laughing. And she's a regular caller and she's very down and very anxious about everything. And you know, so it's just to kind of have a nice soft conversation with her just to see how she's getting on" - ALONE Staff Member*

Indeed, many older people spoke highly of the staff and volunteers, praising their reliability and helpfulness and emphasising that they felt respected and cared for.

> *"My Support Coordinator has been extremely helpful and caring, going out of their way to assist me with a couple of issues, and very generous with their time. For me, it means I now have a safety net" - Older Person*

Referrers echoed these views, noting that ALONE staff frequently exceeded expectations with thorough assessments, practical support, and a professional, caring approach that led to tangible improvements in older people's wellbeing. Family referrers particularly valued the responsiveness and holistic nature of the service, highlighting the greater effectiveness of in-person support for fully understanding household conditions and providing comprehensive help.

> *"Absolutely. I am so impressed and so delighted...always above and beyond even my expectations in relation to the service that I have been given by the organisation over the last number of years, I cannot say enough good things about ALONE" - Professional Referrer*

At the same time, staff emphasised the importance of maintaining high-quality, person-centred care while managing growing service demands.

"We need to start thinking about if we're going to continue to grow... we need to start looking at trying to get funding for additional staff because we'll get to a point where it'll impact the service offering" - ALONE Staff Member

Flexibility vs. Fidelity to Service Model

Staff interviews reflected a high level of fidelity to ALONE's service model, with clear structures and processes guiding their work. Most staff expressed a shared commitment to aligning with organisational objectives and following established procedures, recognising the importance of consistency and clarity in delivering services.

"My day-to-day involves supporting the staff team to make sure that they are supporting older people as per ALONE's mission and vision" - ALONE Staff Member

While core processes were generally respected, staff acknowledged the need to balance fidelity with allowing room for responsive, thoughtful adaptation in practice. The degree of adaptability required varied depending on role, team, and context. It was emphasised that the ultimate priority should be the benefit to older people and the organisation.

"Generally, if it's something to the benefit of the older people and our services, if it's a proven benefit then you know that would automatically prioritise it.... it's really about prioritising it for sensible reasons. But then we have to work it into what our business as usual" - ALONE Staff Member

2c. Contextual Factors

Several factors that impact the success of implementation of ALONE's services were described by staff and older people.

Communications

Internal communication was a recurring theme in staff interviews, with many acknowledging current strengths and continuous improvement efforts. While several teams reported effective communication practices, staff noted there is still room to enhance communication, both internally and with professionals in other organisations.

"I've had one situation in particular... I should have been alerted to risk factors before I went" - ALONE Staff Member

Staff also noted that communication in remote or lone working contexts can be more difficult. Despite these challenges, staff expressed optimism that with continued focus, communication can be a key enabler of effective and safe service provision.

External communication was also seen as vital to ALONE's work, supporting engagement with referrers, the public, volunteers, and older people. Interviews indicated that ALONE has a strong reputation, bolstered by word of mouth and informal feedback.

"I think our reputation in the community is exceedingly good because we've volunteers coming in who say... my mum had a service from ALONE or my friend volunteers with ALONE. So, word of mouth is really important. I think that successes are based around the older people and the stories you hear and the anecdotes you come across" - ALONE Staff Member

Staff Attitudes

Staff interviewed generally viewed their roles within ALONE positively, appreciating the autonomy and strong peer support. Many expressed high levels of job satisfaction and a sense of purpose, especially through activities like engaging with older people, volunteers, and external agencies, as well as contributing to policy and advocacy work.

"So that's the part of the job I love the most. I love engagement. ... I love when we get quite tricky cases because I like that kind of work.... the satisfaction that I get then when we can support is huge" - ALONE Staff Member

Although some challenges were noted such as resource limitations, training and staff retention, most interviewees felt proud to be part of an organisation making a meaningful impact.

External Partnerships

Interviewees highlighted the importance of strong relationships with external agencies in supporting ALONE's work and suggested that more could be done to strengthen these links - such as inviting organisations to present to ALONE staff and dedicating a role to manage external partnerships.

Partnerships with other organisations was viewed as critical by older people, who had experienced challenges accessing services and found ALONE support useful in navigating local systems. For example, one interviewee was extremely complimentary of the support received from an ALONE Support Coordinator following an extended hospital stay.

"She knew how to get in touch with people that I would struggle to contact. Especially the HSE. She knew everybody in there – trying to get the carers in place and so on. And if I wasn't getting what I needed, she used to rattle the cage" - Older Person

Risk Management Procedures

Interviewees acknowledged that ALONE's work involves inherent risks for older people, staff, and volunteers, making effective policies and procedures for risk management essential. While current procedures were generally seen as strong, areas of focus for mitigation were identified. For instance, maintaining continuity when volunteers disengage and safeguarding lone workers and volunteers, especially in complex or high-risk situations, was described.

"There are a handful of cases where there's alcohol involved or there is serious family dynamics that they would, you know, you have to put the volunteer safeguarding in place as well" - ALONE Staff Member

Internal Resources

ALONE's management structure was seen as having several strengths, particularly the positive impact of strong personal relationships. ALONE staff highlighted the value of existing tools and systems, while also identifying areas for improvement, particularly in onboarding, local knowledge sharing, and access to resources. While technology and platforms like ALONE's MIS were seen as helpful, challenges such as delays in accessing materials and limited in-person training were noted.

"I would have loved somebody to hand me a directory, an encyclopaedia, a how to guide to be like practically on the ground. Like if somebody has this issue / difficulty / question / query this is where you go. Because sometimes it takes you so much work. And so much effort for it, and it is time consuming when you come across something that you haven't come across before trying to figure out how to get to the bottom of that" - ALONE Staff Member

Discussion

This report presents findings from the national impact assessment of ALONE's services, offering valuable insights into their impact on older people's wellbeing, quality of life (including self-rated health), loneliness, and use of healthcare services. Given the limited evidence available both in Ireland and internationally on the effectiveness of support coordination and community-based services for older people, these findings make an important contribution to this sector.

Compared to the wider population, older people supported by ALONE experience greater levels of loneliness, reduced wellbeing, lower self-rated health, and increased reliance on health services – underscoring the vulnerability of this group. Nevertheless, this evaluation provides evidence suggesting a potential link between receiving ALONE services and improvements across multiple outcomes. Clear improvements were observed in loneliness, quality of life, and a sense of personal capability among those receiving support. Older adults engaged in ALONE's Support & Befriending services showed greater gains in several of these areas.

Feedback from older people consistently emphasised the value of having someone to talk to, practical support when needed, and a sense of being seen and cared for. The relationships built with ALONE staff and volunteers were frequently described as transformative, offering not only companionship but also reassurance, stability, and hope. Similarly, referrers and ALONE staff noted visible improvements in the confidence, independence, and outlook of the older people they had connected with ALONE.

The evaluation also highlights how ALONE's model supports not only individuals, but the broader health system. Reduced use of emergency services suggests that timely, community-based support can prevent crises and enable older people to manage their needs more effectively at home. There was also a decrease in the use of other community health services, which may indicate that people are turning to ALONE to get the help they need. These findings are particularly relevant within the context of the HSE's ECC programme and national strategies to shift care into community settings.

Although there were no significant differences in overall costs between the three time points, in a population where health care costs can be expected to increase over time this could be considered a positive outcome. Additionally, analysis revealed that poorer quality of life at the start of support was linked to higher healthcare costs at follow-up, while higher levels of loneliness were associated with lower costs. This may suggest that more isolated individuals are less likely to seek help from the health system, further reinforcing the importance of outreach and proactive engagement.

Implementation of the ALONE service model was shown to be both robust and responsive. While staff and stakeholders identified areas for improvement, the overall delivery of services reflected a deep commitment to person-centred care. Staff and volunteers consistently demonstrated compassion, professionalism, and flexibility, ensuring that individual needs were met without compromising service quality. The organisation's culture of care was evident in the way teams adapt to meet individual needs while maintaining service quality and integrity. Referrers expressed high satisfaction with the referral process, with adoption high among professional referrers.

Conclusion

In 2024, ALONE supported almost 44,000 older people across its services. Through rigorous analysis, this project has demonstrated the profound impact of ALONE's services to older people and the wider health system. These positive findings provide a strong foundation for continued investment in and expansion of ALONE's integrated support model.

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